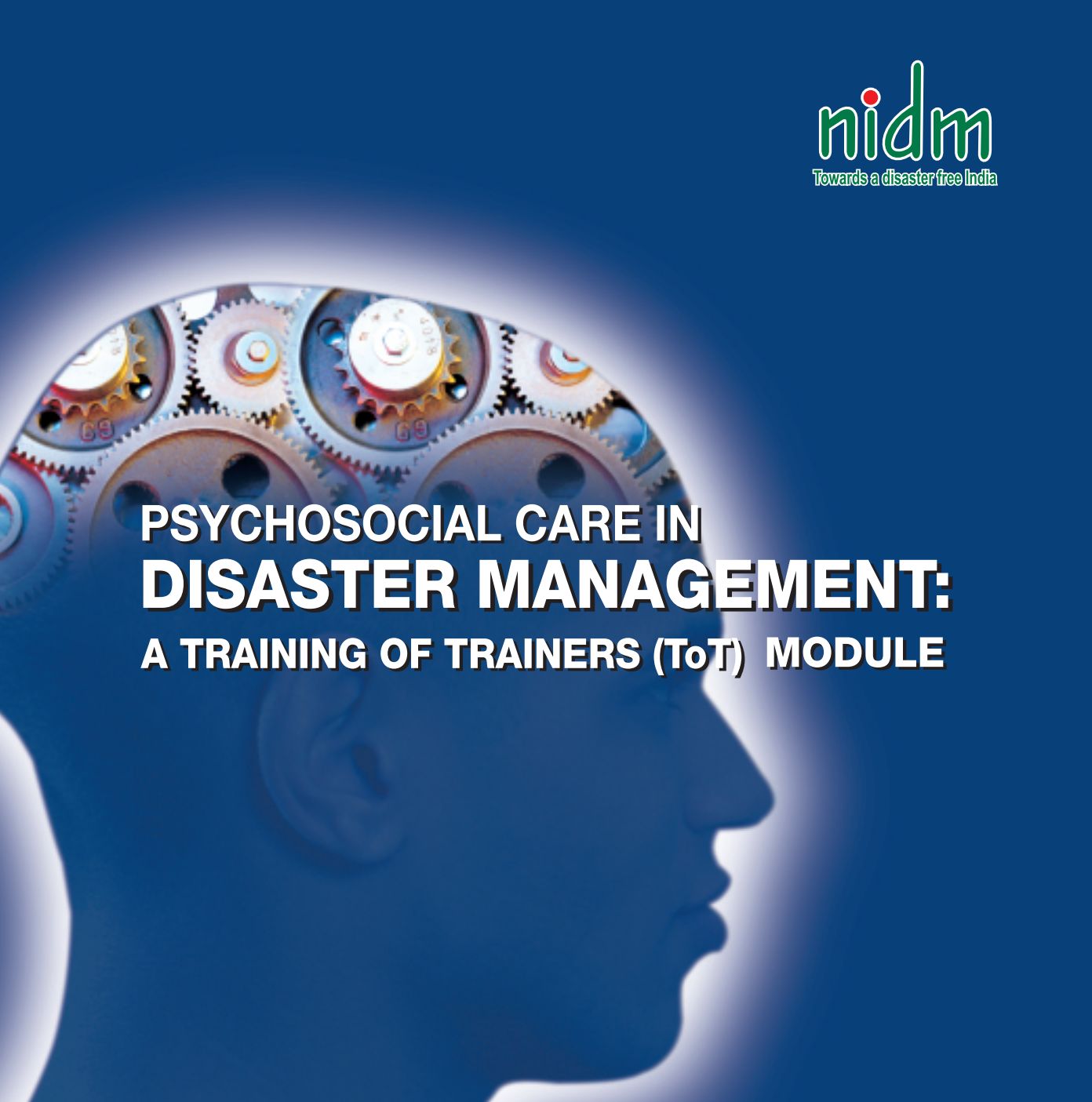




PSYCHOSOCIAL CARE IN DISASTER MANAGEMENT: A TRAINING OF TRAINERS (ToT) MODULE



**NATIONAL INSTITUTE OF DISASTER MANAGEMENT
MINISTRY OF HOME AFFAIRS, NEW DELHI**

PSYCHOSOCIAL CARE IN DISASTER MANAGEMENT: A TRAINING OF TRAINERS (ToT) MODULE

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ToT MODULE-PSS in DM Series -1

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MODULE AT A GLANCE.....

- » **Name:** ToT on Disaster Psychosocial Support
- » **Developed by:** National Institute of Disaster Management (NIDM)
- » **Technical Support:** National Institute of Mental Health & Neuro Sciences (NIMHANS)
- » **Total no. of sub-modules:** Six
- » **Target Audience:** Non-Medicos from Multiple Sectors
- » **Training Programme on the basis of this Module requires:**
 - › No. of Training Days: 5 Working Days
 - › No. of Training Hours: 27-30 hours
 - › No. of Trainers required: A minimum of Two
 - › Type of Training Hall: Should have movable chairs and tables
 - › Sitting Arrangements: Semi circular
 - › All Training Materials as Mentioned
- » **No. of Total Pages-** 106 excluding annexure/handouts

Foreword

Every disaster, natural or manmade, results in deaths and injuries, damages and destructions, which are always visible. What is not so visible are the mental agony, trauma and stress of the survivors who have suffered losses of their near and dear or sustained damages of their assets and property. Often such invisible impacts of disasters escape the notices of decision makers till the mental health patients crowd the hospitals or suicide rates go up. Often such distress has continued for years after the physical damages have been restored and reconstructed. Early recognition and counseling could have prevented many such prolonged agonies.

Belated though it is there has been recognition of the need and importance of psychosocial counseling immediately after disaster. Often the numbers that need such counseling are far beyond the capacity of available mental health experts. This has encouraged innovative research and practices on community based psycho-social counseling by which the simple tools and techniques of counseling can be taught to the community workers and other local level functionaries. In order that such trainings can be imparted in a scientific and systematic manner, a critical mass of trainers have to be trained with the concepts, methods and techniques of counseling.

The National Institute of Disaster Management (NIDM) which is the apex body created by an Act of Parliament for training, capacity building, research and documentation on disaster management has conducted six such Training of Trainers (ToT) programmes on post-disaster psycho-social care during the past two years. Based on the experiences gained in these programmes, a Training of Trainer's module has been developed in consultation with the experts of the National Institute of Mental Health and Neuro Sciences Bangalore and further reviewed by experts on the subject.

In this module an effort has been made to introduce the various concepts and practices on disaster psychosocial care in a systematic manner for a five-day training programme. This document would provide general as well as specific guidelines for the trainers to carry out the training programme without much external assistance.

I thank Dr. Sujata Satapathy Assistant Professor of the Institute who conducted all the ToT programmes and developed this module almost single handedly. The participants who attended the programmes provided valuable feedback on the relevance and effectiveness of its contents and methodology. I sincerely thank them all. I thank the reviewers for their valuable inputs to improve the shape of the module.

P G Dhar Chakrabarti, IAS
Executive Director
NIDM

An Introduction to the Module

The aim of any training is to transfer knowledge and skills to one or more specific target groups of trainees on a particular subject area, which is relevant to their job performance, so that work efficiency would be improved. For this purpose, training manual and modules, which contain basic texts, model forms, pictographs, illustrations, short handouts, and notes for facilitators/trainers are used. Sometimes these two are used interchangeably. While it is difficult to make a clear distinction regarding which is more appropriate and useful, training module is a document, which includes the contents of a training manual along with the details of methodology, hence perhaps is broader in scope of application and expected outcomes.

Moreover, these two could differ in terms of their purpose, readers/client profile, design, style and extent of presentation of contents, expected outcomes from the readers/participants/clients, and evaluation methods and indicators. Training module is primarily more helpful to people/organizations, which are directly involved in training activities. Even a general training module and a training of trainers' module may also look different in terms of these above-mentioned indicators. However, both the general and ToT modules can be written on the basis of theme and sub-themes, day-specific subject areas, session-specific topics, specific target audience, institution specific formats. Nevertheless, the extent of imparting knowledge, skills and attitudes will vary in both the modules along with the methodologies.

As compared to a general training module, a ToT module is simpler; more self explanatory, flexible with experimenting learning methodologies, and participatory (learners' driven teaching-learning environment); highly structured with interdependent sequential themes; and puts less emphasis on the extent of reading materials provided inside the module. The structure of any ToT module is generally very much author or institution specific. One of the generally followed formats/styles of writing of a training module includes headings such as, context & description of the unit/session or sub-module/day (depending upon the type of module), which may vary in size from unit to unit depending on the need of elaboration (seeing the participants profile), learning objectives, methods of delivery of the contents, duration of the session, training materials & equipments required, teaching/performance aids, trainer's note, and session plan.

This training of trainers' module on disaster psychosocial care is a five-day module that focuses on providing the necessary and adequate knowledge and skills on the subject to persons working in the disaster management and related departments. After the training if the person can conduct/facilitate three other programmes at the state or district level

he/she can be called a master trainer on disaster psychosocial care. Apart from the professional implications, this module should help a trainee to rejuvenate his/her self-development and coping abilities to handle daily life stressors in more effective manner.

The module has a total of six sub-modules and each sub-module has few (two-seven) learning units on the basis of which programme sessions have been designed. A programme schedule has also been annexed for ready reference. The module is explicitly self-explanatory.

The ratio of lecture/power point presentation and other methods mentioned in training design brief is 30:70. The module prepared by NIDM has been extensively modified and adapted from the basic six day ToT manual developed by National Institute of Mental Health and Neuro Sciences (NIMHANS). Since, NIDM trains predominantly people from government sector and the responsibility and job profile of these people are somewhat different from people in non-government sectors, it was considered necessary to modify and adapt the module to match with the needs of the target trainees. The module has been modified and finalised on the basis of experience during six programmes conducted by NIDM over a period of two years on disaster psychosocial care for the target groups mentioned below. The module needs to be used with the ToT Workbook developed by NIMHANS.

The module is finalised and published after a peer review by professionals from premier institutions working in this area. This module can be considered as a **standard 5-day ToT module on disaster psychosocial care for non-medical professionals**. This should be applicable to people between 20-50 years of age irrespective of culture, religion, area of residence, sex, and sector of work. The module has an all-hazard approach and discusses all types of disasters and all vulnerable groups in a disaster.

NIDM acknowledges the valuable support provided by all resource persons and institutes, especially, the NIMHANS for providing technical inputs in the module at various stages of preparation.

Author

Who shall use this Module?

This module shall ideally be used /guided by a person who has already undergone the training or a trainer or a person involved in conducting training programmes. However, the module should be seen as self-explanatory and complete, so that a new person can use it effectively. The following organisations/people are the potential user of this ToT module on disaster psychosocial care.

- » Department of disaster management, health, women and child development, social welfare, rural development, education, and panchayati raj
- » State Administrative Training Institutes (ATIs) and other training institutes in the above-mentioned departments
- » People working in NGOs/CBOs and faith based organisations
- » Social workers
- » Volunteers in NSS, NYKS, NCC
- » NDRF and first responders teams

How to use the Module

The chapter on ToT module design brief will be an introductory chapter, which will provide the users the objectives of the module, target audience, basic structure and emphasis of the module, training methodologies and other information regarding the module.

The chapter on pre and post training assessments will guide on how to carry out evaluation and impact assessment of the programme with the set of questionnaires to be used and other necessary details.

The actual technical sessions of the training start from then on wards as per the sub-modules provided in the contents. However, this would be done in an elaborate manner during each session or by combining few continuing session with proper facilitating guidelines.

Contents will be provided session wise and the trainer/s can proceed day wise as per the suggested programme schedule given in Annexure.

Although the submodules do not describe sessions such as inauguration, valediction, manual review, recapitulation, feedback, etc, the total duration of a submodule includes the time taken to conduct these sessions. It is reflected in the suggested programme schedule. The purpose of doing this is to provide little flexibility to the trainers to arrange or plan sessions daily as per their convenience or institutes' protocol.

Trainers Guide

The trainer/facilitator or the programme director may find the following tips useful for the smooth running of the programme.

General

1. During the inauguration/introduction session, the trainees should be asked to put their mobiles/cell phones in silent mode and suggested that in case they get an urgent call they should go out to receive the call and join back the session. They should also be asked to take prior permission with valid reasons, if they are to miss a session in between.
2. All group activities should be photographed and be shown after the training sessions are over everyday (if possible & convenient)
3. A group photograph should be taken on day-2 or 3, and so that the print out is given to the trainees with the certificate.
4. Participants list with name, designation, address, contact numbers and e-mails should be circulated at least thrice during the training before the final printout is brought out for circulating along with certificate and photograph. One copy is to be circulated, so that all of them can make necessary corrections on that and give the same back to the trainer/programme director.
5. All the training materials and equipments should be kept ready before the training.
6. The trainees should be informed about the duration of lunch and tea break and other group activities clearly every time. They should also be told about the time when the next day starts.
7. It is important to mention here that the duration of each session specified in various sub modules may vary from the actual duration of the session while conducting the training programme, depending upon the number of trainees participating in the programme. As most of the sessions are very much process oriented and trainees' - centered, the duration would largely depend upon the size of group. Therefore, the total training hours varies between 27-30 hours.
8. The trainees should also be informed to share their problems during the training and also on logistic issues so that every possible care should may be taken to make their stay comfortable.
9. No participants shall be given a certificate if s/he remains absent for more than one hour during training days. Exceptional cases may be considered favourably at the discretions of the programme director.

Training specific

The programme has some common sessions everyday, which are not reflected in the programme matrix, but mentioned in programme schedule to avoid repetition. The trainer should keep the following points in mind:

1. The trainees shall be told that the programme follows a strict time table and the minimum training hours would be seven hours per day for the entire duration. Therefore, they should book their return tickets accordingly.

2. The training days (except first day) shall start with a recapitulation session which should be ideally of 15 minutes in the morning.
3. Following the recapitulation, group presentation on the manual review, which should be of 10 minutes for each group (if the number of groups are two/three), needs to be done.
4. Two energizers per day, one of which should really be given/played immediately after the lunch.
5. Group composition shall change for every activity/exercise through different methods. This would expedite the process of group social support net work building process.
6. Trainers' note will be there in every session, which will guide the trainer to proceed step by step.

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TRAINING OF TRAINERS MODULE ON PSYCHOSOCIAL CARE IN DISASTER MANAGEMENT

Introduction

Disaster-affected people experience various psychological reactions. These reactions immediately follow the event while socio-economic impacts like lack of employment; homelessness, environmental destruction and disorganisation emerge as a consequence, following the devastation caused by the disaster.

After a disaster, the emotional reactions among members of a community may vary from each other and this also may usually undergo changes over time depending upon the coping capacity and socio-economic condition of that community. Therefore, post-disaster psychological interventions should be flexible and based on an ongoing assessment of needs. The emotional reactions should be understood based on the manifestation of various stress reactions, level of effort put by the people for their own reconstruction, the pattern and amount of disability created due to these psychological stress etc. Some factors that could influence the reactions among people are nature and severity of the disaster, amount of exposure to the disaster, availability of adequate social support, age, gender, marital status of the person (single, widowed, married), separation/displacement from locality, separation from family/primary support group, personal losses of the survivor (loss of kith and kin, property, source of livelihood, personal injury).

Target Group

This module is meant for the training of non-medical personnel, including officers from different departments such as disaster management, social welfare, women and child development, education, health, rural development, Panchayati Raj Institutions (PRIs) and ULBs. However, faculty members of state ATIs, and other training institutions are also potential target groups for this training as per the forthcoming national guidelines on disaster psychosocial care and mental health services, as they are the people who will take this training to its logical end with the support of trained personnel from the above-mentioned government departments.

Note: The two words trainees and participants have been used interchangeably throughout the module. Both words refer to the people participating in the programme.

Entry Behaviour

Target Level of trainees	: Middle level officers, trainers and field workers
Age	: 25-50 Years
Years of Service	: One to 20 years
Educational qualification	: Graduation as minimum
Disaster Experience	: Substantial/ Little / Nil
Disaster Psychosocial Service Experience	: Little/Nil
Medium of Instruction	: Bi-lingual (predominantly in English)

Overall Objective

The objective of this module is two fold, first is to provide knowledge and impart skills in basic disaster psychosocial care services so that a core group of trainers on this subject prepared in every state and second, is to create a group of psychosocial care givers who can be deputed to the affected areas to provide psychosocial care services to the disaster affected people. Apart from this, one of the hidden objectives of this module is to build the social support network and we-feeling bond among the trainees, which is very important from the point of view of a disaster.

Learning Objectives

At the end of the programme (on the basis of this module) the participants would be able to

1. Mention and state different components of basic concepts of disaster management
2. Define disaster psychosocial care and how it is different from disaster mental health services
3. State the significance of disaster psychosocial care in the entire process of disaster management
4. Describe various impacts of disasters on the community
5. Differentiate between normal and abnormal reactions
6. Explain the basic principles of disaster psychosocial care.
7. Describe the effects of stress on body and mind.
8. List and illustrate the techniques of providing psychosocial care
9. Demonstrate different skills and techniques to work with different vulnerable groups

10. Mention the criteria for psychiatric referral
11. Explain how to administer different psychological scales and assessment tools in the field.

Methodology

- » Power point presentation
- » Interactive sessions
- » Participatory learning/Experiential learning
- » Process orientation to issues
- » Needs assessment
- » Discussion & group work
- » Role plays
- » Working with different types of mediums
- » Psychological scale administration
- » Body mapping exercises
- » Psychological games
- » Handholding exercises
- » Evaluative exercises
- » Self care exercises
- » Recording and reporting
- » Confidentiality and ethical group work
- » Self introspection
- » Regression

Training Materials and Equipments Required

- » Flip Chart and its stand
- » LCD Projector
- » Speakers
- » Mike
- » Markers
- » Chart Sheets- Large and multiple colour
- » Folder and other training kit
- » Photocopies/printouts of resource materials and ToT Workbook

- » Chocolates/toffees and a bowl to keep it
- » Session materials such as cards for normal and abnormal reactions, etc
- » Clay set -2
- » Family of Dogs/ Animal Set, balloons, and a small tennis ball,
- » All Thematic Cards used for children
- » Plate, Oil, Matchbox, cotton, blotting paper for stress management session
- » Two packets of candles (at least one for each trainee, trainers, programme directors, etc)

Teaching/Performance Aids

ToT Workbook: This workbook would help the trainees to note down the highlights of each session in the page corresponding to that session.

Handouts: Essential papers are to be given to the participants. Trainees should be instructed appropriately which hand outs they have to keep with them and which are to be returned back to the trainer/facilitator.

Scales: Psychological tools to measure a particular psychological variable which the participants have to return back to the trainers after the analysis

Case Study: These are small case studies to be given to the groups of participants to carry out role play session as part of internalising the basic skills and techniques of psychosocial care

Exercises: Psychological games, group work, group exercises which are to be used by the trainees during the training

Compact Disc (CD): Resource materials used in this programme (such as power point presentations, course materials and photographs)

Manuals: These are small books/booklets which the participants are to review after the training is over on day-2, 3, 4. This is called after training tasks, which would be shared on the next day.

Contents

- » Basic concepts of disaster management
- » Basic concepts of disaster psychosocial care
- » Disaster knowledge and skills assessment

- » Impact of disasters on people
- » Survivors needs after a disaster
- » Concept of loss and Circle of support
- » Normal and abnormal reactions
- » Stress reaction among the survivors
- » Umbrella of care
- » Seven basic technique of helping people
- » Impact of events scale for adults
- » Body mapping
- » Family assessment schedules
- » Self reporting questionnaire
- » Impact of events scale for children
- » Qualities of a good care giver for children
- » Age specific symptoms of children
- » Thematic story cards
- » Family portrait templates
- » Helping process for children
- » Templates for assessing role plays
- » Referral indicators
- » Trees of sustenance
- » Template for disaster psychosocial care needs assessment
- » My home work
- » Role and task
- » Our ethics

Language of Instruction

The medium of instruction would be primarily English, but Hindi would be used as and when required.

Group Size

A total of 15-25 trainees can be trained at a time, while 20 is an ideal number. More than 25 participants should not be allowed as most of the sessions are activity, game and exercise based. Therefore, it will be difficult for the trainer/facilitators to give individual attention to participants during various sessions. Moreover, the duration of each session would also increase if there are more than 15-20 participants.

Description of the Training Hall

Since the programme is full of group work, exercise and games, it is highly recommended that the training hall should have removable furniture (a hall not with fixed furniture like, meeting/conference hall), which can be rearranged. After the sitting rearrangement, a clean carpet (if available) should be spread in the hall because of two reasons:

- » If the chairs have wheels, then carpeting the room prevents participants from falling while games are on
- » Compared to a floor, carpeting is better for self-care (such as breathing and relaxation exercises) activities when sleeping/sitting is required,

Note: In case the hall is carpeted, the participants/trainees may be requested to remove their shoes out side the training hall to prevent dust and to maintain the cleanliness.

Sitting Arrangements

Except the introduction to the course/ inauguration part of the programme, for rest of the time the sitting arrangement of the participants should be done in semi circle position (without any desks/tables). Just arrange the chairs in a semi circular (in case of 25 or more participants the shape could look like a circle also) position so that there is eye contact between any two participants. After the first half day, the name plates should be removed and kept at the back side, so that real sharing and communication takes place among the trainees



Trainers/Facilitators/Resource Person Required

A total of 3 trainers/resource persons are required for the entire duration to conduct this module-based programme. One point is extremely important here to mention that, it is better if at least two of them stay for the entire duration. This will help in building the course context and delivery of the module in a better way. This will make the learning process continuous and consistent and trainees can always refer to their doubts they may have at any point of time in this duration.

Expected Outcome

This training programme is expected to provide an in-depth knowledge about the psychological consequences of disasters and needed skills, to build the capacity of trainees on different aspects/dimensions of disaster psychosocial care, and the competencies to train persons at the state and district level.

Evaluation & Validation

Two types of formal evaluations need to be carried out during the five days of training. The trainer is expected to evaluate day-wise individual sessions based on the feedback received during the recapitulation session. Apart from that, a formal evaluation of the programme will be done after the programme. Impact assessment evaluation of knowledge would be done through pre- and post training assessment scales. The evaluation of skill transfer would be done during various sessions where role plays and demonstrations are carried out.

An Overview of Disaster Psychosocial Care Management in India

This module consists of the following five learning units.

- » Pre-post Training Assessment
- » Introduction to Disaster Management
- » Impact of Disasters
- » Introduction to Disaster Psychosocial Care
- » Disaster Experience Sharing

Objectives

The key objectives of the module are to:

- » Carry out a pre training assessment to know the entry level behaviour of the trainees
- » Provide a comprehensive overview of the disaster management concepts, classification of disasters and disaster management system/ systems prevalent in India
- » Explain different impacts of disasters on the community
- » Describe case studies of different disasters to highlight the magnitude and severity of psychosocial issues and to explain the disaster psychosocial care services provisions in India.
- » Collect and record disaster experiences of the trainees.

Duration

6 hours / 360 minutes including the inauguration and ice breaking

Methodology

- » Icebreaking exercises
- » A small film on a disaster (e.g. Nagaland landslide, 2005)
- » Psychological questionnaire/scales
- » Lecture/power point presentation
- » Case study
- » Group exercise
- » Experience sharing

Trainers' Note

The trainers/facilitators should conduct an ice breaking exercise to allow trainees to introduce themselves. This session may be included within the inaugural/introductory session so that the dignitaries also come to know the background profile of the trainees. The trainees should be requested to mention their name, designation, organisation, state/district, training on disaster management, hobbies/likings, and family members.

Any of the following options may be considered:

- » Self introduction
- » Body-body exercise
- » Fish bowl technique
- » Other ice breaking exercises

However, if it is done separately it is better. Even if a small introduction takes place during the inaugural session, doing such an ice breaking session for 30 minutes would help the trainees to know each other and initiate group participation process.

In case there is no formal inaugural ceremony, then the programme director and trainers can explain to the trainees regarding the programme objectives and contents, the process of participatory learning and some general ground rules mentioned before page number - viii & ix under trainers guide heading.

Material: Brochure & Programme Schedule

Learning Unit 1.1.1- Pre-post Training Assessment

Context and description of the Session

The session consists of 4 written exercises to determine the knowledge level of the trainees before the actual training starts. This would be repeated in the post-training session during valediction so that a comparison could be made between entry and exit behaviour of the trainees, to know if the training made a difference. All the training instruments used here contain necessary instructions for working on these instruments.

Learning Objectives

- » To compare the entry and exit behaviour of the trainees
- » To evaluate the knowledge and skills gained from the training
- » To assess perceived competency of trainees on disaster psychosocial care
- » To carry out a formal internal evaluation.

Methodology

Questionnaires/scale administration

Duration

45 minutes

Tool Description

- i. Trainees' expectations from the ToT Programme This is an open ended questionnaire with five questions. This exercise can also be done by circulating small coloured cards and on which trainees are asked to write down their expectations and later on the facilitator/trainer could display all cards on the wall/training board.
- ii. Disaster psychosocial care opinion questionnaire This is a true/false type of questionnaire with 20 questions covering statements on trainees' basic ideas about disasters and their impacts. Statements against Sl. No. 1,2,4,5,7,10,12,14,16,18,19,20 are true statements while the rest of the statements are false or myths. Each right answer is scored as one point, thus 20 is the highest score, which means the trainee has the highest level of understanding.
- iii. Ten-point scale on trainees perceived competency on disaster psychosocial care services This is a ten-point rating scale with ten options on the level of perceived competency on ability, knowledge and skills to provide disaster psychosocial care services. The trainees should be instructed to encircle one number (from 1-10) given in the middle column of the scale. Or else, if they find it difficult then they should encircle the options available on both the sides. A higher number on the rating scale indicates higher perceived competency.
- iv. Trainees' knowledge on disaster psychosocial and mental health This is a sentence completion test consisting of 20 multiple choice questions on different aspects of disaster psychosocial and mental health care. Each statement has 4 or 5 alternative answers.

EXERCISE 1.1.1 (A)
(HANDOUT 1.1.1. 1)

Expectations from the ToT Programme

Name:

Date:

Instructions: Please express your true feelings related to the questions below. Return the completed questionnaire to the trainer/facilitator. You do need to sign the questionnaire.

What do you hope to learn during these 5 days:

The trainer's role during these days is/are to:

Your role as a trainee during the course is/are to:

From the course overview the course seems to be:

I would/would not love to be associated with health activities in the pre and post disaster scenario, because:

EXERCISE 1.1.1 (B)
(HANDOUT 1.1.1. 2)

Disaster Psycho-social Care Opinion Questionnaire

Name: **Date:** **Assessment:** Pre/Post

Instructions: Please answer the statements mentioned below. Write F, if the statement is FALSE and T if the statement is TRUE in case of disasters

No.	Statement	T	F
1.	Disaster situations affect a person's physical and mental/psychological health		
2.	Everyone affected by disasters experiences various psychological reactions		
3.	A strong person is not affected psychologically by disasters		
4.	Females experience greater stress and emotional turmoil in disasters as compared to males		
5.	These psychological reactions/responses are normal		
6.	Children are not affected mentally by these disasters		
7.	People with disability and elderly people have very specific needs to be addressed during response, relief and rehabilitation phase		
8.	It is always better to forget these incidents		
9.	Sharing disaster related thoughts and emotional reactions with others repeatedly is a sign of mental weakness		
10.	Crying helps us to feel better and little relaxed		
11.	Males are not supposed to cry and share their emotional problems with others		
12.	If proper care of food, cloth, health, water, sanitation, housing is taken, survivors would be in better mental health condition		
13.	Providing basic psychosocial support means providing care services to those who are mad		
14.	People who talk of suicides in the aftermath of disasters should be taken seriously		
15.	Taking alcohol, drugs and smoking help to reduce stress and sadness		
16.	If the survivors feel better then the outcome of livelihood programmes will also be better		
17.	People with psychiatric illness are similar to people showing psychosocial / emotional reactions		
18.	Survivors feel difficulty in sleeping, eating, and concentrating		
19.	Disaster related thoughts and flashbacks are very common		
20.	Little care and support to the survivors work well and contribute to survivor's recovery		

EXERCISE 1.1.1 (C)
(HANDOUT 1.1.1. 3)

Perceived Competency on Disaster Psychosocial Knowledge & Skills

Name: **Date:** **Assessment:** Pre/Post

Instruction: Read the sentences given in different boxes and find out one sentence in a box that is most appropriate about you. Then encircle the number corresponding to that box following the arrow mark connecting that box with the number given in the middle column.

I don't know anything about disaster psychosocial care	1	Providing basic amenities to the survivors is more important than psychosocial care
	2	
I know that psychosocial care is not important for in helping people deal with disasters	3	Psychosocial care is required only for people with mental illness
	4	
I know the need for psychosocial care but know very little of how to provide it	5	I know how to provide disaster psychosocial care to general community
	6	
I know about psychosocial care and know how to provide the same to vulnerable groups	7	I know about the basic skills and methods for providing psychosocial care and know how to help CLWs in hand-holding activities in field
	8	
I understand the importance of holistic care and will be able to provide the same to more vulnerable groups	9	I am confident that I understand the concepts dealing with psychosocial care and will be able to train others on the same
	10	

EXERCISE 1.1.1 (D)

(HANDOUT 1.1.1. 4)

Trainees' Knowledge on Disaster Psychosocial & Mental Health Care

Name: **Date:** **Assessment:** Pre/Post

Instructions: Read the incomplete sentences written in bold. Each of these sentences has 4 or 5 alternative choices. Few of these sentences have 6 choices also. Put a tick mark or encircle the most appropriate alternative that completes the sentence.

1) During and after disasters, affected people function

- a) With full efficiency and capacities
- b) With maximum efficiency and capacities
- c) With less efficiency and capacities
- d) With no efficiency and capacities

2) Psychosocial and mental health problems are seen only in

- a) Rescue phase
- b) Relief phase
- c) Rehabilitation phase
- d) Rebuilding phase
- e) All of the above phases

3) Emotional and psychological reactions/responses to a disaster are

- a) Normal
- b) Common
- c) Raised in the immediate response and relief phase
- d) Not normal
- e) All of the above except d)

4) Many emotional reactions are due to

- a) Life loss and injury
- b) Property and material loss
- c) Livelihood loss

- d) Problems in daily life living after disaster
- e) All of the above

5) Impact of any disaster is

- a) Same for men and women
- b) Different for men and women
- c) Women are more vulnerable than men
- d) a and c
- e) b and c

6) More vulnerable group in a disaster consists of

- a) Children
- b) People with disability
- c) Women
- d) Aged people
- e) People dependent on critical medical/health care
- f) All of the above

7) The major types of impacts of disasters are

- a) Physical, livelihood, loss of household and loss of property
- b) Loss of life, loss of family members, depression and loss of job
- c) Health problems, poor social support, poor governance and lack of resources
- d) Physical, economic, psychological and social
- e) Loss of infrastructure, loss of livelihood, poor law and order, health problems

8) The impact of disaster depends upon

- a) Age and sex of the survivors
- b) The type of loss experienced
- c) Severity of exposure to the disaster
- d) Efficiency and effectiveness of governance and administration
- e) All of the above

9) Which one of the following statements is correct?

- a) Disaster does not affect everyone
- b) Disaster affects people who are less capable

- c) Disaster is an individual specific event
- d) No one who experiences or witnesses a disaster is untouched by it.
- e) All of the above

10) Psychological reactions after a disaster will be different in case of children between the age of

- a) Before the birth of a child
- b) 0-3 years
- c) 3-7 years
- d) 7-11 years
- e) 12-16 years
- f) All of the above

11) The common social problems which arise after disaster are

- a) Lack of privacy in relief camps
- b) Poor sanitation facilities in the relief camps
- c) Family disorganisation and lots of orphans
- d) Migration
- e) All of above

12) Psychosocial support means

- a) Counselling the affected persons
- b) Helping to achieve maximum social support
- c) Helping the survivors to get compensation, and resources available in the community
- d) Referring the severely affected survivors to the psychiatrists
- e) All of the above

13) The normal reactions due to a disaster are

- a) Denial
- b) Intrusive thoughts
- c) Anger and irritability
- d) None of the above
- e) All of the above

14) The abnormal reactions due to a disaster are

- a) Headaches and poor appetite
- b) Flash back
- c) Repeated thoughts about the event
- d) Sleeping problems
- e) Feeling tired
- f) None of the above

15) The psychological reactions and problems

- a) Are unchangeable
- b) Can be reduced with psychosocial help and support
- c) Occur only in women
- d) Increase day by day after disaster for all the survivors
- e) Always lead to severe mental illness

16) The immediate psychological./ emotional reaction (s) due to disaster is/are

- a) Shock
- b) Grief
- c) Depression
- d) Post-traumatic stress disorder
- e) None of the above

17) Psychosocial care services can be provided by

- a) Psychiatrists
- b) Mental health professionals
- c) Anyone trained in this area in the community
- d) Doctors
- e) Teachers and highly qualified people
- f) Religious leaders

18) The psychosocial care helps survivors

- a) To forget the distress/event
- b) To master over the emotional distress and reactions
- c) To make people cry a lot

d) To reduce distress level and to reduce long-term mental disorders

19) The basic techniques of psychosocial care are

- a) Being sympathetic to the survivors and give monetary compensation
- b) Providing social support , allowing them to ventilate their feelings
- c) Listening actively to the survivors, and being empathic to them
- d) Helping them to find relaxation activities, and to opt for spirituality
- e) Help the survivors to go back to their routine work
- f) All of the above except (a)

20) Psychosocial care services should be a part of

- a) Overall relief and rehabilitation activities
- b) General health care
- c) District mental health programme
- d) Charitable services available after the disaster
- e) Disaster management

Trainers Note and Session Plan

The list of pre-and post-training instruments with description is mentioned above and hard copy of each hand out would be given to the trainees: Some of instruments prepared by NIMHANS are appropriately modified and used here to make them more suitable, relevant and adequate keeping the participants entry behaviour in view. All the filled in copies should be collected from the trainees after the session and repeat the process again during post-training assessment. Put the expectation handout on the wall/notice board in the training room with the help of adhesive tape or paste or thumb pins. At the end of the training these should be verified one by one to check if their expectations are fulfilled.

Session Plan

Training Activities	Time
Expectation from the programme Handout	5 min
Disaster Psychosocial Care Opinion Questionnaire Handout	10-15 min
Perceived Competency Handout	5 min
Trainees knowledge on disaster Psychosocial and Mental Health Care Handout	20-25 minutes

Learning Unit 1.1.2- Introduction to Disaster Management

Context and Description of the Session

India has witnessed a number of horrifying disasters caused by natural as well as man-made hazards in last two and half decades. Each one of them wrote its own signature with variations in terms of death, destruction, disability, diseases, panic, and fear among the population at risk. This session will introduce the broad concepts of disaster management to the trainees. It contains definition of different terminologies used globally and locally, classification of disasters, DM Act, DM approach and mechanisms in India, and case studies of few past disasters. This session particularly attempts to orient them to the training slowly with the help of a film and power point presentation.

Learning Objectives

The trainees will be able to:

- » Define different terminologies used in disaster management
- » Distinguish between different terminologies
- » Enumerate different types of disasters and their classification
- » State the importance of DM Act
- » Describe the disaster management cycle
- » Explain the disaster management system operating at national , state, district and panchayat level
- » Mention few past disasters

Methodology

- » Film on disaster
- » Power point presentation

Duration

90 minutes

Teaching /Performance Aids

- » Handout 1.1.2.1- Hard copy of the presentation
- » Handout 1.1.2.2 – Reading material on basic concepts of disaster management/ DM Act 2005 or whatever is available to the trainer

Trainers Note & Session plan

The trainer can make a power point presentation that was given to him/her during the TOT on Psychosocial Care s/he attended or can prepare fresh presentation on the basis of the literature available in this area. A copy of the presentation and some reading materials on this topic are attached herewith in the Annexure for the trainer's convenience.

Contents	Teaching methods	Teaching Aids
Concept of disaster, different terminologies, Classification of disasters, past disasters, Global and Asian context, aggravating factors, DM Act of India, DM cycle, DM systems in India, Film on any disaster that happened in India	Lecture/ Power point presentation & interaction	Flip chart/chalk board Handout 1.1.2. 1 & 2

Session plan

Training Activities	Time
Introduce the concepts and types of disasters. Make the presentation very interactive. Highlight the differences between disasters caused by natural and manmade hazards. Then illustrate the natural disaster vulnerability map of India and let the participants read it for their own state's vulnerability profile. Discuss for 5 minutes the vulnerability of their respective state.	25 min
Include the past mega disasters. Focus on the increasing frequency of disasters and the aggravating factors, DM cycle, Approach of India towards DM. Open the house for question and answer.	15+5=20 min
DM Act and DM systems in India	10 min
Summary and evaluation of learning in this session. Ask one of the participants to summarise whatever has been covered in the session and how they plan to use this knowledge. Invite other participants to supplement whatever their colleague has told. The trainer should check out that the objectives of the session have been achieved.	5 min

After the interactive presentation, the film on a disaster would be shown to the trainees. Instruction should be given to the participants to observe the film attentively and note down what they feel important to remember so that it would be easier for them to do the next session. Handouts are attached in the annexure.

Learning Unit 1.1.3 - Impacts of Disasters

Context and Description of the Session

Any disaster leaves a profound trail of suffering to the community affected by it. In order to work with the disaster affected people. It is important to understand different types of impacts and survivors' needs. The categorisation of impacts on the survivors will help to deal with the situation in more organised and focused way. There are mainly four types of impacts, such as physical, economic, social-educational, and psychological. These impacts would largely vary in different types and intensities of disasters. This session particularly attempts to orient them to the real training on psychosocial care by bringing out psychological as well as social impacts of the disasters. The important point needs to be mentioned here is to remember that the attempt is not to compartmentalise the impacts rather it is to understand the inter connections and interdependency existing among all types of impacts. All these have cyclic effect on each other. Therefore, intervention in one area will help to bring changes in other areas and also in developing a holistic care model. The film shown before would help to identify the impacts and organise those in different categories. The survivors' experience game would make them understand the psychological impacts in a better way. This is also important to mention that factors such as age, sex/gender, disability status, type of disaster, intensity of disaster, type of loss the survivors experience do affect the type and intensity of psychosocial impacts the disaster would have on the survivors.

Disaster Case Study

Fire in Sabarmati Express and Subsequent Gujarat Communal Riots-2002

Physical Impact:

Stomach-aches, Diarrohea, Headaches, Body aches, Burns (heat, acid), Physical impairments (limbs, sight, voice, hearing), Injuries (bullet, sharp objects and others), Fever Cough and Cold, Miscarriage, Physical Assault.

**Emotional reactions:**

Anger, Betrayal, Irritability, Revenge-seeking, Fear, Anxiety, Depression, Withdrawal, Grief, Additction to pan masala, cigarette, beedi, drug abuse.



Repeated thoughts about the disaster and related events



Worry

**Socio-economic impact:**

Loss of trust between communities, Lack of privacy, Single parent families, Widows, Orphan stat with loss of both parents, Discontinuity in educational plans.



Loss of handcraft



Disorganisation of life routines



Homelessness



Loss of Employment



Migration

Learning Objectives

The trainees will be able to:

- » Enumerate different types of impacts under the broad headings of impacts provided to them
- » Establish the inter connections between different types of impacts
- » Explain the reason why a particular impact is mentioned under a particular heading
- » Brainstorm
- » Speak out their experiences of emotions and thoughts through survivors' experience game
- » Relate their experiences of the game to the group work they did so as to generalise these feelings, emotions and thoughts in a disaster context
- » Identify various factors which contribute to differential impacts of disasters, especially psychosocial impacts

Methodology

- » Group discussion
- » Group work presentation
- » Power point presentation -5 slides on enumeration of the impacts to supplement the list prepared by the trainees
- » The survivors' experience- The car and the driver game

Duration

90 minutes

Teaching/Performance Aids

- » Workbook page number- page 10
- » Handout 1.1.3.1- Hard copy of the presentation
- » Flip chart paper or large sheets of chart papers
- » Markers

Trainer's Note & Session plan

The participants should be divided into 4 groups and each group should be given a topic to discuss among themselves and present the discussion highlights of their group work before all the trainees. The topics given to them were physical, economical, social and educational and psychological impact on the disasters affected individuals, family

and the community. Groups could be formed by simple method of counting or other methods like favourite leaders/animals/film-sport stars.

After the group discussion and group presentation the list prepared by the trainer could be presented through a power point presentation or simply by telling them to read the handout of the presentation given to them. The trainees should be requested to add or delete to list that is being presented by a particular group.

The trainer needs to give various examples to make the participants understand how these impacts are interconnected and bringing change in one aspect brings change in other aspects of needs and services provided to the survivors.

The trainees should be asked to open page no. 10 of their workbook and complete it as the group presentation proceeds

Experience of the Survivor Game [car and driver] (45 minutes) **Page No-12 of the Workbook**

Procedure

The participants are paired into two in each group. One among each pair would assume to be a car and the other person has to assume him/herself as the driver who would be driving of the car. Instructions are given by the trainer on how to drive the car with only nonverbal commands by holding the shoulders. After some time the role of the participants are reversed. After every one has had the experience of being a car as well as a driver, the trainees are asked to share their feelings when they were car and when they were driver.

The trainer lists down the feelings and thoughts of the trainees on the flip chart under separate heading of car and driver in two columns.

Trainers' Note and Session plan

Training Activities	Time
Instructions about group work, group formation and groups settling down in different places	5 -10min
Group discussion	15+5=20 min
Group presentation: each group 5 minutes and extra 5 minutes for group interaction among these impacts there are reversible and irreversible impacts.	25 min
Survivors' experience game and free listing of experience	15 + 5 min
Summary: Factors contributing to these impacts, especially the psychosocial impacts and evaluation of learning in this session. Ask one of the participants to summarise whatever has been covered in the session and how they plan to use this knowledge. Invite other participants to supplement whatever their colleague has told. The trainer should check out that the objectives of the session have been achieved.	15 min

Learning Unit 1.1.4 - Introduction to Psychosocial Care in Disaster Management in India

Context and Description of the Session

India is a theatre of Disasters. Natural disasters are quite frequent in different parts of the country, be it earthquake, Tsunami, cyclone, flood, drought or land slides. Further the human made disasters like industrial, chemical, fire, nuclear, riots, refugees, internally displaced persons and prolonged conflicts and other complex situations retard country's overall development. These disasters are quite devastating and life threatening for the affected people. Disasters usually leave a trail of human agonies including loss of human life, livestock, damage to properties, loss of livelihood, physical injuries and all development works. *Along with relief, rehabilitation and the care of physical health and injuries, psychosocial and mental health issues are also important and they need to be addressed.* In any disaster the magnitude of psychosocial and mental health problems is enormous. Apart from logistic and material help, the sufferings of human beings will require psychosocial and mental health interventions.

Psycho-Social Support

Psychosocial support in the context of disasters refers to comprehensive interventions aimed to address a wide range of psychosocial problems arising in the aftermath of a disaster. These interventions help individuals, families and groups to restore social cohesion and infrastructure along with maintaining their independence and dignity. Psychosocial support helps in reducing the level of actual and perceived stress that may prevent adverse psychological and social consequences among disaster affected people

Disaster Mental Health Services

Disaster Mental Health Services refer to the interventions for identification and treatment of manifest stress related psychological signs/ symptoms or of the mental disorders among disaster affected persons. In addition, interventions aimed at mental health promotion and prevention of psychological symptoms among disaster affected population are also included under disaster mental health services.

The Psycho-Social Support and Mental Health Services (PSSMHS) should be considered as a continuum of the interventions in disaster situations. While psychosocial support will comprise of the general interventions related to the larger issues of relief work

needs, social relationships and harmony to promote or protect psychosocial well-being, the mental health services will comprise of interventions aimed at prevention or treatment of psychological symptoms or disorders.

There is adequate research evidence at national and international level regarding the mental health and psychosocial consequences of disasters. It has been recognized that most of the disaster affected persons experience stress and emotional reactions after disaster as a 'normal response to an abnormal situation', and are able to cope well with a little psychosocial support. However, a significant proportion of people are not able to cope effectively with the situation in the absence of appropriate/ adequate support system and they experience significant signs and symptoms requiring psychosocial support and mental health services. The symptoms are directly related to trauma experience. The Greater the trauma, the more severe is the response if other factors are same. The trauma & subsequent experiences due to the major disasters like earthquake and Tsunami may be most severe for majority of the people while trauma in minor or peripheral disasters may be less severe. There is some evidence that human made disasters like riots and conflicts may have more distressing consequences. Statistics indicate that at the end of the first year, over two-thirds of the affected population recover, leaving one-thirds having significant symptoms that disable them. There is strong evidence that the experiences of the people subsequent to the disaster have direct relevance to recovery. The more the problems and life difficulties the survivors experience during the recovery phase, the more persistent will be their emotional reactions. This warrants appropriate interventions in accordance with the phase of recovery of the affected population with the diminished social supports being built for speedy recovery. The importance of mental health and psychosocial interventions after disasters has been increasingly recognized.

A review of Indian work on psychosocial and mental health aspects of disasters in India in terms of service delivery, training and research activities carried out over more than last two decades reveals a progressive shift in the nature and scope of services, the focus and objectives of training activities and in the issues pursued in the research activities. This shift is well reflected in the developments that have taken place during five major disasters viz. Bhopal Gas Tragedy (1984), Marathwada Earthquake (1993), Orissa Super-Cyclone (1999), Gujarat Earthquake (2001), Kumbakonam Fire (2004), Tsunami (2004) and Kashmir EQ (2005). The developments in the area of service, training and research have been occurring parallel to each other as well as following a combined approach. The journey of psychosocial care in disasters from the medical model to a social model owes a lot to the contribution made by NIMHANS.

Learning Objectives

The trainees will be able to:

- » List out different disasters that happened in last two and half decade in India
- » Differentiate between the magnitude of psychosocial impact among different groups of survivors
- » Differentiate between disaster psychosocial support and mental health services
- » Explain the institutional mechanism Govt. of India has planned for providing psychosocial care in disasters
- » Identify their roles as a community level workers
- » Highlight the relevance of psychosocial and mental health care services in disasters

Methodology

- » Power point presentation
- » Questions-answers

Duration

45 minutes

Teaching/Performance Aids

- » Handout 1.1.4.1- Hard copy of the presentation / reading material

Trainer's Note & Session plan

The power point presentation has to be pictorial and illustrative with relevant data and studies on psychosocial impacts of all disasters that happened in last two-three decades. The importance should be given on how the medical model care model has been replaced by the social care model with the help of the community level workers. Highlight the relevance of these services and how the acceptance has emerged for this model of care services in all parts of the country and region. Do mention the genesis and highlights of the National Guidelines on Psychosocial Support and Mental Health Services in Disasters in India.

Training Activities	Time
Contents: Case studies of disasters Medical vs. social model of care Phases of care CLWs NG on PSSMHS	25 min
Summary: Summarise the session with few questions and answers	5 min

Learning Unit 1.1.5 - Disaster Experience Sharing

Context and Description of the Session

Every individual has some kind of disaster experience or the other that happened to him at personal, official, and community level. The situation involves some important characters and situations which the person needs to share with others. S/he needs to describe how s/he coped with the situation and people helped to overcome the disaster experience. The trainee has to focus more on the emotions and feelings experienced during this disaster.

The session is aimed to reinforce trainees' personal experiences and to present a more generalized picture of the disaster survivors' experience.

Learning Objectives

At the end of session the participants would be able to:

- » Ventilate their experiences of any kind of disaster through which the importance of sharing and how it helps in self care would be made clear.
- » Analyze the emotional turmoil each one of them went through, and help other participants to relate it to the sufferings of the disaster victims and generalize their thought, feelings, emotions and behaviour.
- » Share their emotional turmoil which would help others in understanding their own situation but also recognize their coping styles to find a solution for a particular issue.

Methodology

- » Sharing of experiences
- » Recording the experiences

Duration

45 minutes

Trainers Note and Session Plan

The participants are asked to voluntarily share their disaster experience that happened at personal level or otherwise. Five minutes are given to them to close their eyes and try to recall any such event that happened to them and once finished then to raise their hands. They are also requested to be brief and specific so that all people get a chance to express their feelings and thoughts. After the given time, the first person who raised hand is requested to share his/her disaster experience while the others are told to listen carefully so that analysis at the end becomes rich. The experiences of all those volunteered are recorded by the facilitator or the co-facilitator.

Understanding Psychosocial Needs of the Disaster Survivors

This module consists of the following seven learning units.

- » Learning Unit 1.2.1 : Development of Needs Spreadsheets
- » Learning Unit 1.2.2 : Concept of Loss & Social Support Network
- » Learning Unit 1.2.3 : Normalcy and Abnormalcy of Disaster Psychosocial Reactions
- » Learning Unit 1.2.4: Life Events and Family Cycles
- » Learning Unit 1.2.5: Spectrum of Care
- » Learning Unit 1.2.6: Understanding Needs of More vulnerable Groups
- » Learning Unit 1.2.7: Principles of Psychosocial Support

Objectives

The key objectives of the module are to:

- » Illustrate the nature and types of needs disaster survivors have and the psychological connotation of these needs
- » Explain the process of going through an individual loss and the circle of social support network embedded to cope with that loss
- » Differentiate between normal and abnormal reactions exhibited by the disaster survivors
- » Describe the nature and type of life events in at different stages of life
- » Explain the importance of integration of psychosocial care in disaster response, relief and rehabilitation activities

Duration

6 hours / 360 minutes

Methodology

- » Open house discussion
- » Illustrations
- » Group exercise

- » Experience sharing

Teaching/Performance Aids

- » ToT Workbook
- » Flip chart
- » White board with markers
- » Normalcy vs. Abnormalcy cards

Trainers' Note

The methodology and process of each session varies and training materials required for each session largely depend on that particular session. This would be specifically mentioned in each session in next few pages. The trainer should be very alert about time management and facilitate the process of learning unit with lead questions/points so that trainees organise their thoughts more coherently.

Learning Unit 1.2.1 - Development of Need Spreadsheet

Context and Description of the Session

The needs of disaster survivors are always linked to the impacts of disasters. The survivors' needs could be categorised on the basis of types of impacts/loss any disaster leaves. The participants can come up with a list similar to the following, which is not exhaustive in itself.

- | | |
|---|---------------------------------|
| » Food | » Protection |
| » Medical management | » Immunisation |
| » Education | » Safety in camps |
| » Reassurance | » Training for livelihood |
| » Job and job security | » environment protection |
| » Moral support | » Spirituality |
| » Self esteem | » Relief and rescues |
| » Social support | » Recreation |
| » Psychosocial Care | » Counselling |
| » Economic support | » Safe drinking water |
| » Transport facility | » Sanitation |
| » Electricity | » Transportation |
| » Privacy for women | » Media |
| » Children specific entertainment programme | » Marketing |
| » Rehabilitation | » Infrastructure |
| » Shelter | » Good communication facilities |
| » Insurance | |

Learning Objectives

At the end of session the participants would be able to:

- » Brainstorm and describe all types/categories of needs the disaster survivors have in the post-disaster situations.
- » Analyze the relationship of emotional turmoil and these needs in case they do not get fulfilled.
- » Establish the linkage between the psychological base and nature of all kinds of needs.

Methodology

- » Free listing and brainstorm
- » Open house debate

Teaching-Performance Aids

- » Flip Chart with stand
- » Colour markers
- » Page 11 of WORKBOOK – Need spreadsheet

Duration

30 minutes

Trainers Note and Session Plan

The participants are asked to voluntarily share their understanding about what the disaster survivors would need after a disaster. The trainer may himself-herself write everything on the chart sheet or may invite a participant to initiate this session after instructing appropriately to the participants. The participants are asked to open page 11 of their workbook to note down the results of the group activity.

Allow the participants to come up with as many needs as possible. The trainer/facilitator could supplement to the list in between

After the free listing session is over in 15 minutes, the participants are asked to mention whether the needs mentioned by them have a psychological component/base or not. The facilitator/trainer/ volunteering participant would encircle those needs with different colour marker to highlight the group opinion.

Learning Unit 1.2.2 - Concept of Loss & Social Support Network

Context and Description of the Session

The psychological response to a disaster depends on three main factors

Disaster

- » Place of occurrence
- » Magnitude
- » Suddenness
- » Type

Community

- » Level of preparedness
- » Social support network
- » Leadership
- » Past disaster experience

Survivor

- » Age
- » Sex
- » Level of education/exposure
- » Marital status
- » Physical health
- » Disability status
- » Personality
- » Coping skills
- » Magnitude of losses
- » Social support available

The psychological reactions that people experience as a result of the disaster may be either adaptive or maladaptive. Adaptive responses allow individuals to overcome the difficulties caused by the disaster. For instance, obtaining information or developing effective survival skills.

Maladaptive reactions can include denial, ineffective actions etc. Maladaptive reactions can be prevented from occurring and if they do occur then they can be treated. The incident of a young girl can be considered here from Orissa cyclone. The rescue team saw her hanging from a tree after five hours, but she was not having any clothes on her body. After accepting the clothes from the rescue team, she immediately jumped in the floodwater and committed suicide.

After a disaster there are four main phases, which the survivors go through. The first phase is considered as rescue which is up to 72 hours after the disaster. The second phase is relief which continues for three months after the disaster. The third phase is rehabilitation, which lasts for one to two years and the last phase is rebuilding, or reconstruction, which extends over lifetime. Reconstruction phase is the longest period when the population rebuilds personal skills, social support and leadership. This overlaps with the rebuilding phase.

Phases after a disaster	Duration	Characteristics
Occurrence of the disaster	Hours	Apathy, Disorientation, Wandering Surprise, Fear, Perplexity Anxiety, Helplessness
Heroic	Up to 1-2 weeks	Feeling strong, Direct feeling of saviour, Heroism, Solidarity, Optimism
Honeymoon	2 weeks to 3 to 6 months	Great solidarity, Eagerness to rebuild, Sharing of common experience
Disillusionment	2months to 2 years	Withdrawal, Loneliness, Anger, frustration, Community disorganization, Negativity, Hostility, Impulsiveness, Violence, Alcohol and drug abuse
Reconstruction	2-5 years and Lifetime	Acceptance of losses Realistic assessment of the situation, Search for alternatives to rebuild lives

Losses due to the death of a near and dear one, separation from loved ones and material losses are inseparable part of human existence. Under normal circumstances, everyone goes through this process without much difficulty because family and relatives come

together and share the loss. Support from friends and neighbours occur automatically in terms of provision of vehicles, space for visitors, taking care of food and other arrangements. Rituals are initiated soon after the death. For example, the effected family temporarily suspends some activities, prayers are offered to the deceased, arrangements are made for cremation etc. Individuals start their daily life routines; get back to their jobs once the rituals etc. are over. All these help the individuals to understand the personal meaning of loss, come to terms with the changed situation and to carry on with their lives. So in the normal circumstances the usual social support systems are in place to help a person or to cope with the loss. At the primary level the family provides the support, while at the secondary level the neighbours and friends come and help. Lastly at the third level, the community groups and other measures play crucial role in recovery and getting back to normal life.

In a disaster situation, normalcy of the social structure as described above which otherwise plays a crucial role in the healing process does not exist because everyone in the area has been affected, so friends and neighbours are unable to support the survivors. The family as a unit may no longer exist leading to a sense of isolation, helplessness and despair. There may not be time or space to carry out the normal process of mourning and the related rituals do not occur automatically. People may not be able to resume their daily life for sometime and have to continue living under stressful conditions.

Coping with Loss

Circles of Support

It is very clear that the usual social support systems are eroded after a disaster. The family and the neighbourhood no more exist as a functional unit. The tertiary level of support system exists to some extent in terms of larger community, government and other external agencies. So, it is essential to pull these external resources (out of the affected community) for rebuilding the social support system and normalize the life of the survivors.

Need for External Support Systems

In a disaster, the first two circles as mentioned earlier become nonfunctional. The family as well as the neighbourhood is affected and no more able to provide the required support for recovery. At the third level the government and external agencies take the main role to rebuild the entire support system. Therefore, external aid agencies need to step in and help with the recovery and rehabilitation process. These agencies come in for varied periods, some for the immediate relief phase and others for the longer-

term rehabilitation process. Each agency has its own agenda and outlook. The agencies that come in during the aftermath of a disaster also vary in their professional backgrounds; they could be lawyers, doctors, social workers, individuals etc. Therefore, after a disaster, building primary level support is very essential by providing caring atmosphere and establishing rapport. Here the role of psychosocial care giver becomes very important as providing other support may not lead to the adequate outcome without adequate rebuilding of the individual capacities and family resources at the primary and secondary level.

In India, the government primarily responds to any disaster and different departments are in charge of different disasters. Apart from the government agencies a lot of other players also come to the forefront. These include:

- » Professionals from the medical, legal and other such fields.
- » Student volunteers
- » Religious social service groups
- » Non-government organizations both national and international
- » Business communities
- » Civil society bodies
- » Individuals in their own capacity contributing their skills or money

During the initial stage of help, there is a focus on immediate relief and look at the basic needs of the survivors. Once these basic needs have been taken care of in the relief phase and the survivors have settled down moderately, the need of for providing emotional support becomes the primary goal. This is extremely important as by this time the survivors slowly start reflecting upon what they have been through, realize how they have survived and its gravity, and also start understanding their losses and go through the associated pain. Therefore, providing the psychosocial support as per the situation is very crucial for recovery.

Learning Objectives

At the end of session the participants would be able to:

- » Describe the concept of loss in a disaster situation and the type of support to be provided during the situation
- » Explain the linkages and dynamics between the personal loss and social support network that happen in a pre-disaster situation
- » Distinguish between the social support network in a normal and disaster situation
- » State the role of external social support agencies in a disaster.

Methodology

- » Open house discussion
- » Illustration

Teaching/Performance Aids

- » Flip Chart with stand
- » Colour markers
- » Page -13 of WORKBOOK- Circle of support



Duration

30 minutes

Trainers Note and Session Plan

The session is very much a process oriented open house discussion, where the trainer/ facilitator asks the participants to assume that an individual's father died and to describe about the events/ activities that take place subsequent to this eventuality.

Participants could come up with the idea that the friends, neighbours and relatives would come for the immediate help. They will help in different ways from informing the relatives to the financial helps. Also the community would come into action in the form of arranging for funeral. Then after the funeral the individual and family would follow some rituals to cope with the loss with the support from within as well as from the relatives and the community. So they get back to the normal routine.

The trainer/facilitator has to emphasize the differences amongst the social support provided by the primary, secondary and tertiary support system in a normal situation which helps the individual and the family to get back to normalcy.

- » The social support network system has to be drawn on the flip chart
- » and participants should be asked to open up the relevant page of their workbook.

Then s/he has to link up the situation to the disaster situation and explain how all these three circle of support is washed away since everyone in the community is affected by disaster. After establishing/justifying the need of external support system in a disaster the following should be explained to the participants:

There is a need for a long term care to help the affected individuals to get back to their normal life. Though all the support systems are collapsed, there are some external agencies that come for help at the tertiary level. Some of them are the government agencies, NGOs, individual volunteers, group of people, political, religious groups, private companies etc. The help rendered by them should be made available to the survivors and the help should be at the individual level by motivating them to involve in some activities, at the family level by helping them to reach their relatives, share among themselves and at the community level by forming committees and self help groups to address the issues followed by disaster. This should be explained by giving various field level examples.

Learning Unit 1.2.3 - Normalcy and Abnormalcy of Disaster

Context and Description of the Session

Psychological reactions change over time, it is essential to understand stage specific reactions of the survivors. The reactions could be following a normal or abnormal mode of occurrence. This session would help us to identify a survivor who is exhibiting and leaning towards the abnormal mode of occurrence of reactions and how can we help him/her to get back to the normalcy. This would also detail out the distinction between the normal vs. abnormal reactions exhibited by the survivors.

Normal Reaction	Abnormal Reaction
OUTCRY (immediate) (Fear, sadness and rage)	OVERWHELMED (Swept away by immediate emotional reactions)
DENIAL (one to two weeks) (Refusing to face the memory of the disaster)	PANIC/ EXHAUSTION (From the escalated emotions)
INTRUSION (six months) (Unbidden thoughts of the events)	EXTREME AVOIDANCE (Drugs etc to deny the pain)
WORKING THROUGH (six months on wards) Facing the reality of what has happened)	FLOODED STATES (Disturbing images and thoughts about the event)
ADJUSTMENT (Life long) (six months on wards) Facing the reality of what has happened)	PSYCHOSOMATIC RESPONSES (Bodily complaints)
	CHARACTER DISTORTIONS (Long term disorders)

Case study

There is a lady who lost her child in a cyclone/tsunami/EQ. It is normal that she will be distressed and will show the related reactions. She may for sometimes, deny the reality. Memories of the child and events associated with the child and that particular disaster may come back to her again and again to her even if she tries to avoid it. However, with

time and changing situations she would be able to accept the truth and relive her life without her son and finally would move on in life. This is a series of normal reactions of a mother who lost her son in a disaster.

On the other hand there is another woman who has lost her son but days and months together she cannot stop crying and faints out of exhaustion. She denies any talk of the event and her denial of the truth continues. She cannot sleep or even eat or concentrate on any activities; therefore, drugs may be needed to get sleep. For a long time, the events and images about the same keep occupying her mind so much so that she is unable to carry on with daily life activities. She may also develop vague pain in different body parts and other bodily symptoms for which there is no biological cause. She may also exhibit major psychological distress symptoms. This would then be considered as abnormal reactions of a mother who lost her son in a disaster, hence would require medical and psychological interventions to get her back to normalcy.

Learning Objectives

At the end of session the participants would be able to:

- » Describe the concept of loss in a disaster situation and the type of support to be provided during the situation
- » Describe the normal and abnormal reactions
- » Explain the difference between normal and abnormal reactions
- » Link the reactions to different phases of disaster management

Methodology

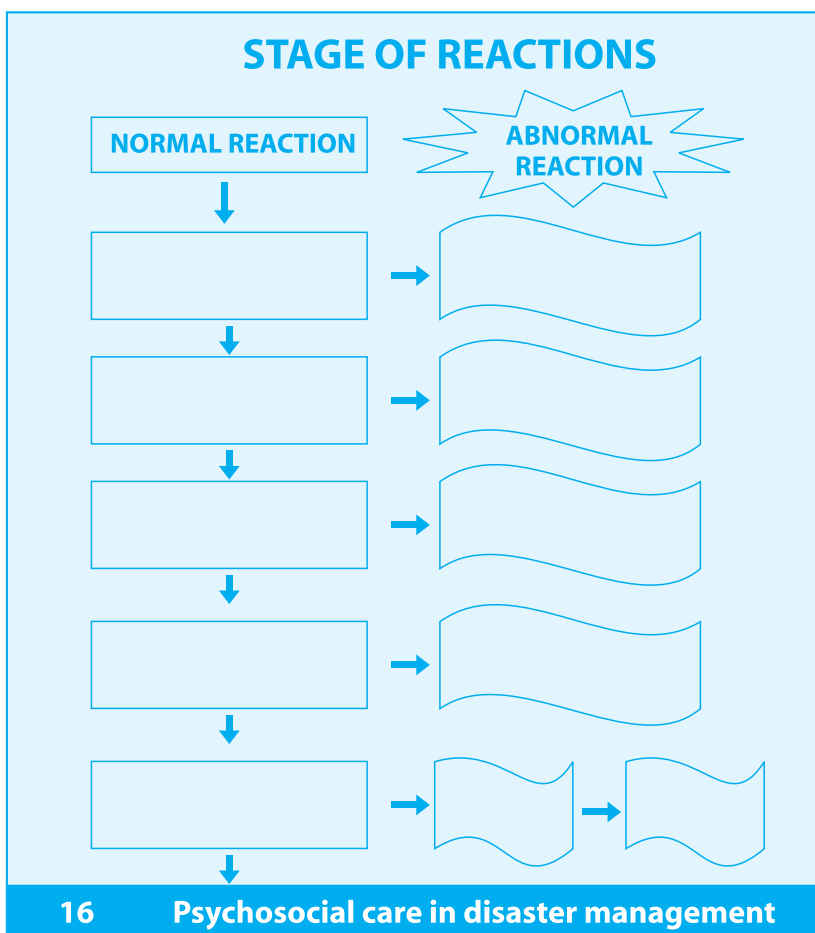
- » Lecture-demonstration
- » Illustration

Teaching/Performance Aids

- » Normal abnormal cards
- » Adhesive tapes/stapler/binder clips
- » Flip chart board
- » Page No. 16 of the WORKBOOK

Duration

45 minutes



Trainer's Note and Session Plan

The session should be conducted in a very informal way, by having open discussion with the participants to describe the normal reactions human beings show in an eventuality of death or loss in the family. The trainer should explain with lots of illustrations and case studies appropriate to every normal vs. abnormal reaction cards. The trainer should display the cards one by one after explaining a particular emotional reaction exhibited by the victims. Normal and abnormal cards should be displayed sequentially and against each other as displayed on the picture. The trainees should be asked to open page number 16 of the ToT Workbook and to fill in respective emotional/psychological reactions boxes at appropriate places.

Learning Unit 1.2.4 - Life Events and Family Cycles

Context and Description of the Session

Lazarus (1966) differentiated psychological stress from other types of stress in his integrative cognitive phenomenological stress model, where he defined stress as a particular kind of commerce between a person and his environment. A cognitive phenomenological analysis of the commerce reveals variety of relationships occurring between the person and the environment, which are mediated by cognitive appraisal processes. Psychological stress referred to both the internal and external stimuli, which are aversive and threatening for an individual. However, like physical stressors, psychological stressors do not cause psychological stress directly but through intervening socio-personal and cognitive factors. These factors include components such as, how an individual perceived/appraised the significance of the events according to higher needs and expectations; whether he/she perceived/appraised them as harmful or threatening to his/her state of mind; and how well he/she adjusted and coped with the events to decrease their influence. Cohen (1985), in support of Lazarus pointed out that life events themselves were not necessarily stress producing. Rather, their cognitive appraisal was central to it. Cognitive appraisal depends on many factors like, person's emotional and social maturity, social and financial background, gender, age and experience in similar situations, education, physical and mental capability, and the perceived social support around the person.

Kessler (1979) examined the relative contribution of exposure and vulnerability to the impact of stressors. He contended that people coming from lower social class were exposed to more stressful experiences; and comparable events affected their emotional functioning more severely than those in higher social class. The stress coefficients reflected the combined effects of total events, undesirable events and chronic stressors (disaster related economic concerns and health problems), which made the stressed more vulnerable to psychological distress like, depression, low social-emotional adjustment, low self- confidence, and frustration.

Life events related stressors are different in each stage of life. In the eventuality of a disaster, many people might face such kind of situations where they end up suddenly in a life stage without experiencing in between stages, which creates a vacuum in their lives. Disasters create tremendous stress for the survivors due to the sudden displacement from own houses/familiar environments, difficulties in staying in relief camps, uncertainty about the future, anxiety and apprehension related to the

unpredictability of after shocks in case of an earthquake or the threat, and chaos related to the rebuilding of personal, family and community life. Survivors experience various kinds of stressors due to the socio-economic impacts of the disaster

LIFE STAGE	LIFE EVENTS
Honeymoon	Bonding Setting up a home Dreaming of a family
Toddler	Birth of a baby Bringing up the child Thinking of the child's future
School going child	Admission to a good school Monitoring the child's progress in school Bringing up a good child
Adolescent	Taking care of new needs Dealing with career choices Trying to get the child to think of his or her future
Launching the child	Getting the right career Marriage of the child Get the children started on their life stages
Retirement	Once all duties are over Preparing for old age Taking care of self
Empty home	Once partner dying Children leaving home Any illness

Source: NIMHANS ToT Facilitation Manual

However, the life events during particular life cycle stage could be different for different people depending upon their life experiences, although a majority may have common stressors as mentioned in the above-mentioned table. It is important to understand here that whether the life event is good or bad, it will produce some amount of stress. Hence, understanding different dimensions of stress producing stimuli is very crucial. There are usually fifty two life events in any one's life. These events could be expected or unexpected, desirable or undesirable, entry or exit events, personal or impersonal depending on the value, the person attached to the same.

If we look at the severity of life events, then loss of life causes greatest amount of stress followed by events involving loss of property, law and order issues and then health issues. In a disaster situation, many of the life events come together at the same time in the life of the survivors and this leads to lot of change and alterations in the normal family life cycle.

Learning Objectives

The session on family life cycle helps in mapping the vulnerability factors of the individual and the family which in turn helps in giving better intervention.

During and at the end of the session the trainees would be able to:

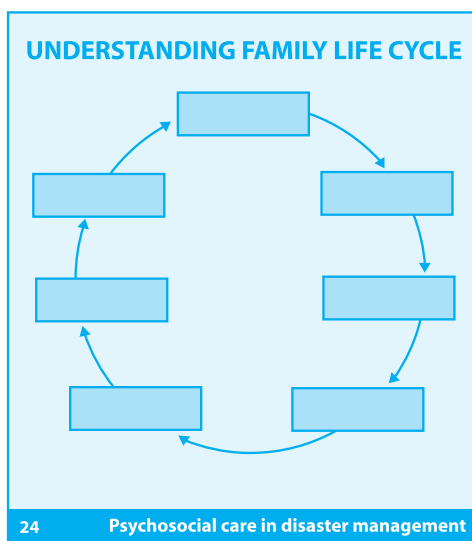
- » List different stages of life the family life cycle
- » Discuss the stressors in each stage of the family cycle and how it increases during disaster.
- » State how disasters induce a life stage related vacuum in the survivors' lives.

Methodology

- » Brief lecture followed by discussion
- » Illustration and experience sharing

Teaching/Performance Aids

- » Flip chart board & Markers
- » Page No. 24 & 25 of the WORKBOOK



Duration

45 minutes

Trainer's Note and Session Plan

The trainer starts with a very brief lecture on how the nature and type of stressors are different in different stages of life. Then s/he facilitates the open house discussion on sharing of life experiences of the participants at in each stage of the life cycle. There are seven stages namely honeymoon stage, couple with toddler, couple with school going children, couple with adolescent children, launching out stage, retirement and empty nest. The stressors and happy moments in each stage were related to the own experiences of the participants which helped them to understand the stressors at each stage which is very normal in a normal situation. The discussion and sharing of experience should be supplemented with illustrations to understand the fact that the life cycle is broken in a disaster situation. For example, a young married man/woman who had lost his/her wife/husband would directly go to the empty nest stage which has multiple stressors than expected. There would be vacuum in their lives.

This is a process oriented session where the trainer should ensure that the participants are clear about the disruption of normal family life cycle in a disaster situation. This disruption in the cycle causes more stressors which go beyond the coping capacity of the individuals and the family, thus needing attention and support from broad social support organisations/institutions/individuals.

Learning Unit 1.2.5 - Spectrum of Care

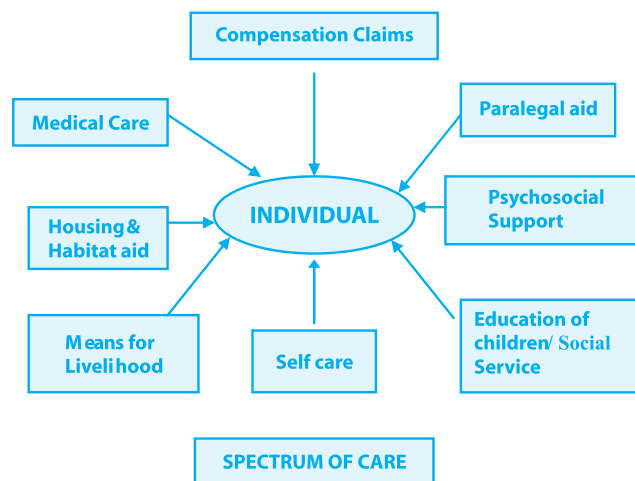
Context and Description of the Session

Psychosocial care is a part of the holistic care services model. Provision of holistic care is most crucial for fast and appropriate rehabilitation and recovery of the disaster survivors. The most important step in psychosocial care and recovery process is to recognize that psychosocial care is essential for the entire population experiencing a disaster. People differ only in terms of the degree of support needed. It is important to mention here that not to look at holistic intervention care model is a limited approach to provide care and support. There is need to understand that there are many aspects to psychosocial care. Just like an umbrella there is a need to cover all the aspects rather than focusing on giving emotional support alone.

After any disaster there is a need for a multi-pronged approach to relief and care, of which psychological support forms an integral part but is not the only help that people require. It is important to note that even if it is not the only help, it is an essential and necessary element of the relief work for quicker and more effective rehabilitation of the survivors of any disaster.

The umbrella of care would cover seven basic issues (listed below) that a psychosocial caregiver would need to look at.

Umbrella or spectrum of care would cover issues related to



While making an intervention with any person, the worker would need to identify his/her needs and attend to specific problems, such as loss of family, home and relief measures.

A large number of issues of loss of source of livelihood, compensations, difficulty in construction of homes, blow in gratification of primary needs, non-payment of compensation, loss of comforts, loss of social status and relations, security problems, feelings of powerlessness, helplessness, lack of adjustment, low level of occupational redundancy, loneliness, low self esteem, negative attitude towards self, low level of self efficacy, fear about reoccurrence of the event, anxiety, stress, hostility, mental illness, and tension, need to be addressed in the rehabilitation programme.

A proper coordination of all the issues is essential in building up a holistic care model or to provide for a spectrum of care services to the affected population.

Learning Objectives

At the end of the session the trainees would be able to:

- » Define the meaning of holistic care and purpose of holistic care services
- » Make the participants understand the reason of integration of psychosocial care with the broad spectrum of care available for the survivors.
- » Describe various components of the umbrella of care
- » Mechanisms/systems to provide such spectrum of care services to the disaster survivors

Methodology

- » Group work
- » Interactive session

Teaching/Performance Aids

- » Flip chart & Markers
- » Page No. 17 of the WORKBOOK



Duration

30minutes

Trainer's Note

A picture of umbrella needs to be drawn and the participants should be asked to tell the importance of umbrella and the important components of umbrella. Using this analogy, the participants should be asked to list possible support that should be given to the survivors. Each support is like the thin steel rods in the umbrella. Also using the analogy of dropping money in a torn pocket, i.e. torn pocket is like lack of psychosocial support and the money is the other type of help given the importance of the holistic approach of using the psychosocial support along with other types of help can be explained.

The trainer should ensure that the participants are able to understand the importance of the holistic approach of giving different types of care like medical care, paralegal aid, housing aid, compensation aid, self care and livelihood issues and the other possible help like coordinating with the NGO along with psychosocial care and integrating psychosocial care with their regular activities. Internal validation of knowledge should be ensured at the end of the session.

Learning Unit 1.2.6 - Needs of More Vulnerable Groups

Context and Description of the Session

As mentioned earlier, the reactions to and impact of a single disaster event may vary among specific groups of survivors within the affected community, i.e. people with special needs or more vulnerable groups. The populations affected by disasters contain a high proportion of children, people with disability, women, elderly people and people needing special medical care facilities. As the life conditions for such groups in the pre-disaster phase are already in a vulnerable stage, they become more vulnerable in terms of their specific needs in the post disaster management phase. Lot of inter group and intra group variations are there in terms of the nature and kind of special services these groups of people need during a post-disaster phase. For example within the children group itself the following categories of children are more vulnerable:

- Children who were physically, neurologically, mentally and sensory challenged in the pre-disaster period and those who became disabled after the disaster
- » Children who need critical medical care facilities e.g. children suffering from cancer, diabetic, asthma, poor heart condition, blood borne diseases, HIV-AIDS, etc.
- » The children with special needs who become orphans after a disaster, as this is the most vulnerable group for different types of exploitation.
- » Adolescents, especially girls

In a disaster scenario, specific needs of many of these groups are generally overlooked or remain inadequately addressed, which make life of these categories of people much more difficult. Further, as a care giver (directly or indirectly) one must try to encompass their specific needs and requirements into the general relief and rehabilitation package. They also need to be handled by a group of trained care givers who understand the genuineness of their needs and helplessness. Starting with search and rescue till the recovery and rehabilitation phase, these groups need special attention of the disaster workers/care givers and managers.

Learning Objectives

At the end of the session the trainees would be able to:

- » List the categories of more vulnerable groups in a disaster situation
- » Identify the types of special needs of each group
- » Mention the inter and intra group variations in terms of needs of different groups.

Methodology

- » Psychological Game
- » Free listing
- » Group discussion followed by group presentations

Performance/Teaching Aids

- » Coloured Chart papers & Markers
- » Picture cards of various vulnerable groups

Duration

60 minutes

Trainers Note and Session Plan

The trainer should start with the game of visibility vs. invisibility. Once this is done, the participants should be asked to analyse the game and identify the categories of more vulnerable groups. Then the free listing should be done on the flip chart.

Then the trainees should be divided into four groups who should be working on four main categories of vulnerable groups named as, children, people with disability, senior citizens and people dependent on critical health care facilities. The trainees should be given 10 minutes to discuss within the group and 5 minutes to present their work. They should also be instructed to identify the intra group variations in terms of needs of the respective group of survivors. They should also be informed that the next part of the session would be on how to provide care services to these groups and would be taken up in forth coming sessions during next few days of the training.

Intra Session Activity	Duration
Game: visibility vs. invisibility	7 -10minutes
Analysis of the game	5 minutes
Free listing of more vulnerable groups	5 minutes
Group formation and settling down	3-5 minutes
Group discussion	10 minutes
Group presentation	20 minutes (5 minutes for each group)

Learning Unit 1.2.7 - Principles of Psychosocial Support

Context and Description of the Session

The session includes seven widely accepted principles for providing psychosocial support to the disaster survivors. These principles would serve as guidelines to do away some of the myths prevalent in this field.

1. No one who experiences or witnesses the event is untouched by it

Disasters, depending on the nature and magnitude, cause enormous loss to life, property and the environment of the area. Grief, sadness, anxiety, anger are common in such situations. Almost all the individuals who are part of this event experience such reactions. Even people who have followed the event through the television or print media would be affected by it.

Some people may not on surface seem very distraught or affected, but given the space they will share their experiences and feelings about the event. It's a myth that strong people or men in general do not need support and can manage without external support. It's not only the people who have been overwhelmed by the event but everyone needs support. However the degree of care required or the time span for which it is required may vary.

2. Disaster stress and grief reactions are normal responses to an abnormal situation

Since a disaster is an abnormal event beyond the coping mechanism of an individual and the survivors are not prepared to meet a disaster hence they manifest their trauma and stress in the form of varied reactions. These are perfectly normal and most people would overcome these reactions given the right kind of psychosocial support and care is extended to them. The survivors need to be helped to understand that what they are experiencing is normal, this would ease the stress they are experiencing as a result of the reactions.

The survivors need to understand that disasters disrupt all aspects of daily life resulting in practical problems like finding temporary housing, food, clothing, timely and appropriate relief measures, and other basic amenities. The stress of living in cramped living spaces with limited resources adds to the stress of survivors.

3. Disaster results in two types of trauma

Any disaster-affected population suffers individual and collective trauma. Individual trauma manifests itself in stress and grief reactions, while collective trauma can lead to

deterioration in the social ties of survivors with each other. The loss of these natural buffers in the community need to be restored through mental health interventions, such as outreach, support groups and community rebuilding programme. In large scale natural disasters collective mental trauma is much more prevalent.

4. Disaster mental health services must be tailored to the needs of specific communities to be served

Mental health and psychosocial interventions should be based on the demography and characteristics of the population, the ethnic and cultural groups in the community, place. The language of the care providers may need special consideration.

5. Interventions must be appropriate to the phase of disaster

It is of paramount importance to recognize that survivors experience varying emotional reactions in different phases of the disaster. While in the initial phase listening, supporting, ventilation, catharsis and grief resolution are helpful, handling frustration, anger and disillusionment become important in the latter phase. Psychosocial and mental health care providers should know the phase specific needs of the survivors. A phase specific need assessment should be carried out by the care givers working in this field.

6. Support systems are crucial for recovery

Family is the most important support group for individuals. Attempts should be made to keep the family together and members encouraged in getting involved in each other's recovery. Out of box thinking regarding the interventions should be preferred in special cases rather than any pre-designed intervention. For example the concept of "Mamta Griha" - the innovative project which was initiated for the orphan children after Orissa Cyclone 1999.

7. Attitude of the caregiver

The psychosocial care givers should approach the survivors with warmth and genuine interest, along with ensuring privacy to them. Try to break the deep rooted and culturally prevailing myths and mis-conceptions. These should be taken care of by the care givers very carefully with the aim to curb them appropriately without hurting the emotions of the survivors. Use of mental health labels like 'neurotic', 'counselling', 'psychotic', 'psychotherapy', etc needs to be avoided by the caregivers and an active community outreach approach is required to intervene successfully in disaster situations.

Learning Objectives

At the end of the session the trainees should be able to:

- » State the importance of the basic principles of psychosocial care giving.
- » Describe different principles and their application in a disaster scenario.

Methodology

- » Interactive Lecture

Teaching/ Performance Aids

- » White Board & Board Marker

Duration

20minutes

Notes for the Trainer

The trainer would write down the principles of emotional support one by one on the white board and discuss with the trainees with small illustrations. At the end of the session the participants should be asked to repeat the principles and one of them should write them on the white board. The trainer should announce in the class that the principles written on the white board should not be wiped off till the end of the training programme.

Techniques of Psychosocial Care

This module consists of the following two learning units.

- » Learning Unit 1.3.1: Basic Techniques of Disaster Psychosocial Care
- » Learning Unit 1.3.2: Role plays on Basic Techniques

This module enumerates seven basic techniques that people involved in various aspects of disaster management can extend regularly to the survivors directly and indirectly to facilitate the process of restoring normalcy and rebuilding emotional strength and integrity of the survivors. It may seem intangible in terms of immediate effects, but all these simple skills help in the rebuilding of the community as a whole and the disaster survivor in particular.

Objectives

The key objectives of the module are to:

- » Train the trainees on seven basic techniques of providing disaster psychosocial care
- » Explain the process of initiating and closing the techniques
- » Describe the applicability of these techniques in different situations
- » Review and assess the skill transfer level through role play

Duration

4 Hours/ 240 minutes

Methodology

- » Lecture
- » Illustration
- » Group activities
- » Role play

Teaching/Performance Aids

- » ToT Workbook
- » Flip chart and white board with markers
- » Balloons, tennis ball

Trainers' Note

The methodology and the process of each technique varies and the training materials required for each technique largely depend on that particular technique. This would be mentioned while describing each technique in the following pages. The trainer should be very alert about time management and may facilitate the moving forward of the session with lead questions/points so that trainees organise their thoughts more coherently. After each group activity/game/exercise, the trainer needs to elaborate the importance of each technique and how does it work. The trainer should also encourage questions from the participants to clear their doubts.

The trainer should keep the case studies (3/4 depending on the size of the group) ready for the role play activity. Case studies could be prepared separately for all groups and should not be more than two-three lines. S/he can then cut printed case studies in pieces or use paper cutting as case study. Hand written case studies can also be prepared on 3-4 pieces of papers in extreme situations.

The duration of these two sessions could be adjusted as per the progress of the sessions, as many techniques need group activity, group performance and the follow up discussion.

Learning Unit 1.3.1 - Basic Techniques of Disaster Psychosocial Care

Context and Description of the Module

The session is focussed on describing the following seven psychosocial techniques to the trainees.

I. Ventilation

A disaster survivor may experience great internal stress and turmoil in the post-disaster phase due to the type of loss s/he has sustained. In addition to that the environmental stressors (e.g. camp life, no toilet, no auxiliary aid for a person with disability, no appropriate and nutritional food for specific groups of people, uncertainty, struggle for basic amenities, etc) in a typical post-disaster scenario might aggravate the condition and affect the internal mental equilibrium of the survivors. Depending on the nature and personality of the survivor, these strong emotions can either be expressed or suppressed. However, it is found that very often people tend to suppress these emotions and come up with lot of psychosomatic symptoms later on. For example, non-release of pressure from a pressure cooker or a balloon could lead to a disastrous situation. Therefore, helping the survivors to ventilate out or to release these emotions is extremely important.

Thus, ventilation is a process to help the disaster survivors in expressing their thoughts, feelings and emotions related to the disaster and the resulting living conditions. Depending on the number of interactions with the survivors different methods of ventilation could be used. It is important for helpers to be able to meet with people and help them talk about what they have experienced and share their feelings and emotions. Facilitating ventilation works like a safety valve and has long term buffering impact on the mental health of the survivors. And the next method, i.e. empathy is highly needed to carry out an effective ventilation process.

II. Empathy

The terms like “sympathy” and “empathy” are often used interchangeably, while the context, meaning and the feeling and emotions associated with each term are different. While sympathy broadly means “feeling sorry about what wrong happened to some body and looking at the event from your own perspective”, “empathy” necessarily means “looking at the event from the other person’s perspective and trying to realise the trauma of the other person by keeping himself/herself in that situation”. The idea of being able to feel and experience the pain as your own is done by trying to be in the

other person's situation. This helps the care givers in better understanding of the survivors' internal emotional turmoil. It is based on the sensitivity and ability to recognise what the other person is going through certain feelings or emotional experiences. This skill of developing empathetic attitude towards survivors comes through regular habit of active listening of the survivor.

III. Active listening

In a post disaster relief camp situation there will be lot of noise and distractions, and lack of privacy when care givers try to interact with survivors. Therefore active listening is an important skill to facilitate ventilation and develop empathy, which in turn facilitate the whole process of providing emotional support. The following guidelines can help the care givers in achieving better results.

- » **Look at the person while he/she is talking:** This indicates the care giver's interest in what is being said.
- » **Respond occasionally while listening:** This helps the survivor in feeling that s/he is being understood and taken seriously. Sometimes it helps to paraphrase what has been said, often giving the speaker another viewpoint.
- » **Avoid interruptions:** Let the other person finish his/her thoughts. Do not interrupt unless there is confusion and the details are jumbled.
- » **Be tolerant:** Do not prejudge or moralise or condemn or interpret how the other person should feel.
- » **Empathise:** Share the experiences of the other person as if they are your own.

This is one of the most important technique for a worker and one of the most difficult to adhere to. It takes a long time for a worker to actually start using it. Once they start using it they are able to realize the power such listening has in alleviating the pain and stress of the survivors and how much it helps them to build a rapport with the survivors.

IV. Social support

Everyone feels very comfortable with a certain level of emotional and social support that comes from others around him or her. Social support networks are extremely important for feeling comfortable and secure. In a disaster situation all the support systems get disrupted, hence the need to rebuild and restore. For example if we go to a new town to work or study and we know no one there, since we have come for the first time we would feel insecure, lonely, scared, and at times fearful. If we meet some people from our background (language, religion, region etc) then we would immediately feel a sense of happiness, want to be with them, try to meet them, and feel relieved.

V. Externalization of Interests

In temporary shelters and relief camps, survivors generally do not get any work to do. The basic necessities for survival are met without much effort within a week, thus giving them plenty of time to think and worry a lot. Therefore, engaging them in small but productive activity/work (keeping age, gender, physical status, skills and interest as considerations) would help them in imbibing a positive thinking and feelings. This technique is very crucial from the participatory community disaster management approach. This also helps the survivors in providing a channel to ventilate/express some of their repressed emotions and feelings. In addition this technique has a positive impact on their self-esteem and self concept. The women/men at camps can be engaged in the community kitchens, the adolescents can be engaged in taking care of camps/day schools of the younger children, men can be engaged in keeping law and order in the camps, and so on. Once they are engaged, their minds will be meaningfully occupied and the physical movement will also add to the increased level of feeling better and energized.

VI. The Value of Relaxation

Introducing relaxation activities for children (for instance some games, songs, dancing, painting, colouring and other things) and adults involving physical movement has proved to be very beneficial in helping survivors recover from their trauma and pain. These activities will help to channelise their energy and control some stress producing hormone. Simple relaxation techniques can be taught to them to bring relief from the painful memories or emotions.

VII. Turning towards Religion and Spirituality

Religious belief or belief in a higher power greater than man is an integral part of human beings' existence and this gives great relief and support during critical periods of their lives. Similarly, spiritualism can also help in rebuilding shattered life gradually. Disasters upset the daily religious and spiritual practices by raising lot of queries in the mind of the survivors regarding the God's existence and his/her repayment of survivor's good deed and religious practices. Helping people to turning towards his/her practiced religious rituals and practices (e.g. daily worship, prayer and related activities) would also facilitate the ventilation process, whereby there is a possibility of verbal/non-verbal expression of feeling/emotions and thus, making the survivor more peaceful in mind. Therefore, it is important to reinforce the religious practices and spirituality in the person we are working with because it has tremendous power to heal the pain and suffering.

Learning Objectives

At the end of the session the trainees should be able to:

- » Describe the process of each technique
- » Explain the appropriateness of applying each technique
- » Differentiate between two similar looking techniques
- » Identify the sensitive issues involved in each technique.
- » Mention the interdependence/relationship among the seven techniques.

Methodology

- » Interactive Lecture
- » Group activity
- » Games

Teaching/ Performance Aids

- » Flip Chart & Markers
- » Balloons & Ball

Duration

90 minutes

Notes for the Trainer

The trainer would write down the principles of emotional support one by one on the white board and discuss with the trainees with small illustrations. At the end of the session the participants should be asked to repeat the principles and one of them should write them on the white board. The trainer should announce in the class that the principles written on the white board should not be wiped off till the end of the training programme.

Learning Unit 1.3.2 - Basic Techniques of Disaster Psychosocial Care: Role Play

Context and Description of the Session

This session is meant to know the extent to which the techniques described in the last session have been understood/internalised and how the trainees would practice these techniques in real situations. Hence, all the trainees are bound to participate in the role play and have to apply few or all techniques on the basis of the case study given to a specific group. The case studies should be based on different disasters such as cyclone, earthquake, fire, bomb blast, train accident, and different vulnerable groups such as women, alcoholic, adolescents, children, elderly, a chronically ill person, a male survivor. However, it should not be longer than 2-3 lines. Longer descriptive case studies would block the trainees' original imagination of the event, leading to limiting the roles as per the description.

While one group is performing, other groups would be observing and when the performance of that group is over, all other groups would be analysing the application of techniques. The trainees should be adequately instructed about the criteria of analysis and observation before the actual role play takes place.

The general criteria for observation and analyses during the role play are the characters chosen for role play, the issues addressed, entry of a character, sensitivity of the group members, rapport establishing, ventilation process and method followed, quality of active listening and right application of other techniques. In addition, the observers from the other three groups when a group is performing should note the following things:

- » What is the actual problem?
- » Normal or abnormal reactions
- » Different techniques used
- » Spectrum of care used
- » Non verbal communication
- » Any suggestions

Post-role play discussion lead points should also emphasize the role of care givers. They should:

- » Not use harsh words
- » Not interrupt too often while interacting with the survivors.
- » Show good coordination and body language among the team members

- » Seek community support to help the client
- » Not give any false promise
- » Should not introduce themselves by saying they are there to give PSC to the people
- » Not make them dependent.

Learning Objectives

At the end of session the trainees would be able to:

- » Apply various techniques of psychosocial care in different disaster situations.
- » Clarify and rectify their mistakes during discussion
- » Identify small but sensitive and critical issues/factors which could affect the effectiveness of the techniques.
- » Become more confident in applying the techniques.

Methodology

- » Role play

Duration

90 minutes

Trainers Note and Session Plan

The trainer should try to follow the given session plan so that the role plays become more structured, effective and meaningful ways of learning. First the case studies are to be given to different groups (one case study to a group). Then the general instruction (such as, time limit for preparation and enacting the play, role of other groups while one group is in action, and observation-analysis criteria) should be given by the trainer. Once the groups are settled and start preparing the trainers should go to each group to facilitate the process of preparation by clearing any of the doubts the groups may have. Time should be maintained very strictly.

Activities	Duration	Role of the trainer
Case studies & General Instructions	7-10 minutes	Clarifying doubts Clarifying group / case study specific doubts
Group Preparation	10-15 minutes	Observation
Group presentation	10 minutes for each group	Appreciating the group performance but supplementing the analysis done by other groups
Discussion after each play	5 minutes	Thanking all groups and concluding the session.
Closing the session	5 minutes	Announcing the importance of the next session on working with vulnerable groups for this session

Working with More Vulnerable Groups

Module 1.4 is about Working with More Vulnerable Groups and consists of the following learning units.

- » Learning Unit 1.4.1 Working with Women
- » Learning Unit 1.4.2: Working with Children
- » Learning Unit 1.4.3: Working with People with Disabilities
- » Learning Unit 1.4.4: Working with Elderly People

This module describes the specific vulnerabilities of some groups in the society and how their pre-existing vulnerabilities get compounded in a disaster. Different learning units explain the vulnerability of different groups and what are the essential techniques to provide psychosocial care. This module is supplementary to the earlier module on basic techniques and principles of disaster psychosocial support.

Context and Description of the Session

While all survivors face one or the other form of psychological distress, it could be very high among the children, disabled, elderly, survivors dependent on critical health care facilities and women, due to their underlying vulnerability in general during non-disaster period in the society. These groups of survivors are more prone to adverse psychosocial and mental health consequences of disasters due to a number of reasons. Special attention should be given to these groups while planning for psychosocial support, especially in designing the intervention programme.

Children's reactions to any disaster (more so in case of man made disasters) depend on their developmental age, sex, physical status, social and emotional maturity, and the nature of loss they have experienced and/or witnessed. Emotional consequences in children are often the result of the losses suffered by them in the form of death of a near and dear one, loss of friends and relatives, loss of property and familiar places, loss of pets, injury and hospitalization and struggle for food, shelter and other basic amenities.

There are some groups of children who have additional susceptibilities and require even greater care and support. These are:

- » Orphaned and unaccompanied children, especially girls
- » Children whose parents are missing
- » Children whose parents have remarried,
- » Children who have been disabled or injured and

- » Children who are physically or mentally challenged.
- » Children who are dependent on critical health care facilities

Due to the biological make up, and economic, social, psychological and cultural disadvantages in the normal society, generally women are more vulnerable and known to face greater emotional distress during any disaster. Their loss, their emotional reactions and needs should be addressed by the care givers specially ensuring to them basic amenities and security in the relief camps, legal help and other aspects of the spectrum of care principles in psychosocial support. Women if willing should be included and involved in the psychosocial care programme and community outreach activities.

The following groups of women need more attention:

- » Pregnant and lactating women
- » Disabled women
- » Women on critical health care facility
- » Women who lost their children and plan to undergo recanalization surgery
- » Elderly women
- » Women with prior history of psychiatric illness

Elderly people are often faced with the problems of reduced physical & mental capabilities, delayed response syndrome, increased transfer trauma & the array of emotional difficulties, dementia, and rigidity to accept changes. These problems get compounded in case of a disaster and often in widely varied circumstances. While basic health facility is the priority for those having critical medical needs, all elderly should be attended by these non-medical trained care givers on a priority basis. Elderly people are often neglected and their psychological needs are overlooked in a disaster. While they need strong and persistent verbal factual reassurance, any short-long term rehabilitation and rebuilding, psychosocial care intervention should be designed to cater to their individual needs.

As per the PWD Act (1995) of Govt. of India, people with disabilities are a highly diverse group. Thus, each disability has its unique characteristics and disability specific needs. Since, their life conditions even prior to disaster are at a higher deprivation level, life conditions after a disaster become even worse. This could induce higher level of psychological distress and negative emotional reactions, which in turn could jeopardize their whole life functions. Therefore, psychosocial care givers should take extra caution to safeguard their self respect and cater to their mental health needs. In case special

intervention programme is needed to address their overall safety, dignity and needs, more emphasis should be placed on the inter-sectoral collaborations for their betterment. The following aspects should receive special attention of the care givers in the post-disaster phase:

- » Accessibility to shelters and availability of basic amenities
- » Availability of auxiliary aids, equipments and services during the relief
- » Special livelihood programme
- » Treatment for any associated psychiatric illness
- » Long-term community rehabilitation

People with chronic mental illness should be provided service through the District Mental Health Programme or other available mental health services along with other psychological therapies by the mental health professionals. It would be required to maintain continuity in the treatment of these people by more frequent contacts and actively reaching out to them. The following categories of people dependent on critical health/medical care facilities should be given special consideration while planning the psychosocial services in a post-disaster phase:

- » People on Dialysis
- » People with organ transplantation
- » Alcohol/drug dependents
- » Heart patients
- » People living with HIV/AIDS (PLWHA)
- » People on Specific therapies (such as Cancer patients)
- » Insulin dependent diabetics on high doses of insulin

Objectives

The key objectives of the module are to:

- » Sensitize the participants about the specific needs of the more vulnerable groups
- » Train the trainees on different methods of providing disaster psychosocial care to more vulnerable groups
- » Explain the process of initiating and closing the techniques through use of different mediums and group activities
- » Describe the applicability of these methods in different situations
- » Analyse role play done earlier in this new context

Duration

4 Hours/ 240 minutes

Methodology

- » Presentation
- » Group activities/Games
- » Body Mapping
- » Regression
- » Mediums for Children

Teaching/Performance Aids

- » ToT Workbook
- » Flip chart and white board with markers
- » Caly sets
- » Family of Dog set
- » Emotional Face Cards
- » Story Cards
- » Handkerchief

Trainers' Note and Session Plan

The methodology and process of intervention for each group is different, therefore the trainer/s should be very alert about time management and facilitate the progress of the session with lead questions/points so that trainees participate and gain more from the session. The children's session consumes more time followed by the women, disabled and elderly. After each group activity/game/exercise, the trainer needs to elaborate the importance of each technique and how does it work. The trainer should also encourage questions from the participants to clear their doubts.

Session Plan

Session	Methodology	Duration
» An overview of Needs of Vulnerable Groups in Disasters (This PPT can be divided into 4 parts, 5-7 minutes each and then be presented while a particular session on a group starts).	Presentation	30 minutes
» Women	Body Mapping Group activity	30 minutes
» Children	Regression & Play therapy	60 minutes
» Disabled	Group Activity	40 minutes
» Other groups	Group discussion	20 minutes

Learning Unit 1.4.1- Working with Women

In addition to the presentation, the women issues should be discussed through a group activity called “Body Mapping”.

Progress Process

» Learning Objectives of Body mapping

- › Identifying biological, social, psychological and cultural disadvantages/ vulnerabilities associated with the perception of women body
- › Overcoming hesitation and stigma associated with women’s body
- › Accepting and loving your own body

» Process of Body Mapping

- › 4-6 large pieces of coloured papers should be jointed with adhesive tape so that real contour drawing of a lady could be done on the paper.
- › Identifying and drawing various body parts including private parts
- › Discussing important roles and vital functions of all parts and societal perception
- › Needs during a disaster
- › Specific vulnerability of males

Duration

45 Minutes

Trainers’ Note

The presentation made at the beginning of the session should include the reasons for special vulnerabilities of women in a disaster context.

If there are a representative number of lady participants there, then only this methodology should be adopted, otherwise the facilitator/trainer could just supplement the discussion on women issues in disasters with the review of the manual on women in disasters. Men’s susceptibility to substance abuse, multiple sexual partners, etc may come up as the problems. If so pls. discuss that briefly with the trainees.

ToT Workbook may be consulted and participants should be instructed to work on page no. 33-35.

Learning Unit 1.4.2- Working with Children

Context and Description of the Session

Regression is a process of recalling past events which have a remarkable influence and impact in someone's life. The focus is always laid on the emotional aspects of incident. Play therapy methods include methods used to facilitate the process of describing memorable incidents from survivors' life with the help of thematic story cards, facial expression of emotions card, clay models made by the survivors, identifying family of animals, etc. These methods are very useful for disaster affected children as children many times fail to express their emotional turmoil properly. These methods are equally important as the process of activity.

The participants would come to understand how the various mediums can be used for children to help them express their feelings and in:

- » Mastering their emotions.
- » Understanding the development and changes through peer interaction.
- » Building their self esteem
- » Skill development
- » Decision making
- » Problem solving
- » Coordination and cooperation with the peer group.

They would also understand that through the use of such mediums the psychological status of the children could be identified and improved. The various psychosocial care programmes can be undertaken and regular follow up done with out any medical treatment.

This session aims to enable the participants and expose them to various mediums which they could use to help the children to express and master their emotional reactions.

Learning Objectives

At the end of the session the trainees would be able to

- » Recall either a positive or a negative life event which caused emotional flux of reactions in him and her
- » Identify the people who provided help and social support in overcoming the crisis.
- » Describe how the methods helped them to ventilate their suppressed emotions

- » State their level of comfort in using these methods with children
- » This would also help the participants to share some of their repressed memories of childhood, which they never shared with anyone and feel relaxed.

Methodology

» Presentation

- » **Regression.** Participants should be asked to close their eyes for 5 minutes and recall an incident that happened in their childhood between 5-15 years of age. They would be requested to share the experiences which are entirely confidential. Emphasis should be on the emotional experience s/he had during that incident. While trainees who volunteered to share others are requested to listen to him/her actively and learn the lessons. It is ensured that most trainees share their experiences.

» Play therapy methods

The facilitator divided the group into 3 of each and distributed a set of clay for the 1st group, dog family set to 2nd group, thematic cards set to 3rd group.

Teaching or Performance Aids

- » **The Medium of Clay :** The 1st group is asked to make some thing out of the clay that was given to them . What they miss most in their personal life or the things they could not get in their life. The group members should also be instructed to describe the incident in front of other groups once the group activity is over.
- » **The Medium of Thematic Cards :** The second group is instructed to read the picture and relate it to their childhood incidents and describe the incident in front of other groups once the group activity is over.
- » **The medium of Family of Dogs:** This is a set of 5 small and soft plastic made dogs of a dog's family. The dogs are positioned in different ways with different facial expressions. The group is instructed to identify with the dogs and describe the incident of their childhood using these five dogs.

Duration

60 minutes

Notes for Trainers

As mentioned in the earlier note in the beginning of this module, the trainer should be very particular about the time management. The presentation done earlier at the beginning of the module as an overview should include the reasons for special vulnerabilities of children and how children psychosocially react to disaster situations.

Learning Unit 1.4.3- Working with People with Disabilities

Context and Description of the Session

Persons with disabilities comprise a heterogeneous group of people, in terms of age, type of disability, and the conditions which led to acquiring a disability in addition to other demographic factors such as gender, ethnicity, and socio-economic status. This community is considered to be at high risk during any disaster because of the unique characteristics of each disability and the special needs associated with that type of disability, diversity in pre-disaster living conditions, and diversity in the disaster-imposed disability population. The populations affected by disasters contain a high proportion of the disabled. The nature of the disabilities of those affected and acquired because of disasters is different from the rest of the non-disabled but affected counterparts in terms of their specific physical, psychosocial and economic needs. Their disabilities, by and large, result directly from the conditions created by disasters, such as armed conflict, communal violence, landmines, floods, earthquakes, fire, etc. The disabled from the disaster-affected areas have limited or no access to health and educational services. These affect their desperate conditions even more adversely. Besides, being disabled they face abuse, exploitation, and neglect much more than their non-disabled counterparts. All these needs are marginalized in pre-disaster life conditions of PWDs prevailing in India and get compounded in case of a disaster or emergency situation. Thus, in addition to these disaster induced specific needs, previously existing health, psychosocial, financial and security hazards are also aggravated during such chaotic time leading to a complex life conditions where they are forced to live in.

Within the disabled group, children become special in terms of their specific needs in a disaster management cycle. In addition, children with special needs who become orphans after any disaster and who need critical medical care facilities e.g. children suffering from cancer, diabetic, asthma, poor heart condition, blood borne diseases, HIV-AIDS, etc. form the most vulnerable group and very vulnerable to different types of exploitation and abuses. Their safety, health, educational, emotional and social needs are generally overlooked in the chaotic situations after a disaster, and demands extra care from the care providers.

Hence, initiating and sustaining support till they regain their psychological, social and economic stability should be the primary concern of the care givers.

Learning Objectives

The participants would be able to

- » Distinguish various types of disabilities as per the classification in PWD Act-1995.
- » Specify the disability related problems of PWD during the post-disaster phase.
- » Explain special vulnerability of women and children with disabilities.
- » Describe specific needs of different categories of PWD.
- » Explain the steps that should be taken care of by a care giver to address the psychosocial needs of these people.

Methodology

- » Power point presentation
- » Psychological Game: Finding the Destination & Social Support Process

Duration

30 minutes + 5-7 minutes in case the presentation is made in the beginning of this session.

Teaching/Performance Aids

- » Handkerchief
- » Coloured Chart Papers
- » Handout 1.4.1

Trainer Notes & Session Plan

While during the first group activity (game), the trainer/facilitator does not need to make groups, the second group activity needs 3 different groups to participate on 3 different issues as mentioned.

Activity	Methodology	Duration
PPT	PWD Act-1995, Population, Categories, Needs	5-7 minutes
Game	Finding the destination & process of social support	15 minutes
Group Activity	Women, children, and chronically ill with disabilities	10 minutes
Presentation	Group presentation	15 minutes

Learning Unit 1.4.4 - Working with Elderly People

Context & Description of the Session

Elderly is a relative term. Some people feel the effects of aging earlier than others. So, each family must determine for itself when it has members who can be categorized as elderly. One definition might include those persons whose faculties, senses, physical or mental capabilities are declining and assistance from others is often desired or actually needed.

However, in disaster situations all categories of older people tend to become more vulnerable due to the following factors:

- » Physical and emotional frailty arising in the later years, particularly among the so called “old-old” or those well beyond age of seventy-five.
- » Acute late life feelings of personal loss intensified by disaster damage.
- » Those more susceptible to hyperthermia
- » It can be more difficult for some of the elderly to understand the significance of what is taking place. Some could become easily confused or disoriented.
- » Many elderly do not want to evacuate even when ordered to do so. They would rather “ride it out” at home they know and feel comfortable.
- » Their pets are key points in decision making for the elderly. Many will not go to a public shelter because their pet cannot accompany them.
- » Elderly require more planning. They move more slowly and with greater effort than younger people. They are inclined to have more medicines, medical aides such as walkers, and other considerations, which require more advanced planning and preparation time to move.
- » They may require special medical attention, such as the assistance they would receive at a special needs shelter.
- » When evacuating they could require more rest stops.

Literature on the psychological impact of natural disasters on elderly has been mixed. Some studies have posited an increased incidence of distress among older survivors, based on the assumption that the elderly are more likely to be exposed to disaster-related danger and to have less health, financial and social resources. Others have found that older adults who have survived previous disasters fare better psychologically in subsequent disasters than their inexperienced counterparts. The prior experience, researchers believe, may effectively inoculate elders against the potentially debilitating depression and anxiety that can set in following the injury and/or loss of personal property which can result from natural disaster.

The tendency to find dissimilarity, rather than similarity increases, as persons grow older, has greater significance in disaster relief situations. There is a definite need to meet the needs of older persons who require special help, as well as to make an effort to utilize the strengths and skills of many older persons who can contribute (Administration of Aging Publications, 1994).

Learning Objectives

The participants would be able to

- » Define “elderly”
- » Explain special vulnerability of elderly people.
- » Describe specific needs of elderly people in different categories, and how these needs are related to their overall psychosocial needs.
- » Specify the steps that should be taken by care givers from different government departments to address the psychosocial needs of these people.

Methodology

- » Power point presentation
- » Group discussion

Duration

30 minutes + 5-7 minutes in case the presentation is made in the beginning of this session.

Teaching/Performance Aids

Coloured Chart Papers

Trainer Notes & Session Plan

Three groups would work on 3 different categories of elderly people.

Activity	Description	Duration
PPT	Elderly Population: Vulnerabilities & Needs	5-7 minutes
Group Discussion	60-70 yrs, 70-80yrs, >80 yrs.	10 minutes
Presentation	Group presentation	20 minutes
	Concluding the session on more vulnerable groups	10 minutes



Stress Management & Care of Co-workers

This module consists of the following two learning units.

- » Learning Unit 1.5.1: Understanding Stress Symptoms and Management
- » Learning Unit 1.5.1: Self-care and Care of Co-workers

This module enumerates the process of building of stress symptoms that could affect the body and mind of the people working in the disaster affected areas. This module also lays due emphasis on the stress reduction techniques through which self care and care of co-workers could be achieved.

Objectives

The key objectives of the module are to:

- » Experiment on stress symptoms
- » Explain how to recognise these symptoms
- » Describe the applicability of stress reduction techniques in different situations
- » Review and assess the skill transfer level through role play

Duration

3 Hours/ 180 minutes

Methodology

- » Experiment cum Demonstration
- » Group activity
- » Group relaxation exercises
- » Group presentation

Teaching/Performance Aids

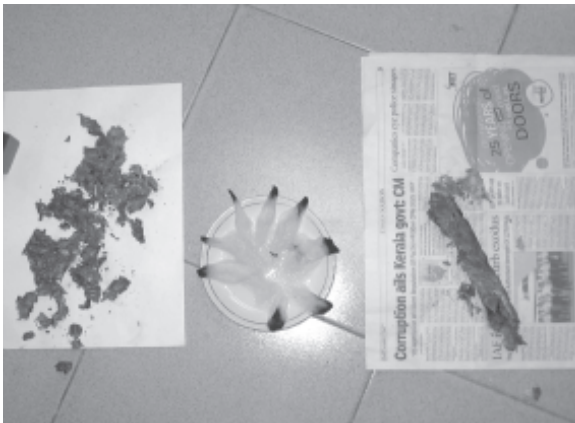
- » ToT Workbook
- » Flip chart and white board with markers
- » Stress Reactions cards
- » Cotton, Match box, Oil, two quarter plates, thick white paper or blotting paper,

Trainers' Note

The methodology and process of each activity varies and training materials required for each activity is different. It is important to mention here that after forming groups for experimenting with symptoms of stress, the **trainer must find out from the group who would experiment on physiological symptoms of stress** if any member has a health problem, which can prohibit him/her to undertake physical stress,

- » If any group member has undergone health surgery or having cardio-vascular problems, asthmatic problems, diabetics, etc.
- » Consent from the members of the group is a must.

After each group activity/game/exercise, the trainer needs to elaborate the importance of each technique and how does it work.



Learning Unit 1.5.1 - Understanding of Stress Symptoms & Management

Context and Description of the Session

The concept of stress was first used by Selye (1956) in his biological stress theory. It was defined as a set of specific physiological responses to environmental stimuli, e.g. chronic fatigue, nervous breakdown, physical damage etc. The important role of psychological factors in understanding the occurrence and modification of stress responses remained unrecognised.

Lazarus (1966) differentiated psychological stress from other types of stress in his integrative cognitive phenomenological stress model, where he defined stress as a particular kind of commerce between a person and his environment. A cognitive phenomenological analysis of the commerce revealed a variety of relationships occurring between the person and the environment, which were mediated by cognitive appraisal processes. Psychological stress referred to both the internal and external stimuli, which were aversive and threatening for an individual. However, like physical stressors, psychological stressors did not cause psychological stress directly but through intervening socio-personal and cognitive factors. These factors included components such as, how an individual perceived/appraised the significance of the events according to higher needs and expectations; whether he/she perceived/appraised them as harmful or threatening to his/her state of mind; and how well he/she adjusted and coped with the events to decrease their influence. Cohen (1985), in support of Lazarus pointed out that life events themselves were not necessarily stress producing. Rather, their cognitive appraisal was central to it. Cognitive appraisal depended on many factors like, person's emotional and social maturity, social and financial background, gender, age and experience in similar situations, education, physical and mental capability and the perceived social support around the person.

Kessler (1979) examined the relative contribution of exposure and vulnerability to the impact of stressors. He contended that people coming from lower social class were exposed to more stressful experiences; and comparable events affected their emotional functioning more severely than those in higher social class. The stress coefficients reflected the combined effects of total events, undesirable events and chronic stressors (economic concerns and health problems), which made the stressed more vulnerable to psychological distress like, depression, low social-emotional adjustment, low self-confidence, and frustration.

The aversive and threatening experiences of the stressors of adolescence became cumulatively active in interaction with an impairment/disability. As the environment

and the impairment both imposed certain limitations on them, the number and effects of different stressors became multiplicative. Parson (1958) hypothesised that impairment disrupted established role patterns and the meeting of social role expectations, which created more stress, role conflicts and strained interpersonal relationships resulting in performance deficits.

Diverse Stress Responses

A. Cognitive Responses:

- » Low awareness of the environment
- » Restricted scope of perception
- » Lowered ability to concentrate
- » Disturbed memory functions
- » Hesitation in decision making
- » Change in content of thinking
- » Low creativity and change in performance
- » Less ability to utilise relevant information

B. Emotional Responses:

- » Feelings of deprivation, guilt, anxiety, tension, aggression, irritation, worry, sadness, hopelessness and maladjustment.

C. Self-image:

- » Low self confidence
- » Identity problem
- » Depression & Helplessness

D. Psychosomatic/Physiological Responses :

- » Headache & Body Ache
- » Muscular tension and pain
- » Gastrointestinal disorders/low appetite
- » Sleeplessness
- » Difficulty in breathing
- » High Blood Pressure (Source: Zimbardo, 1979)
- » Vague pain in different parts of the body
- » Increased heart beat & palpitation
- » Sweating in palms and feet

- » Shaking of the body & Fatigue
- » Butterfly sensation in the stomach

BEHAVIOURAL	SENSATIONAL	EMOTIONAL
Substance dependence Sleep problems Tea smoking Restless Eating problems Aggression Irritation Speech problems Accident prone Eat, talk, walk faster Unkempt and untidy Low productivity Bad time management	Heart rate Headaches Nausea Aches and pain Tremble Fainting Numbness Dry mouth Stomach cramps Sweaty Indigestion	Anxiety Guilt Embarrassment Depression Hurt Jealousy Feel like dying Cry frequently Moody
COGNITIVE	BIOLOGICAL	INTERPERSONAL
I must do well Life should not be like this I must have what I want This is terrible I cannot take this any longer Everyone should like me	Digestion problems Blood pressure Heart problems Tiredness Allergies Low immunity Mental problems	Cannot keep relationships Suspicious Gossip Competitive Withdraw Fearful and unassertive Aggressive

Source: NIMHANS TOT Handbook

It is important for the caregiver to understand that he/she is involved in work that is going to make demands on his/her physical and emotional life. The daily stressors of work in disaster affected area and with disaster survivors will produce stress in them. It is important for them to understand this aspect and take some preventive actions to enable them to cope with this stress.

The following situations could produce stress while working in disasters

- » Listening to the painful experiences of people
- » Travel to inaccessible places
- » inadequate food and portable water to sustain
- » Being with the people in the camps where the living conditions are stressful
- » Dealing with the frustrations and anger of the survivors
- » Having to deal with multiple demands for instance, the government office, the survivors, agency they are working with, attending trainings and meetings

- » Working long hours
- » Not getting time to relax and take care of personal issues
- » Not able to contact the family members
- » The weather in the area etc.

It is important to understand that different people would respond to stress in this situation differently, depending on their personality, coping styles and social support network. Also what stresses one person may not necessarily stress out another person, therefore a fixed stress management technique/standard cannot be laid out for everyone. However, some easy and quick techniques which can be used for relaxation would be shared with the participants.

Relaxation Exercises

Abdominal breathing

- » Sit comfortably
- » Close your eyes
- » Put one hand on the abdomen
- » Focus on your breathing and try and see that you are breathing from your abdomen rather than your chest
- » Concentrate on the fact that your stomach is rising as you breath in and falling as you breath out

Count breathing

- » Sit comfortably
- » Close your eyes
- » Count 1-2 two as you inhale
- » Release your breath slowly counting 1-2-3-4 (double the count of your inhalation)
- » Practice this till you feel relaxed

Nostril breathing

- » Inhale naturally and then let out with a whooshing sound. Hold for some time and then let out again
- » Breathe through one nostril and breathe out through the other one
- » Combine breathing with visualization that you are getting energy and refreshment
- » Listening to some music while practicing these will enhance positive impact of the techniques

Free Meditation

- » Sit comfortably or lie down and close your eyes
- » Put on some music and listen to the music
- » Do not try to think of anything, just concentrate on your breathing
- » If any thoughts come in do not try to control them or force them out, instead spend time on them and let them go as they come
- » Do it initially for about 5 minutes and slowly as you become better at it go on increasing the time period to about 20 –25 minutes and it would prove to be very relaxing

Candle meditation

- » Sit comfortably
- » Light a candle or a lamp in front of you
- » Concentrate on the flame
- » Spend time just looking at the flame glowing and flickering
- » If you feel after some time close your eyes and look at the image in your mind
- » Slowly open your eyes after you are completely at ease
- » Do it initially for about 5 minutes and slowly as you become better at it go on increasing the time period to about 20 –25 minutes. It would prove to be very relaxing

Relaxation

- » Lie down on the ground
- » Slowly move from your feet to your head saying the following to yourself

“The toes feel completely free and relaxed”

Repeat this for all your body parts pausing between each statement and talking in a calm and slow voice if you are leading a group and silently if you are doing this for yourself.

Toes	Calf	Hips	Shoulders	Neck
Heels	Knees	Stomach	Arms	Face
Sole	Thighs	Chest	Hands	Head

Now your total body is completely relaxed and there is no tension or strain anywhere. Stay with this relaxed self for as long as you wish.

Learning Objectives

The participants would be able to:

- » Experience different stress symptoms and be able to recognise the symptoms in body and mind.
- » Explain the reactions of stress affecting the body and mind
- » Describe and list the key stress reduction measures
- » Learn and demonstrate small and quick relaxation techniques

Methodology

- » Experiment-cum Demonstration
- » Group exercise
- » Group relaxation techniques
- » Sharing of experience

Teaching/Performance Aids

- » Stress Reactions cards
- » Flip chart and white board with markers
- » Cotton, Match box, Oil, two quarter plates, thick white paper or blotting paper,

Duration

120 minutes

Trainers Note and Session Plan

Process of conducting the session		
Activity	Description	Duration
1. Brief introduction	common understanding of stress	10 minutes
2. Group instruction	experiencing different reactions	5 minutes
3. Experiment	demonstration Physiological, emotional, social, behavioural reactions	30 minutes
4. Group sharing of experience		30 minutes
5. Differentiating reactions/responses	card sorting	20 minutes
6. Relaxation exercise	Jacobson's PRE, breathing, etc.	20 minutes

Learning Unit 1.5.2 - Self-care & Care of Co-workers

Context and Description of the Session

It is important to be aware of how we react to stress in our life and then take steps to prevent this reaction from disturbing our emotional well being. The steps for self-care have to set in consciously and have to be an integral part of the training and orientation of people involved in psychosocial care giving. They have to watch out for burnout symptoms that could influence their productivity and skills of good psychosocial care giving.

Often in Indian cultural context the work of helping people who are in need, is seen as charitable. It becomes difficult for workers to disassociate from their work and their continuous and strenuous involvement becomes overwhelming and suddenly the worker could face a burn out. All the workers need to be aware of the signs that could suggest that they need to take a break and just rejuvenate and refresh themselves. The idea being that we are working but have to remain effective in our work. Commitment should not be equated to how many hours you stretch out to but how much qualitative work you are able to do. Also the workers generally feel guilty for thinking of their needs before those of people in greater need and trouble. Taking time off for themselves is seen as selfish but this idea and perception needs to be broken right at the beginning and in this the management also needs to play a crucial role in supervising that the workers take self care seriously.

Some signs indicating that self care has become critical for you

- » You find it difficult to leave your work even for a short period.
- » Your sleep, appetite is disturbed.
- » You are unable to enjoy things.
- » You want to avoid going to work.
- » You are easily irritable.
- » You cry easily.

Being aware of how we react can help us identify when we are stressed and then take action to reduce the levels of stress we are experiencing.

Apart from the physical exercise, and other relaxation exercises for stress reduction and to maintain the homeostasis of the body, the following stress reduction measures can also be adopted.

- » Listen to each other's feelings.
- » Do not take anger too personally.
- » Avoid criticism unless necessary.
- » Give each other comfort and care.
- » Encourage and support co-workers.
- » Reach out to others when you are feeling low as well as look around and support others if they are down.
- » Develop a buddy system with a co-worker. Agree to keep an eye on each other's functioning. Check for fatigue and stress symptoms. Take a break when required.
- » Get some physical exercise daily.
- » Regularize your life leaving enough spare time for rest.
- » Listen to music, read books, watch television everyday.
- » Try and eat frequently and get enough sleep.
- » Practice relaxation techniques frequently.
- » Stay in touch with your family and share your thoughts and feelings with them.
- » Keep a diary of your activities and experiences.
- » Keep one day per week only for your personal work and relaxation.

Tree of Sustenance

An analogy of a tree beautifully explains the need for self care. Just like a tree, which is able to provide shade and fruits to passers by who take refuge from the sun under a tree, a worker provides support and care to people who need them. However the tree needs to remain shady by having new growth and leaves on a continuous basis. It draws its strength from the rain that gives it water for nourishment, its roots help it stay in one place and withstand storms that might pass over. Its old leaves fall and give way to new fresh green leaves.

Similarly a workers needs to identify people in their lives who are providing them strength and support to stand tall and face challenges, these would be their roots and they can call for the support of such people in their life. Secondly they need to look at the old leaves i.e. behaviours, thoughts or emotions that are hindering their growth and productivity at work and they need to let go of such leaves and give rise to positive qualities and strengths i.e. green leaves in their lives. Finally they need to identify things in their lives, which refresh them when they are tired. It could be a movie or a hot cup of tea or music, small things that takes away their work stress.

Learning Objectives

The participants would be able to :

- » Recognise the burnout symptoms present in them and other co-workers
- » Learn and practice few stress reduction techniques to relax their body and mind
- » Mention their social support network and their personal strengths and weaknesses

Methodology

- » Presentation on burn out symptoms & stress reduction measures
- » Open discussion

Teaching/Performance Aids

- » Tree of sustenance : ToT Workbook page no.51

Duration

30 minutes

Trainers' Note and Session Plan

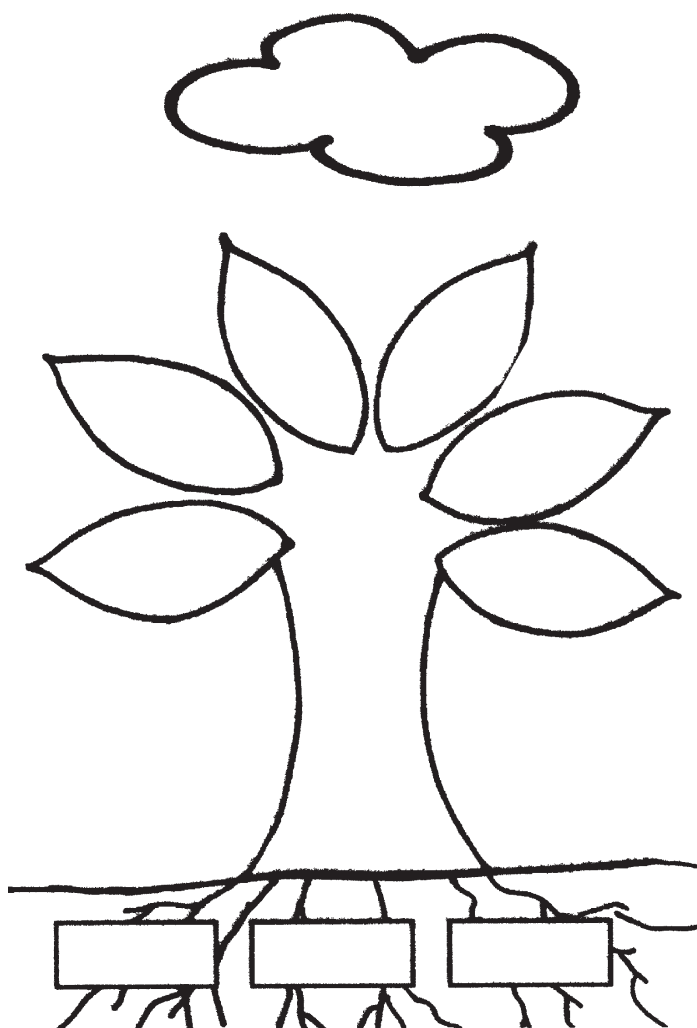
First 15 minutes: The trainer should make the power point presentation very interactive and lead questions/hints should be floated for open discussion during the presentation only.

Last 15 minutes: Working on the tree of sustenance

The process of conducting group work on Tree of Sustenance

The picture of the tree is given to the participants. Then the trainees would be asked to write three names of significant people in their lives (with whom they are comfortable to share their own problems and feelings) and their relationship with them on the roots. Then they are asked to write three of their good qualities on the leaves at one side and the qualities which they don't like on the leaves of the other side. Then they were asked to write three main hobbies on the place above the tree where the clouds are drawn.

The participants should then be told that human beings are like a tree. As the roots are very important for a tree, the sharing of our own difficulties with persons who are very trustable and close to us is important for us. Our good qualities are like green leaves and our qualities which we don't like are like dry leaves. So we should always try and grow the good qualities and shed the dry leaves (bad qualities), which would keep the tree fresh and new. The tree cannot sustain without water given by the clouds. So the hobbies written on the clouds should be followed regularly to keep the tree (our life) alive a for fruitful and peaceful long life.



Disaster Psychosocial Care: Ethics & Essentialities

This module has six learning units focusing on essential components of psychosocial care giving in a disaster situation.

- » Learning Unit 1.6.1: Psychosocial Needs Assessment
- » Learning Unit 1.6.2: Understanding the Scales Administration
- » Learning Unit 1.6.3: Referral
- » Learning Unit 1.6.4: Post-Training Assessment
- » Learning Unit 1.6.5: Ethics and Confidentiality
- » Learning Unit 1.6.6: Programme Evaluation

This module is the last module before completion of the training. Therefore, it includes various issues which are extremely important from the point of view of working with disaster survivors. Although learning unit 1.6.2. is a part of learning unit 1.6.1, it needs to be mentioned separately as trainees might have never used a psychological tool, e.g. Scales for recording data, use of different other recording devices, etc., before this training. Similarly, post training knowledge, skills and behaviour assessment would be conducted in the same way as the pre-training assessment on the first day was done.

Duration

6 Hours/ 360 minutes

Learning Unit 1.6.1 - Psychosocial Needs Assessment

Context and Description of the Session

Assessment of the psychosocial and mental health needs of the survivors' is an essential part of the entire relief, recovery and rehabilitation process, hence it should be continuous in nature. It serves a lot of useful purposes to understand the condition of the people, area you are working in, and the impact of your work; and lot of learning experiences in getting people back into normalcy.

There are many phases during which assessment can be done. The essential one is before any intervention is made in the disaster affected area or just after response phase of the disaster. An assessment can also be done midway after some interventions have been made so that we can understand the impact of work on the people we are working with. It may bring out new issues where intervention is required. The last assessment would be done to evaluate the result of our intervention, to see the progress made at the end of all interventions and the improvements as compared to the conditions at the start of the program. This would help us reflect upon the effectiveness of the work done. It would help to analyze to what extent the aims of the programme have been met.

Another kind of assessment is when we are trying to study in greater detail one aspect of our work. For instance we may be interested in understanding how one particular group, such as the widows or orphans have coped after the disaster. We focus on such groups and carry out specific assessments for them. It could also be in relation to a specialist like a psychiatrist, who does an assessment of someone little more affected by the events and needing greater care.

The methods used for this type of phase oriented assessment could be as follows:

- » Oral sharing with the survivors and leaders of the community
- » Participant and non-participant Observations
- » Group discussions
- » Focused group discussions with workers and /or beneficiaries
- » Semi-structured schedules
- » Other aids like toys for children
- » Participatory techniques like rankings

The need assessment relating to the disaster situation for psychosocial care can be carried out at many levels. This need assessment is very important to identify the current needs of the population as well as to know what are the essential elements of intervention that we should think of. As this module is primarily for the training of officers from government sectors, the post- disaster assessment can be done even if these people have other responsibilities during the post disaster phase. Some of the key questions which these officers can ask the survivors in their interaction could be:

1. Are there people in your village/community who have not returned to their pre-disaster status?
2. Are there people who are going to doctors very frequently with one or other complaint?
3. Are there people who are demanding more and more relief material or compensation beyond what is normal
4. Are there people who are not utilizing relief, reconstruction support and rejecting the volunteers or the organization?
5. Are there people who are showing behaviour like suicidal attempts?
6. Are there people who are started drinking alcohol for the first time and drinking excessively?
7. Are there complaints from women about increased irritability and domestic violence?
8. Are there more than usual number of quarrels, fights in the community
9. What are the specific needs to rehabilitate people who are most vulnerable, like widows, widowers, single parent families, disabled, elderly and people belonging to extreme minority groups?

The assessment can be done in a formal way at many levels;

1. The best level would be if mental health professionals like a psychiatrist, clinical psychologist, psychiatric social worker interview a random sample of the population and carry out an examination to know what is the nature and magnitude of the mental health needs of the population. However, this is very expensive both in terms of human resources as well as the time taken. It is well recognized though that at some point of time at least for some small number of people such an assessment is useful.
2. The second level may be to study patients who are coming to general medical clinics for psychosocial social issues. Majority of the people all over the world following disaster preferred to go to general medical personnel for care rather than go to psychiatrists even when psychiatrists are available. In view of this, a screening of these population may be necessary for separating them as people

suffering from physical problems, psychological problems and both physical and psychological problems and then identify the needs in the community. This method is very simple and there are some screening instruments available that can be used to know if the person scores above the certain number and indicates a high possibility of having psychosocial need. In addition this method is most suitable because they will deal with people who are already seeking help and those who are not getting the appropriate help. Lastly, it also serves as an intervention because primary care doctors to whom patients are coming can also provide the care as part of their contact.

3. The next level of assessment would be through the community level workers of the voluntary organizations working with the population. This would not be as satisfactory as the first and also because these people will not know which conditions are psychosocial in nature. However, with 1 to 2 days training programme and with the use of screening instruments they should be able to make an assessment. There are two levels of making assessment-
 - a) First is to conduct focus group interviews with small groups of 8 to 10 community level workers by a trained professional to draw out from their experience the relevant psychosocial issues. Some of the key topics for such focus groups are included in Appendix I.
 - b) Second is that, the workers having gone through 1 to 2 day training programme themselves can give screening instrument/s which take.....

As they are looking after a random sample of the population the analysis of this information can help in a good understanding of the psychosocial issues. At some point of time it would be desirable for a psychiatrist to examine at least some of these people to know the true nature of their problems. The third method has the advantage of helping in the process of need identification, which may also be used as an opportunity for sensitizing the workers and to prepare them for future intervention activity.

4. The same type of focus group interviews can be held with the leaders of the voluntary organizations, which would be dealing with the total care programme and would be seeing the community for psychosocial issues from different perspectives.

Rapid PSSMHS Needs Assessment Checklist

Gathering and analysing information is an ongoing task and is to be done throughout PSSMHS. Along with the identification of immediate needs and concerns and addressing them, it is always useful to gather and analyse additional information to have a thorough understanding of the victims from an overall perspective. However, it is to be

remembered that in most Psychosocial First Aid service delivery context, time, survivor's needs and priorities and other factors tend to limit information gathering. Therefore the care givers need to be extra sensitive in gathering information in order to provide an efficient intervention. The findings of the needs assessment should be interpreted carefully within the social and cultural context of the event. While this assessment is entirely from the psychological and social point of view, the overall damage assessment done by the district administration should also be considered to understand the true impact of the events, like floods.

The objective of needs assessment is to mobilize funds, collect the necessary materials and supplies to assist disaster – affected populations, ensure rapid delivery of help, restoration of basic services, and plan future action.

Learning Objectives

The participants would be able to

- » Explain the purpose of assessment of needs
- » List different types of disaster phase specific assessment
- » Describe different levels of assessment
- » State the different methods which can be used for psychosocial need assessment

Methodology

- » Power point presentation- interaction

Duration

30 minutes

Teaching/Performance Aids

- » Rapid Need Assessment Proforma

Trainers Note and Session Plan

First 20 minutes: Presentation

Next 10 minutes: Interaction with the trainees on the rapid need assessment Proforma

Learning Unit 1.6.2 - Understanding Scale Administration

Context and Description of the Session

As a part of the intensive assessment of different aspects of survivors' mental health and social health status, it is important to understand the basic components and technicalities of a psychological tool/scale. Trainees should be able to collect data using these scales if they would be able to clarify the doubts of the survivors to whom these scales would be applied. Moreover, these scales are extremely important from the point of view of evidence-based research and documentation, on the basis of which further need assessment and interventions could be planned. The following scales could be shared with the trainees

- » Impact of Event Scale: Adult & Children
- » Hopkins's Symptom Checklist- for measurement of stress symptoms
- » Family Schedule
- » Self-Reporting Questionnaire-SRQ
- » Disability Assessment Schedule- WHO DAS II
- » Quality of Life
- » Quality of Community Life
- » Beck/Amritsar Depression Inventory-BDI/ADI
- » GHQ
- » Other specific scales

The participants should also be told about the method of scoring of the scales so that in case they administer the scale they would be able to score the responses on the scale.

Learning Objectives

The trainees would be able to :

- » Sensitise themselves on different type and use of psychometric tools
- » Explain how to collect data on these scales.
- » Score the data sheets

Methodology

- » Scale administration

Teaching/Performance Aids

- » Different scales
- » ToT Workbook

Duration

30 minutes

Trainers' Note

The trainer should administer at least one scale e.g. the impact of event scale –the adult version or SRQ and then check with the trainees their individual scoring. This will enable the trainees to know how to score the scales and which scale is to be administered under what circumstances.

Learning Unit 1.6.3 - Referral

Context and Description of the Session

The role of a psychosocial care giver varies from one disaster phase to another. It is thus important for the trainees to understand their phase specific roles in the aftermath of a disaster.

A. Immediate phase

Reduce distress

In the immediate phase the first major role that workers have to play is of helping people overcome their trauma and come to terms with their losses (material or life). It is important to deal with the emotions of grief or else the pain remains and hampers the process of rehabilitation. People need to be helped in dealing with their anger, loneliness, sadness etc and move beyond their loss. Spending time listening to them and being with them would help in forming close bonds with the people as well as in healing as they have been able to share their experiences.

Increase Relief

Believing in the inherent dignity and worth of individuals they should be able to demonstrably acknowledge the fact that although people are vulnerable and need assistance it is imperative for them to help enhance the people's inherent capacities. Attitudes of charity and pity should give way to empathetic facilitation, which enables people to recover their full functionality.

Establish linkages

A lot of aid and resources tend to pour in the post disaster phase. At one end are the people and agencies who have material or skills to give but need assistance and guidance to help it reach the right people, and at the other end are those in need who are completely unaware of the availability and access to these resources. It is exactly the place where the psychosocial caregivers should play a crucial role. They should do everything possible to bring these two sides together by establishing linkages between the people who are in need and the resources available in cash and kind, whether from local agencies, social institutions, government, aid agencies etc. They should monitor the rendering of equitable distribution among people. It would be necessary to create self-awareness among people and to provide equal opportunities to all social workers to reach out to the most vulnerable groups among the disaster survivors and help

them move towards total rehabilitation. This is extremely critical in a diverse society like India. The trained caregivers should be able to rise above their personal biases and perceptions and respond to all people in need with urgency, irrespective of religion, caste or class or the situation they are in.

B. later phase

Assessment of needs

After the initial relief phase is over people have more time to reflect upon what they need or want to do with their lives. Psychosocial care givers at this stage should help in making more holistic interventions. They are aware of the problems of the individuals as well as of environmental (social, economic, political, cultural) issues that work for or against these individuals, so while planning interventions they are sensitive to them and try to meet needs at all fronts.

Interventions at this stage should focus on making people own the process and become equal partners in the entire rebuilding process right from planning to implementation. The workers should facilitate this ownership building. They should help survivors to ensure that the options are viable, sustainable and owned by the people.

Monitoring process

Regular monitoring should form an integral part of the needs assessment. This can be done in terms of periodic assessment of survivors' needs through the methods discussed in the previous unit. Monitoring could bring out new issues that need to be addressed and lead to innovative intervention packages for better recovery and rebuilding.

First Indication of Referral

During this whole process, the caregivers might feel that despite of their best efforts, some survivors are not able to get normalized and the situation is beyond their control. This is the first indication for the care giver to realize that these survivors need specialized help and support.

Referring a person to a specialist will require tact and sensitivity because of factors like social stigma, caste, etc. Help may be essential but the individual may not readily accept referral for a variety of reasons. However, the first task is to be able to recognize when it may not be within your own capabilities and skill to help a person and thus the need of referring him/her for professional attention.

There are **six situations (Alertness & awareness, Behaviour, Emotions, Perception, Speech, and Thought)**, which a psychosocial care giver should consider while deciding whether a referral has to be made.

Alertness & Awareness	
Within Caregiver's Control if the Survivor » Is aware of who s/he is, where s/he is, and what has happened with him/her. » Is only slightly confused or dazed or show slight difficulty in thinking and decision making or finding difficulty in concentrating	Consider Referral if the Survivor » Is unable to tell/recall his/her name, name of the place and what has happened to him/her in past 24 hours » Complains about what is happening with him/her
Behaviour	
» Is restless, mildly agitated and excited » Has sleep difficulty and decreased appetite » Sad, rigid, clenches the fists	» Is apathetic, immobile and unable to move around » Is withdrawn and mutilates himself/herself, does not take care of self » Violent and causes harm to others » Uses alcohol or drugs » Repeats ritualistic acts as compulsions
Emotions	
Within Care giver's Control if the Survivor » Is crying and weeping consistently by reiterating about the incident » Has blunt emotions, is numb and hardly reacts correctly to his/her environment » Is easily irritated and angered over trivial issues » Shows high spirits or laugh excessively » Is very quite with no emotions	Consider Referral if the Survivor » Is unable to be aroused and is completely withdrawn » Is excessively emotional and shows inappropriate emotions » Is excessively happy, or sad and depressed
Perception	
» Has all senses intact and has no perceptual disturbance, like seeing the ghosts of those expired	» Hears voices in absence of the actual living organism » Sees things in absence of any living organisms' existence » Has complaints about vague bodily sensations » Takes a constant peculiar body position for days together
Speech	
Within Care giver's Control if the Survivor » Talks excessively about the disaster » Refuse to talk much » Has rapid or stammered speech	Consider Referral if the Survivor » Is talking irrelevant » Shows overflowing of incoherent speech » Does not talk at all for days together
Thought	
» Has a feeling of despair and worthlessness » Has a doubt on his/her own recovery » Is over concerned about unimportant things and neglects important things » Denies what happened to him/her and blames others	» Is excessively preoccupied with one idea or thought » Has bizarre thoughts, which have no answerable reason in that situation » Has a false but extremely firm and strong belief of something that is going to happen to him/her » Is attempted suicide or has suicidal thoughts

Learning Objectives

The trainees would be able to :

- » Describe the conditions where one needs to suggest referral
- » Explain the procedure and level of referral

Methodology

- » Lecture

Teaching/Performance Aids

- » Facts sheets about situation for referral
- » ToT Workbook

Duration

30 minutes (45 minutes in case of group work)

Trainers Note & Session Plan

The trainer should distribute the sheet describing six areas where the trainees have to refer the survivors for specialised help.

First 10 minutes- Lecture on phase specific roles

Next 10 minutes- situations/ conditions of the survivors for referral.

Next 10 minutes – Discussion/question-answer

Learning Unit 1.6.4 - Post-training Assessment

Context and description of the Session

The session puts emphasis on the development of knowledge, skills and attitudes in becoming a good psychosocial care giver as a result of going through the five days training in trainers programme. During pre-training assessments 4 written exercises were administered to determine the knowledge level of the trainees before the start of actual training. The process of assessment would be repeated during the post-training session so that a comparison could be done to know the difference between entry and exit behaviour of the trainees. All training instruments used in this session include necessary instructions for working with these instruments.

Learning Objectives

- » To compare the entry and exit behaviour of the trainees
- » To evaluate the knowledge and skills gained as a result of training
- » To assess trainees perceived competency on disaster psychosocial care
- » To carry out a formal internal evaluation.

Methodology

- » Group sharing
- » Ppt of expectation scoring
- » Questionnaires/scale administration

Duration

45 minutes

Trainers' Note and Session Plan

The process of conducting post-training assessment

- » **Trainees' expectations from the ToT Programme:** They had an open ended questionnaire with five questions. If the exercise has been done by circulating small coloured cards on which trainees were to write their expectations , the trainer should have converted these write ups into p.p.t. bullet points so that each point can be assessed whether achieved or not. If the exercise is done with this open ended questionnaire, the answer to each question can also be displayed in the form of bullet points. **-10 minutes**
- » **Disaster psychosocial care opinion questionnaire :** This is a true/false type of questionnaire with 20 questions covering statements on trainees' basic ideas about disasters and their impacts. Statements against Sl. No. 1,2, 4, 5, 7, 10, 12, 14, 16, 18, 19, 20 are true statements while the rest of th statements are false or myths. Each right answer is scored as one point, thus 20 is the highest score, which should mean the trainee has achieved the highest level of understanding. **- 10 minutes**
- » **Ten-point scale on trainees perceived competency on disaster psychosocial care services:** This is a ten-point rating scale with ten options on the level of perceived competency related to the ability, knowledge and skills to provide disaster psychosocial care services. The trainees should be instructed to encircle one number (from 1-10) given in the middle column of the scale. Or else, if they find it difficult then they should encircle in the options available on both the sides. Higher number on the rating scale indicates higher perceived competency. This can be compared with the pre-training average ranking **-10 minutes**
- » **Trainees' knowledge on disaster psychosocial and mental health:** Should be repeated. **-15 minutes**

Learning Unit 1.6.5 - Ethics & Confidentiality

Context and Description of the Session

Psychosocial and emotional care services deal with human emotions, thoughts and behaviours in situations when people are highly distressed due to their exposure to disaster consequences. It is important to understand that, providing this type of care services is not a charity or pity rather it is an essential aspect of the human rights of the survivors to live with dignity in disaster situations. Therefore, some important ethical principles need to be followed by all trained psychosocial care

ETHICS & CONFIDENTIALITY FOR THE PSYCHOSOCIAL CARE GIVERS

- » **Never make false promises to the survivors**
- » **Maintain the confidentiality of the very private information/problems what the survivors share with you.** However, for case analysis and next step to be taken in that regard or referral, this can be shared with the co-workers during evening meeting
- » **Have the commitment and strive to help and support the survivors in an unbiased manner**
- » **Helping the co-workers and taking care of your self is very crucial.** This is also important to be in touch with each other through e-mail, telephone, personal visits, etc **in the non-disaster period.**
- » **Whenever, the pressure of work or dealing with human suffering become stressful for you, seeking help and support is a must.**
- » **Keep smiling and spread smiling among others**

givers to maintain the sanctity of the services and to provide quality and effective services. However, the care givers are also expected to take care of themselves along with the other co-workers under these situations. The adherence to basic ethics in rendering is not difficult and can help the care givers by reducing their personal stress and anxieties.

Learning Objectives

The trainees would be able to

- » Reiterate the importance of sharing the feelings, experiences and burden during problem time.
- » Share their experiences how this works as a good stress buster and particularly so in a disaster situation.

Methodology

- » Group sharing
- » Handholding
- » Oath taking

Teaching/Performance Aids

- » Candles and match box
- » ToTWorkbook

Duration

30 minutes

Trainers Note & Session Plan

10 minutes: The participants are asked to share their experience of caring attitudes with some co-participant/s during the five days of training. They are asked to describe their feelings about the incidents.

10 minutes: They are asked to make a full expanded circle and hold each others hand while standing in that circle. Give a candle to each one of them. The trainer should light on his/her candle and ask other to pass on the light to the next one standing besides each other. Then, the trainer should request them to close their eyes. The trainer should softly but loudly speak the ethical principles one by one and request the participants to repeat each of them clearly with feeling. Similarly, all the principles should be repeated except the last one.

10 minutes: The trainees should open their eyes and pass on his/her smile to the next person besides him/her to complete the circle. Everyone should then sing a song (patriotic or any meaningful song) to close the training. This is the closure of the training of trainer's programme on "Psychosocial Care Disaster in Disaster Management".

Learning Unit 1.6.6 - Programme Evaluation

The programme evaluation and official valediction ceremony could take place after oath taking as per the protocol of the concerned institute/organisation with an aim to take note of the trainees' suggestions to make the next programme more effective.



ANNEXURE

ANNEXURE

List of Games & Energizers

1. Clapping Exercise
2. Driving/Horse riding Exercise
3. Needs spreadsheet Exercise
4. Fruit Salad Exercise
5. Guided direction to a blind person activity
6. Captain-captain activity
7. Sounding like an animal- Activity
8. Changing the shoes activity
9. Fish market activity
10. Deep breathing exercise
11. Fruit, Flower and Vegetable Activity
12. Mirror game
13. Circle making activity
14. Tying up hands activity
15. Dance on the paper
16. Counting game

Description of Activities / Exercises/ Games

1. Clapping Exercise

Trainees will start counting their number. The first person will say one, the next will say two the fifth will not say anything but will just clap. If s/he fails to do that the counting again starts from one. This will continue till the right counting of the total number of trainees is done.

2. Driving/Horse riding Exercise

This game is played in pairs. All the participants will be given the freedom to choose their partner. Then one will be a horse and other one will be the rider. After 3 minutes the whole thing will be played again with role reversal. The person earlier was the horse will now be the rider and the rider will be the horse. After the game the experience of horses and the riders will be noted down one by one on the chart paper by the facilitator.

Basically the horse's experience and feelings/emotions are compared to that of a survivor's experience and feelings/emotions and the rider's with a person in a normal situation or a care giver. This helps in internalizing the experience, needs and emotions of the survivors in a disaster situation.

3. Needs spreadsheet Exercise

In this activity one of the trainees will be asked to come forward and note down others' view on what does a survivor need after a disaster. The flip chart once full will be analysed to see what are the categories of needs a survivor has and how many of them are psychological in nature. This helps in understanding the need and importance of psychosocial care in the aftermath of a disaster.

4. Fruit Salad Exercise

The participants sitting in the beginning of the circle (the first four only) will be asked to name their favourite fruit and fifth person has to say what had been told by the first one. Similarly, the sixth will repeat what had been told by the 2nd one, 7th will say exactly what has been told by the 3rd person, and so on. Then the trainees will be asked to form groups in their respective fruit group so that 4 groups can be formed for the next session to work on 4 types of impacts of disasters.

5. Guided direction to a blind person activity

Seven volunteers are required for this game. One of the volunteers will be sent outside.

One of the trainees will be a blind person and look to the black board. Other five will be placed in their chairs and the placement of the chairs will be here and there in the room in a disorganized way. The person outside will come in and asked to direct the blind person in such a way that s/he without touching anything/any person sits down safely in the designated place at the end of the room. This will establish the importance of circle of social and emotional support/guided support to the physically disabled, which the caregivers are supposed to provide after any disaster.

6. Captain-captain activity

One volunteer will be sent outside. Out of the rest one will be a captain and he will do some funny actions, which other will blindly follow. The captain will change the actions as often as possible. The person who was outside will come in, observe what the group is doing and identify the captain/leader whom others are following. This will make the person (who was outside) confused and create mental stress regarding what to do, whom



to listen, where to focus on, etc, which is normally happens with the disaster victims. All look similar and everyone seems to be a leader. So, he/they has/have to go into the deep, analyze the situation to identify the actual level of distress in disaster victims. 90% of these victims have unidentified distress, which has to be unfolded through the umbrella of care.

7. Sounding like an animal- Activity

The first person will be asked to say his/her favourite pet (e. g. Dog) and similarly the second (e.g. Tiger) and the third person (e.g. Cat). Others have to follow the sequence by saying Dog, Tiger and Cat, so that 3 distinct groups can be made. Now the people in different animals' group will be asked to stand up, then close their eyes and start sounding like that animal in the group they are in. Then they have to identify their other group members by just following the sound and where is it coming from. Thus, three different groups will be made.

8. Changing the shoes activity

There is a normal say that you have to put yourself in others' shoes to know where it pinches.

This is exactly what this particular game focuses on. Telling something to a person, like, there is nothing to worry, everybody has lost family members, so you should not behave in such way or by this time you should be normal/ok, is very easy. Unless you experience the similar emotions, it is difficult to empathize with the person suffering from abnormal emotional reactions. We can't ask the victims to wear our shoes and walk, rather you keep yourself in their situation to develop empathy towards them.

There is a substitute for this exercise. Call two volunteers and ask them to think on some activity. Tell them to convey their thoughts to each other so that both can perform/ do what the other person has told him to do. The moment both of them are ready to do the activity suddenly, the facilitator will ask both of them to do what they had just told to each other. The lesson is that telling to do something difficult for the other person is so easy, but when you put yourself in that situation then only you will understand the condition (how uncomfortable was it) of other man who was supposed to do that activity.

9. Fish market activity

Two groups will be made keeping three volunteers in each playing the role of a victim, a counselor and a devil who interrupts always what ever the other two do. One volunteer (devil) from each group will be asked to go outside. Thus two people are outside and four are inside. One group (now two members in each group) will be asked to draw something on a chart paper (the victim will draw and counselor will guide him/her). In the other group, the victim will make something with clay/blocks. Then the devils will be called inside and be instructed to create whatever disturbance or interruption he/she can make in their groups. The aim of the devils is not to allow the group doing the right things and interrupts each second.

The rest of the trainees will create an atmosphere of a fish market.

The importance of active listening during a time a disaster and subsequent to that is established. The role of recording the key abnormal reactions and data relevant to that, and achieving the target is emphasized in this game.

10. Deep breathing exercise

Allow the trainees to stretch their limbs on the chairs. Then ask them to close their eyes gently without putting much of pressure on them. Carry out a deep breathing exercise for 3 minutes. Carry out progressive muscular relaxation exercise for another 3 minutes. Then tell them to visualize some of the pleasant things in life and ask them to open up their eyes slowly. Allow them to share their feelings. This exercise is a part of the self-help care supposed to be done by the psychosocial caregivers for themselves,

colleagues, and victims if needed. This exercise provides quick muscular relaxation in the body, oxygenates the body and rests the mind.

11. Fruit, Flower and Vegetable Activity

Ask the trainees to stand in a circle. The person in the centre will be a fruit, flower, and vegetable vendor. The vendor will go on moving inside the circle by calling fruit, flower and vegetable are available, etc. the moment s/he stops in front of somebody and asks the person to tell a name of a fruit/vegetable/flower the person has to say it immediately without delay and stammering. If s/he stammers/delays/can't say then s/he will be the vendor and the earlier vendor will come to the circle. The game is full of fun and is really distressing. This also helps in reducing sleepiness / drowsiness in the trainees.

12. Mirror game

It is used to understand the concept of empathy in a disaster scenario. The game is to be played in pairs. One will be an actor/actress and other one will be a mirror. The mirror has to do whatever the person does just in a similar way the reflections are seen. Then the role reversal will be there so that each one will understand how difficult/uncomfortable it is to stay in certain positions.

13. Circle making activity

Eight volunteers will hold hands together and make a big circle. Then they come closer and hold the hands of the opposite person with opposite hands (just shown below). They have to solve the problem without leaving each one's hand. Other than this they can do any thing (e.g they can jump hands, sit down, go under someone's crossing hands, etc) to make the previous circle they were in before they came to this position. This activity emphasizes on:

- (i) keep looking options during any crisis,
- (ii) keep on trying till you reach near to the goal.
- (iii) develop an attitude to take suggestion/instruction from other
- (iv) impact of any crisis deduces if people work in a team towards the same goal.

14 Tying up hands activity

Tie up the hands of two people, standing in front of each other, with two medium sized ropes (4 knots in 4 hands and cross in the middle of junction). Ask them to open up the tie and make themselves free with the instruction that they will not each other's hand to open up ties in their wrists.

The lessons to be learnt from the activity are:

- » Keep looking options/solutions at the time of any crisis.

- » Seek social support at the time of any problem, where mind stops working.
- » Deep, quick and critical thinking to reach out a solution
- » If not reaching a perfect solution, try to reach near to goal.

15. Dance on the Floor

Ask the trainees to group in pairs. Distribute old newspapers (single big page) to each pair. Give a start signal and ask them to dance in whatever way they like to. Each one minute ask them to fold the paper and again dance on it, till 4-5 times. Share their feelings and experiences after the game.

The aim of this game is to realize the resource crunch during the time of disaster and how little bit of adjustment reduces your anxiety, agonies, dissatisfactions and expectations from the other persons.



16. Counting game

This is simply done to make different groups for role play or group discussion. The counting will start from the first person till the fourth person. The fifth will say one and similarly the ninth will say one and so on.

Disaster Management: Terms & Concepts

Sujata Satapathy, Ph.D

Outline

- PART-I – Faces of Disasters
- PART-II – Disaster Terminologies
- PART-III – Cycle of Disaster Management

Faces of Disasters

Faces of Disaster: Indian Experiences

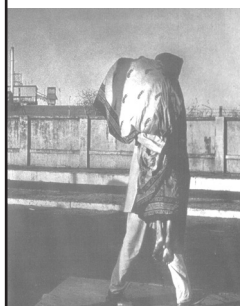


Events Disasters

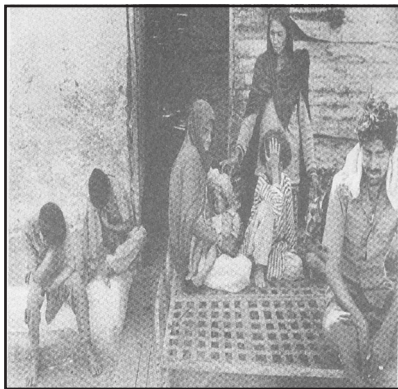


- Bangalore Circus tragedy(1981)
- Accidental fire in a circus tent during a show - 70 children killed
- High emotional stress and morbidity
- Follow-up support to the families over 2 years
- Home based care through simple emotional support

Bhopal Gas Tragedy

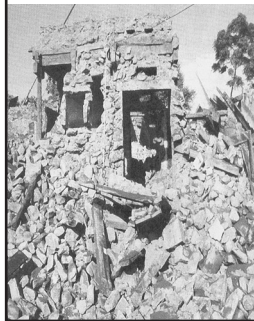


- December 1984
- Over 2000 dead immediately after the event
- Over 700, 000 population affected
- Increased morbidity- 268/1000 vs 117 /1000
- 47% continuously ill at 5 years follow-up



•Almost every family, like the one in the picture, has victims who have been physically damaged for life

Marathwada Earthquake – Sept, 1993



- Over 8000 dead during acute phase, 14000 injured
- Mental health problems double that in the control area
- Training of wide variety of personnel for emotional support
- MIMH
- Overall 34% of the population had psychological distress

Fire in - School Function Dabwali, Haryana December 23, 1995



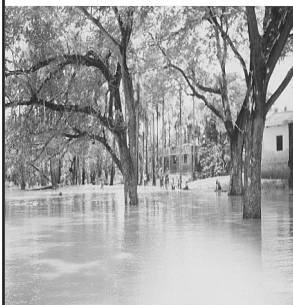
School function
Fire- Dabwali-Dec 1995

Life loss	- 442
< 3 yrs	-26
Students	- 222
Women	- 150
Men	- 44

Fire in Cinema Halls, Temples, Religious discourse

- Tuticorin- 78
- Delhi –62
- Thanjavur- 64-June 1997
- Baripada-204 February 1997.

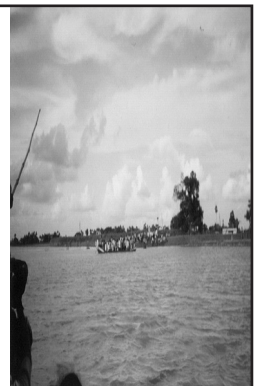
Orissa Super Cyclone- Oct' 1999



- 20,000 killed & 15 million affected
- Child-segregated data
- Psychological distress –45%

Studies showed that the psychological needs in the survivors community even at the end of two and a half years is much greater than that of any normal population.

Nov'2004- as many as 59 people committed suicide in last 5 years- 14-35 yrs. Old – 11 GPs-mostly women & girls - high impact among widows, illiterates & suffering from multiple losses



Gujarat EQ-26th Jan 2001

Over 20,000
persons dead

Over 1500 with
severe
disabilities

- 971 children
- 31 teachers
- 11,761 school buildings
- 36,584 classroom
- 40,000 children and 17,000 teachers



Gujarat Riots- 27th Feb 2002



- 58 persons torched alive in a bogey of Sabarmati express.
- 16 of Gujarat's 24 districts were engulfed in mass violence and physical attacks.
- Rampaging mobs - until mid March 2002.
- Stray violence continued till May 2002.



- Death of nearly 2000 persons
- Estimates of the prevalence of trauma in the population were projected to be between 33% and 90% during various phases of disaster recovery.

Kumbakonam School Fire Tragedy – 16th July 2004

Tsunami- 24th Dec 2004

Salt got deposited in the fields



Adding to the series

Floods in HP, Mumbai, Karnataka,
Chennai, AP, Bihar and MP

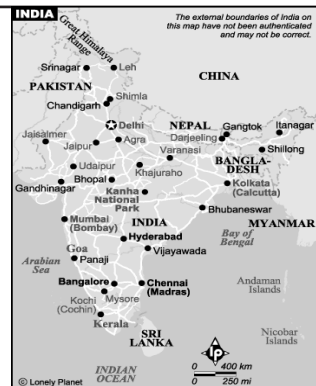
- EQ in J& K
- Delhi serial bomb blasts
- Benaras serial bomb blasts
- Meerut fire
- Barmer floods
- Series of epidemic diseases
- So on.....

This is leading to

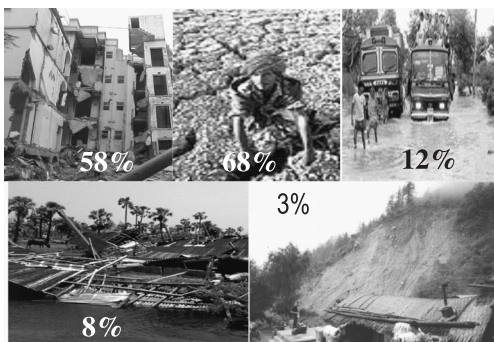
- Average annual loss of human life is 4350
- Average crop area affected annually 1.42 million hec.
- Average number of houses damaged 2.36 million
- Average annual loss is 2 % of the GDP
- Increased allocation of CRF – 22323 crore post funding mechanism

India

It has been said that India is less a country than a continent, and it holds as many variations in religion, language, customs, art and cuisine as it does in topography and Disasters

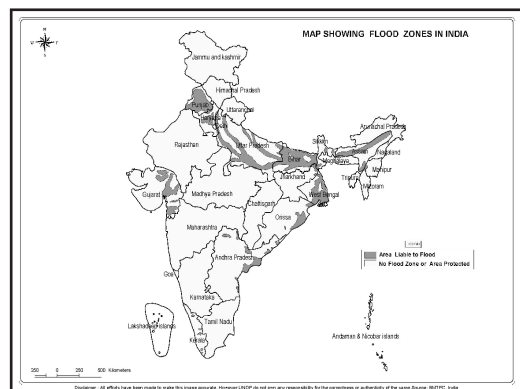
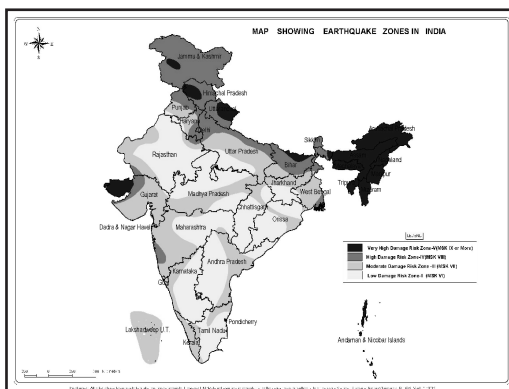


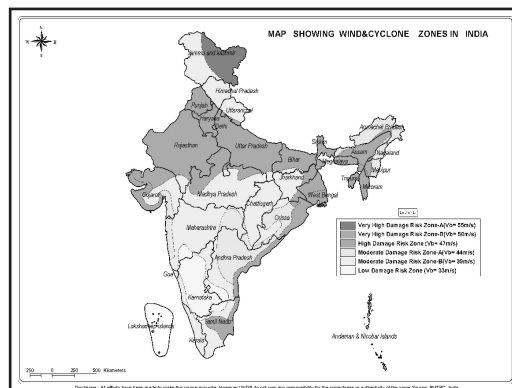
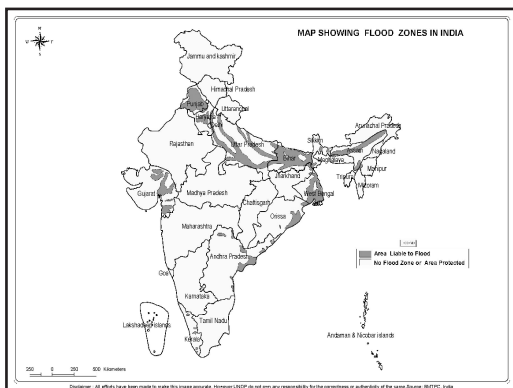
Vulnerability profile of India



Vulnerability profile;

- **Earthquake:** 58% of the landmass prone to earthquake.
- **Flood:** 40 million hectares of landmass prone to floods.
- **Cyclone:** 8000 Km long coastline with two cyclone seasons.
- **Drought:** low and medium rainfall regions which constitute 68% of the total areas, are vulnerable to periodical drought.
- Also vulnerable to other natural calamities like **avalanches/landslides** etc.





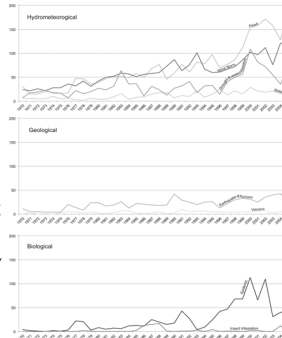
Is it limited to India ?

Hazard	Deaths (Thousands)	% of Total	Affected millions	% total
Drought	276	44	734.1	29
Floods	94	15	140.1	56
Hurricane	61	10	313	13
Earthquakes	531	85	2,496	1
All Natural hazards	531	85	2496	100
Tech. Hazard	93	15	1	0
Total(10 Years)	624	100	2,497	100

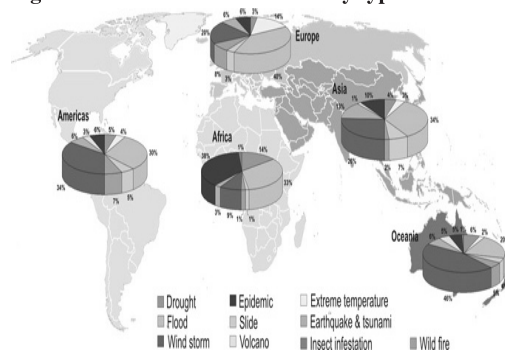
Disaster IMPACTS 1993-2002, Source: IFRC, 2003

Natural disasters 1970-2005

- Hydro meteorological disasters – flood, cyclones, windstorm, droughts - are on the rise
- Volcanic eruptions are same, but incidence of earthquakes and tsunami are increasing
- Traditional epidemics under control, but new epidemics and threats of pandemics looming large

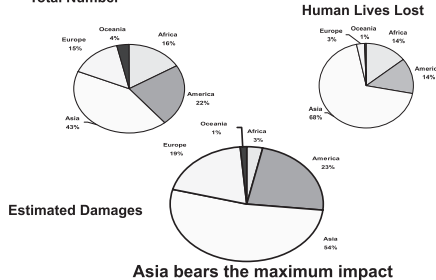


Regional distribution of disasters by type 99- 2005



Disasters and Damages During the last Decade in the World

Total Number



Is it increasing ?????

Decade	Events
1950-59	20
1960-69	27
1970-79	47
1980-89	63
1990-99	86
2000-2010	>25

Each year from 1990-2000, an average of 211 million people were killed or affected by natural disasters-7 times > than those killed or affected by war-cost associated has gone up 14 fold since 1950s

The aggravating factors ---

- Increasing frequency of weather events
- Inadequate attention to disaster-resistant construction techniques
- Population growth & concentration in hazard-prone areas
- Rapid and haphazard urbanization and unplanned settlements
- Exploitation of natural resources
- Lack of awareness compounding vulnerabilities
- Livelihood and occupational patterns
- Poor or Ignorant governance
- Development Failures/disaster-friendly Development

An interaction of

- **Underlying Causes** : poverty, social & economic structure, improper utilisation of natural resources, poor governance, etc
- **Dynamic Pressure**: population expansion, environmental degradation, poor implementation & monitoring of systems, climate change, internal or external migration etc
- **Unsafe conditions**: rapid and haphazard urbanization & unplanned settlements, unstable physical environment, unsafe buildings & infrastructure, fragile local economy, etc

In a nutshell

- Increasing frequency & intensity of hazards followed by disasters
- Disasters frequent in Asian countries
- Impacts much higher in developing countries

PART-II

Disaster : the changing concepts

- Originated from French words: **des** means bad or evil and **astre** means star
- Though different phenomena but have common characteristics

Definitions

- **Hazard:** Any phenomenon, substance or situation, which has the potential to cause disruption or damage to infrastructure and services, people, their property and environment
- **Capacities:** the resources and skills people possess, can develop, mobilize and access, which allow them to have more control over shaping their own future and coping with disaster risks

Definitions

- **Vulnerability** : A concept which describes factors or constraints of an economic, social, psychological, physical and geographic nature, which reduce the ability of a community to prepare for and cope with the impact of hazards
- **Risks:** the probability that negative consequences may arise when hazards interact with vulnerable areas, people, property and environment

- **Disaster** The serious disruption of the function of society, causing widespread human, material and environmental losses, which exceed the ability of the affected communities to cope using their own resources.
- **Disaster** means a catastrophe, mishap, calamity or grave occurrence in any area arising from natural or manmade causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of property or damage to/degradation of environment and is of such a nature of magnitude as to be beyond the coping capacity of the community of the affected area –26/12/05 DM Act, Govt. of India

Classification of disasters by HPC

WATER AND CLIMATE RELATED DISASTERS

1. FLOODS & DRAINAGE MGMT
2. CYCLONES
3. TORNADOES & HURRICANES
4. HAILSTORM
5. CLOUD BURST
6. THUNDER & LIGHTNING
7. SNOW AVALANCHES
8. HEAT WAVE AND COLD WAVE
9. SEA EROSION
10. DROUGHTS

GEOLOGICALLY RELATED DISASTERS

1. EARTHQUAKES
2. LANDSLIDES AND MUDFLOWS
3. DAM BURSTS
4. MINE FIRES

CHEMICAL, INDUSTRIAL & NUCLEAR RELATED DISASTERS

1. CHEMICAL & INDUSTRIAL DISASTER
2. NUCLEAR DISASTERS

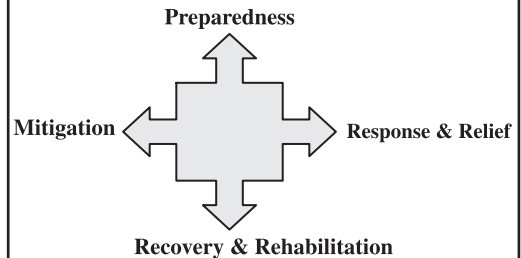
ACCIDENT RELATED DISASTERS

1. URBAN FIRES
2. VILLAGES FIRE
3. FOREST FIRES
4. ELECTRICAL DISASTER & FIRES
5. SERIAL BOMB BLAST
6. OIL SPILL
7. FESTIVAL RELATED DISASTERS
8. AIR, ROAD & RAIL ACCIDENTS
9. BOAT CAPSIZING
10. MINE FLOODING
11. MAJOR BUILDING COLLAPSE

BIOLOGICALLY RELATED DISASTERS

1. BIOLOGICAL DISASTERS & EPIDEMICS
2. PEST ATTACKS
3. CATTLE EPIDEMICS
4. FOOD POISONING

Disaster Management Cycle



Defining terms in a DM Cycle

• Mitigation

It is defined as measures taken to prevent hazards from causing emergency or to lessen the likely effects of emergency.

Preparedness

It is defined as series of activities or a programme designed to strengthen the capacity of an organization to successfully deal with any emergency

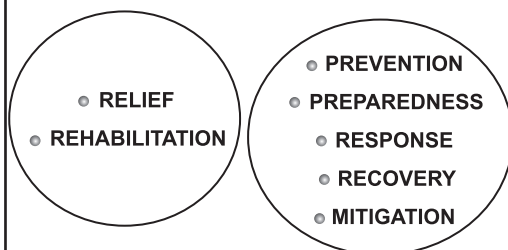
• Response & Relief

Assistance provided during or immediately after a disaster to meet the basic needs of those affected. It can be of an immediate, short-term, or protracted duration

• Recovery & Rehabilitation

It is restoration of normal conditions of life, to create conditions to rehouse the deprived and create and to support the survivors to adjust to normal life post disaster.

Policies: Paradigm Shift



Institutional mechanisms

- National Disaster Management Authority at the National level
- Disaster Management Authorities
- Departments of Relief and Rehabilitation in States are converted into Departments of Disaster Management with wider Terms of Reference to include mitigation and vulnerability reduction
- Capacity building-NIDM
- Disaster Management Act, 2005

Policy

Disaster Management has been included in the Tenth Five Year Plan document.

Legal Framework

Disaster Management Structure in Health Sector

National Level
Emergency Medical Relief Division , Under DGHS,
in the Ministry of Health & Family Welfare.

State Level
Joint Director / Deputy Director,
under Director of Health Services

District Level
CDMO / Civil Surgeon

Block Level
Medical Officer

Disasters & Development

DISASTERS KEEP OCCURRING



THANK YOU

SOCIO-ECONOMIC IMPACT OF NATURAL DISASTERS

Professor Santosh Kumar
National Institute of Disaster
Management

Presentation outline

- Context- Defining Development
- Defining Disaster
- Vulnerability Profile of global & India
- The frequency and intensity of disasters
- Impact of disasters
- Economic Impact
- Social Impact
- Risk Management
- Conclusion



What is development ?

- Promotion of human development share a common motivation and reflect a vital commitment to promoting human well being that entails dignity, freedom, security and equality for all the people

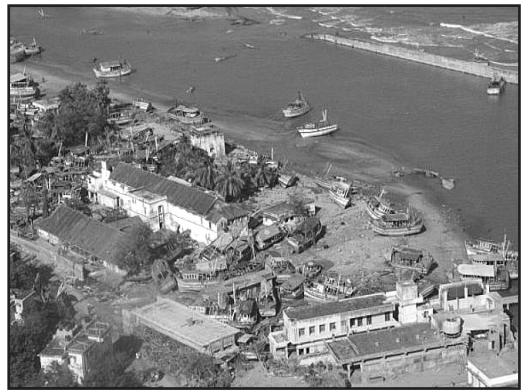
MDG

- Investment in Human Development- health, education, water, sanitation
- Investment in Infrastructure-power, Roads, ports, communication
- Developing industrial development policy-promote investment and public spending
- Helping small farmers in income productivity
- Emphasizing human rights and social equality

How we define disaster ?

As defined in the Disaster
Management Bill, India





Disaster means a catastrophe, mishap, calamity or grave occurrence affecting any area from natural and manmade causes, or by accident or negligence, which results in substantial loss of life or human suffering or damage to, and destruction of property, or damage to, or degradation of environment and is of such a nature and magnitude as to be beyond the capacity of the community of the affected areas.



Three kinds of losses ---

- ▣ **Direct Loss:** Quantified physical losses viz. property, infrastructure & asset destruction
- ▣ **Indirect Loss:** Loss of output, disruption in trade and commerce undermining future profitability, infrastructural damage
- ▣ **Secondary Loss:** short-term and long-term; intangible in nature, difficult to quantify --- diversion of funds, deferring development plans, loss of skilled man-power etc.

Disaster IMPACTS 1993-2002,

Source: IFRC,2003

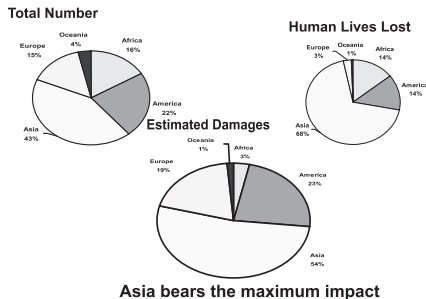
Hazard	Deaths (Thousands)	% of Total	Affected millions	% total
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Earthquakes	531	85	2,496	1
All Natural hazards	531	85	2496	100
Tech. Hazard	93	15	1	0
Total(10 Years)	624	100	2,497	100

Global Annual Economic Loss Due to Natural Disasters

- 1960- \$75.5 billion
- 1970- \$138.4 billion
- 1980- \$213.9 billion
- 1990- \$ 659.9 billion
- Tsunami -
- 2005 Katrina alone US \$160 billion

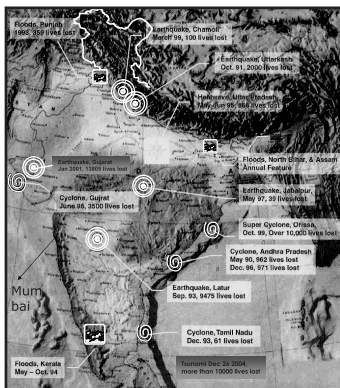


Disasters and Damages During the last Decade in the World



Disaster History by Major Hazard in India, 1996-2001.

Natural Hazard	reported events [#]	reported deaths [#]	people affected [#]	reported losses [\$ mill.]	loss reports [#]	pct. reported [%]	avg. loss per report [\$ mill.]
Windstorm	15	14,606	25,213,696	5,619	15	100.0	374.6
Flood	29	8,875	150,980,330	2,928	18	62.1	162.7
Earthquake	3	20,148	16,367,000	4,707	6	200.0	784.5
Drought	4	20	90,000,000	588	0	0.0	0.0
Other	24	5,939	356,914	0	3	12.5	0.0
Total	75	49,588	282,917,940	13,842	42	56.0	329.6



Major Natural Disasters in the country : 1990 - 2005

Major Cyclones - Four

Earthquakes (M 6+) - Five
 1991 OCT 20 Uttarkashi M6.6
 1993 Sept 30 Latur M6.3
 1997 May 22 Jabalpur M6.0
 1999 March 29 Chamoli M6.8
 2001 Jan 26 Bhuj M6.9

Tsunami - 26 Dec 2004
 Avalanche - Feb 2005

Severe Floods - Every Year

Himachal, Gujarat, Maharashtra, Karnataka-2005
 Severe Droughts - Every 2-3 year

Disasters in India - Vulnerability

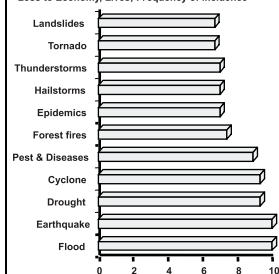
Key Vulnerability:

- 5700 Km Long Coastline - Cyclone-prone
- 40 Mha - Flood-prone
- 68% of Net Sown Area (116 Districts) - Drought-prone
- 55% Total Area - Seismic Zones III - V
- Sub-Himalayan/ Western Ghats - Landslide-prone

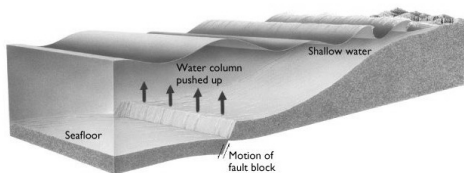
The Indian Sub-Continent is among the World's Most Disaster-prone Areas

Severity Index (Last 50 yrs Data)

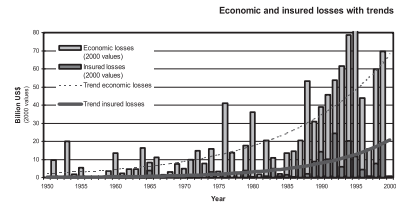
Analysis based on Extent affected (Population, Area); Loss to Economy, Lives; Frequency of Incidence



TSUNAMI: Adding a New Dimension?



Great Natural Disasters 1950 - 2000



Orissa Super Cyclone ---



The loss ---

- ▣ Cumulative loss of nearly 2,750 cr.
- ▣ Severely affected the industrial sector – combined loss of 1,000 cr. in small, medium and large industries
- ▣ CESCO suffered damages of nearly 300 cr. – electric poles and towers uprooted
- ▣ Oswal Fertilizers suffered 200 cr. loss
- ▣ Paradip Port's loss of machinery app. 100 cr.
- ▣ Many industries inundated for days

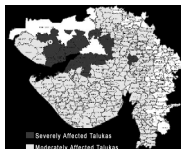
26 January 2001: A Terrible Human Tragedy

Earthquake of magnitude 7.7 Mw (USGS)

One of the worst earthquakes in the last 180 years

Over 11 Lakh homes affected by the calamity

Over 10,000 small and medium industrial units went out of production
50000 artisans lost their livelihood



Around 50 lakh people needed to be given immediate relief

Reported lives lost 13,805

167,000 persons suffered injury

Over 2000 schools, 300 hospitals destroyed

...that too in the wake of two consecutive years of drought.

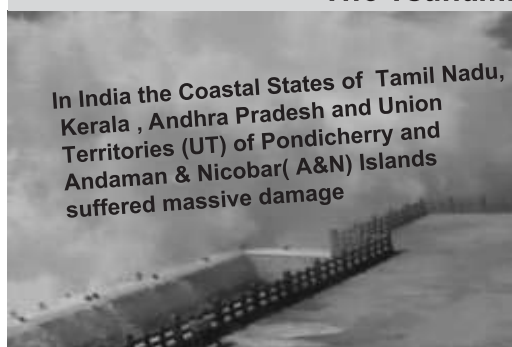
Example Gujarat Earthquake-2001

Sector	Asset Losses (Rs. In Crores)	Reconstruction Cost (Rs. In Crores)
Housing	5166	5148
Health	219	279
Education	670	837
Irrigation	186	419
Rural Water Supply	233	451
Infrastructure (Public & Municipal)	479	651
Power	186	456
Transport	321	358
Ports	98	121
Telecommunication	51	121
Agriculture & Live stock	544	344
Industry	339	205
Services	1163	930
Environment	256	256
Total	9909	10575

The incalculable human cost -

- ▣ 1,70,000 people employed in Salt industry rendered jobless
- ▣ 40,000 families in handicrafts affected
- ▣ 50,000 artisans lost their livelihood
- ▣ Breakdown of support infrastructure and services compounding loss and trauma
- ▣ Opportunity and productive time loss
- ▣ Psycho-social trauma and stress
- ▣ A vicious cycle of poverty, unemployment, loss of access to livelihood assets and collapse of local economy

The Tsunami



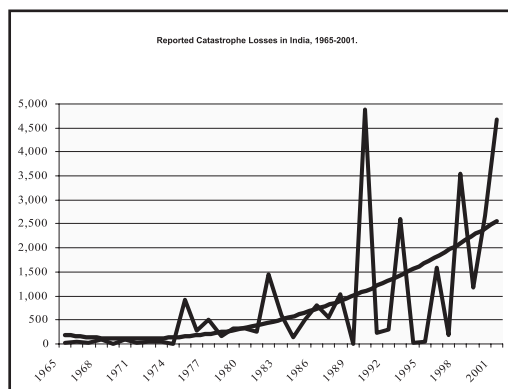
The Damage

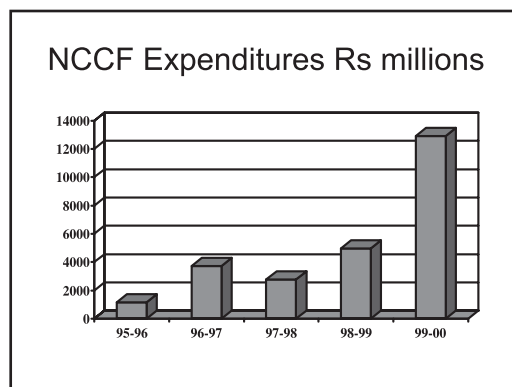
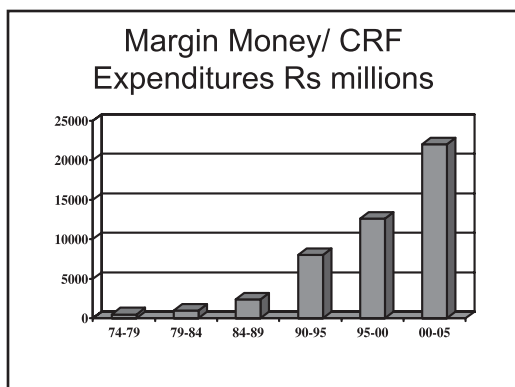
▣ Population Affected:	2.792 million
▣ Human lives lost:	12,405
▣ Villages Affected:	1,089
▣ Dwelling units destroyed:	3.5 million
▣ Number of Boats damaged:	83,788
▣ Cropped Area affected (Hectare):	39,035.18
▣ Damage in monetary terms:	Rs. 11545 crores (US\$ 2.56 billion)

Estimated direct loss in last 32 weeks in India

- ▣ Tsunami- Rs.12,000 crores
- ▣ Himachal flash floods- Rs. 3000 crores
- ▣ Gujarat floods- Rs.4,500 crores
- ▣ Mumbai floods including ONGC loss- Rs.30,000 crores
- ▣ Karnatka floods- 3,500 crores

- ▣ Reported losses from natural catastrophes more than quadrupled during the 15-year period 1981-1995 (\$13.4 billion) compared to the losses registered during the previous 15 years from 1965-1980 (\$2.9 billion).





This is leading to

- Average annual loss of human life is 4350
- Average crop area affected annually 1.42 million hec.
- Average number of houses damaged 2.36 million
- Average annual loss is 2 % of the GDP
- Increased allocation of CRF – 22323 crore post funding mechanism

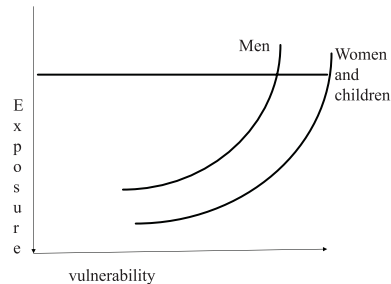
The aggravating factors ---

- Increasing frequency of weather events combined with more and more developmental assets & infrastructure
- Inadequate attention to disaster-resistant construction techniques
- Population concentration in hazard-prone areas
- Rapid and haphazard urbanization
- Rapacious exploitation of natural resources
- Lack of awareness compounding vulnerabilities
- Livelihood and occupational patterns
- Poor or Ignorant governance
- Development Failures

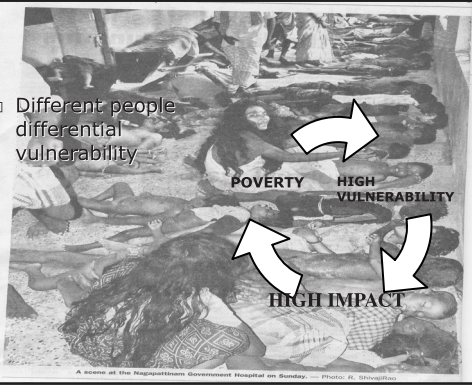


Poor, women children and the old aged are the most vulnerable

- 2001 World Disaster Report indicates, 97 percent of all disaster-related deaths occurred in the poorest of the developing countries, while only 2 percent took place in the industrialized societies.

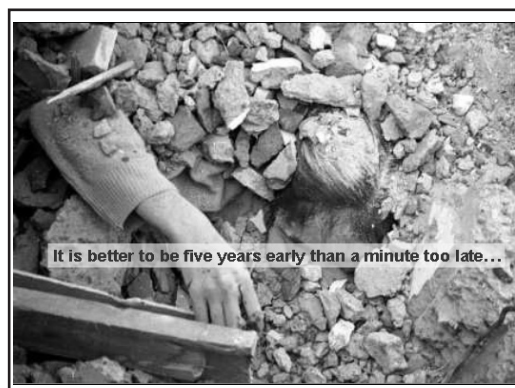
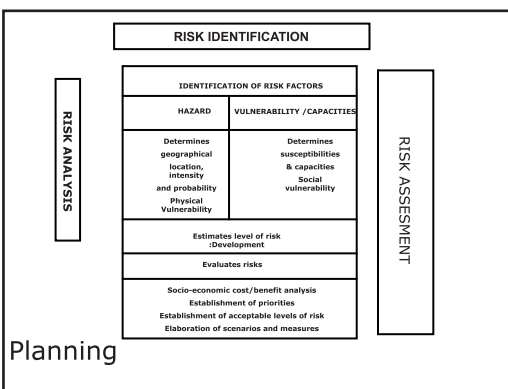


- Different people differential vulnerability



A manifold tragedy ---

- Differential impact and differential capacities
- Reversal of relationships – with nature and society
- Stressed family relations and changing social mores and norms – community cohesion and social support systems impacted
- Increase in violence and discrimination against women and children --- dangers of trafficking and denial of access to education and health care
- Psycho-social trauma and stress
- A vicious cycle of poverty, unemployment, loss of access to livelihood assets and collapse of local economy



Conclusion

- Disaster is a development and the issue of governance
- We need to go for paradigm shift at all levels and all sectors
- We need to get integrated with the community's initiatives
- We have to go for risk management with the strong institutionalized mechanism and
- We have to keep enhancing our circle of influence.

NO time to WASTE

Thank You

www.ndmindia.nic.in
www.nidm.net

An Introduction to Psychosocial Care in DM in India

Sujata Satapathy

The word disaster either natural or man-made reminds us the most horrific images of human sufferings in multifarious ways. However, until recently there has been a general tendency to consider the basic needs of the affected people and therefore, the emphasis was on providing curative care, food, shelter, relief, immunization, income generating activities, and others. Addressing mental health and psychosocial needs has often been considered as secondary and accessory to the basic needs. Nevertheless, a global realization has evolved and emerged that the loss experience and emotions attached to it are complex and is much more than just the superficial aspect reported by media as witnessing disasters through the eyes of television camera hardly gives true insight into the psychological suffering (Boer and Dubouloz, 2000). As the deep hurt and anguish caused by the loss of human life, as well as the disruption of daily life are far more difficult to overcome, more so in man-made disasters, like riots. Therefore, emotional needs have to be given priority along with relief, rehabilitation and care of physical health.

Thus, mental health management as an essential component in all disaster management plans either for man-made or for natural has recently received top attention from the Department of Mental Health of the World Health Organization (WHO), which defines “health” as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Mental health is an important component of the well being of people exposed to disasters and critical to successful rehabilitation and development of the societies in the aftermath. Many immediate reactions largely depend upon the physical explicitness of a disaster, such as, *exposure to extreme danger, witnessing near one’s deaths, helplessness, hopelessness, and trauma of having to choose between one’s own survival and that of others* (Murthy, 2000). Therefore, mental health at individual and community level becomes necessity to be maintained to prevent possible psychiatric disorders after any disaster and to maximize the progress of successful rehabilitation and development of communities in post disaster scenario.

The terms psychosocial support/care and mental health services are commonly used interchangeably. However, one needs to understand the difference between psychosocial support and mental health services very clearly. Nevertheless, both the services are two sides of the same coin, hence interwoven with one another as parts of a comprehensive and continuum care services.

Psychosocial support in the context of disasters refers to comprehensive interventions aimed to address a wide range of psychosocial problems arising in the aftermath of a disaster. For example, listening actively to the survivors, helping them to restart their daily routine works, helping them to get connected with their near and dear ones, providing legal and paralegal help, may also be considered as parts of this intervention package. Any intervention that helps in reducing the level of actual and perceived stress stemming out of the disastrous situation, and in preventing adverse psychological and social consequences among disaster affected people can be defined as disaster psychosocial support/care services. These services can be provided by imparting basic skills training on the subject to the community level people/workers (CLWs). s/he can be a teacher, anganwadi worker, panchayat member, social workers, local NGO people, local youths, members of mahila mandals, etc.

Whereas, **disaster mental health services** refer to the medical interventions for identification and management of manifest stress related clinical psychological signs/symptoms or of the mental disorders among disaster affected persons. In addition, interventions aimed at mental health and psychological well-being promotion, and prevention of psychological / psychiatric symptoms among disaster affected population are also included under disaster mental health services. These services need expertise services of psychiatrist, psychologists, mental health professionals, psychotherapist, etc.

The experience of trauma after any disaster is multidimensional and complex, therefore everyone who is trained in this can make a significant difference in the lives of the affected population. The key goals of adopting a community model of disaster mental health and psychosocial care are:

- » Preventing long-term psychiatric disorders in the disaster affected society
- » Providing relief from mental suffering and psychological distress
- » Maintaining mental well-being and equilibrium
- » Promoting positive mental health
- » All the above four become more important for the optimal utilization of resources and economic opportunities offered through the community rehabilitation and development programmes (WHO, Division of Mental Health, 1991),
- » Strengthening the social support networks in the affected area,
- » Facilitating the community participation in all activities taken place in mitigation and relief & rehabilitation phase.

Often it is observed that the affected adults as well as the disaster workers overlook the need to respond and explain things to affected population in any disaster and need extra care and comfort. If the management fails to address their fears and insecurities

the internal turmoil and pain can leave them sad, confused and frightened and this will remain with them for a long time to come and affect the social and economic fabrics of the society.

Common Psychological Reactions Following a Disaster

First of all one should understand that any psychological and emotional reaction is not itself all negative, for it can increase the chances of the survival of the victim. Stress becomes a threat to mental health when it overwhelms the capacity of the victims to cope with the new situations by mastering their own reactions. A cauldron of emotional reactions can come to boil after a disaster. Although people react differently to traumatic events on the basis of their experiences and personality, there are number of common responses that are experienced by the majority of those involved. These common post-disaster reactions include

- » **emotional** (panic attacks, shock, fear, anger, sadness and guilt feeling),
- » **psychosomatic** (sleep disturbances, physical problems like muscle tension, palpitation, headaches, nausea, diarrhea or constipation, and breathing difficulties),
- » **cognitive** (repeated thoughts and involuntarily triggering the memories, nightmares, confusion, flashbacks, difficulty in concentrating and making decisions, memory problems, shortened attention span, etc), and
- » **behavioural and attitudinal** (disruptions in social relationship, poor motivation and concentration, lethargy, hopelessness, etc) difficulties. Normally, these reactions 'settle' over the first week. If, however, they remain protracted and intense and moreover, If symptoms persist for a period of three months or after that the person is very likely to suffer from various psychological disorders.

When one talks of common reactions among the disaster affected population, one should also differentiate between the psychosocial reactions exhibited/expressed by adults and children. Children are affected by any disaster just the way adult are, although their reactions might differ from those of the adults. Disasters disrupt the sense of well-being by destroying normal predictable and consistent life routines of children thus, deeply hamper the process of healthy psychological and personality development. Since children have limited capacities to process information their sense of what happened is often not realistic and they are not able to comprehend the totality of the situation. Therefore, before planning for any type of psychosocial interventions, one needs to understand the common psychosocial reactions shown by children in various age groups.

Community Based Disaster Psychosocial Care

The psychosocial aspects of disasters on human beings have been acknowledged as an international agenda (WHO, 1992). However, in India, the psychosocial aspects have never been emphasized until very recently after tsunami, 2004. The Bhopal gas tragedy (1984) was the most important disaster to draw the national attention due to its severe impact and the sensitivity of the politico-economic issues involved. The psychosocial impact was studied systematically although intervention programmes were more of psychiatric in nature. Marathwada earthquake (1993), and Andhra Pradesh Super Cyclone (1996) were disasters in which mental health professionals took an active part in terms of providing mental health services and undertaking research to study the psychosocial impact of these disasters.

The ICMR studies over last twenty years have provided strong base for integration of mental health services with general health care services and sensitization of the community members and rescue workers. However, it has been difficult to integrate the mental health services at micro and macro level. Recently, National Disaster Management Agency and National Institute of Disaster Management has mixed experiences in providing health care services in disaster situations. However, the finer details of the mechanisms and strategies for integration of mental health services with general health care services still need to be worked out.

In the post Tsunami phase in India, the WHO along with the Department of Social Welfare, United Nations Team for (UNTRS), and partners have developed a model for providing sustained, low cost community based volunteer provided support systems. Community level workers who are the anchor for this programme are selected from various categories of people, including teachers, health workers, and members of self help groups etc, who have volunteered for this purpose. A cascading system of training was developed and in Tamil Nadu, 2813 Community Level Workers (CLWs) were trained in the 11 affected Districts. They were able to support more than 30,000 families and 150,000 individuals.



Vulnerable Groups OR People with Special Needs

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Contents

- Definition
- Who are more vulnerable ?
- Why are they more vulnerable ?
- Each vulnerable group
 - Specific vulnerability
 - Issues of concern
 - What needs to be done ?
- Consolidating what needs to be done
- Conclusion

Definition

Members of our community with little or no access to address their own preparedness, response and recovery; and people whose life circumstances leave them needing more than what traditional emergency response agencies provide:

Persons with special needs or more vulnerable people

Who are more Vulnerable?

- A. People with disabilities**
- B. People receiving critical health care**
- C. Aged**
- D. Children**
- E. Women**

Why are they more vulnerable

- Inter-group variations in the characteristics of each group – Group specific needs
- Intra-group variations within each group –Complex special needs
- Life conditions prior to disaster – already in a raised deprivation level
- Approach to disaster management till date

A - People with Disabilities

- Unique characteristics of each disability
- Diversity of disability community
- Diversity in terms of prior existence of disability and a newly acquired disability
- Persons with disability Act (1995), India
- Community at higher risks

- **Physically Challenged**
- **Sensory Challenged**
- **Neurologically Challenged**
- **Mentally Challenged**

» **Age, Sex, Social Class variations**

» **Nature of Disability vs. Special needs**

Issues of Concern

- Accessibility to the warning information and evacuation process –destruction of cell towers & back up onsite generator
- Accessibility at shelters
- Accessibility to auxiliary aids, equipments and services
- Lack of support services inside the community in the pre-disaster phase
- Lack of knowledge & coordination of existing disability related resources, which could have ameliorated some of the problems

Accessibility to the EWS/information and evacuation process

- EWS as an important link –comprehensive & disability friendly/accessible
- Multi model warning means
 - ① Technology –based (depends on the communication systems used) – accessible to all - technology imp. tool
 - ② Non-technology based (depends on the socio-economic, political and administrative set up)
- Satellite & mobile phones – deaf/deaf-blind
- EWS rely on SMS – blind- symbion operating system-expensive
- HAM radios – toll no. to community people-expensive
- A network of wireless towers & fixed phone lines

Technology based accessible warning dissemination

- Design –Universal design principle –involve PWD
- Wireless linking- EOCs, broadcasting system,, frontline responders & communities
- HAM & mobiles be available to DPOs
- Awareness & education regarding the existence & usages
- Repeated village announcement- read/seen/heard

Technology itself is less of an issue during disasters

- Social aspects of the application of technology

Type of Impairments and Warning System

Visual Impairment: Auditory signal system / alarms, Announcements, Posters written with large characters and colour contrast

Hearing Impairment: Visual signal systems – red flag, symbols, Pictures, Turn lights off – on frequently

Intellectual Impairment: Special signals – red flag, symbols, Clear and brief announcements by rescue workers

Physical Impairment: Auditory signals system/alarms, Announcements

Evacuation

- Announcement/communication systems
- Accessible vehicles
- Accessible shelters
- Aids & Appliances
- Sign language interpreter
- Family members/neighbours- safety & security

What needs to be done?

- Training in disaster management with a component on Disability, especially for the people in search & rescue, evacuation, response & relief, and community support groups
- Specially designed education and awareness programmes for the disabled
- Provision of dissemination of EWS (e.g. alert system for visually & hearing impaired) to the disabled at the community level

Contd.....

- Disability specific auxiliary aid – relief
- Special care – during the planning for livelihood restoration of disaster victims

Consolidating what needs to be done?

- Mapping & yearly updation of vulnerable groups should be included in village level disaster management plan
- Gender and Special population Segregated data
- Awareness, education & training of VG at the community/grass root level
- Provision of need specific physical & mental health facilities at PHC
- Protection of security in camps
- Capacity building programmes having a component on people with special needs

Conclusions

- Group-wise specific and diverse needs – inter-group and intra-group diversity
- Different ways of coping with different pace
- Village level disaster management plan-DDMP
- Sensitization programme for disaster workers in all sectors and levels
- Accessible communication and warning dissemination system

Contd.....

- Specially trained search & rescue team and people operating relief operations Protection of Security in shelters/camps
- Policy on disaster management and other relevant policies should be more specific about the provisions/ actions to be taken for people with special needs
- Preparedness plan for all phases of disaster must include a component on people with special needs

DISASTERS KEEP OCCURRING



HEALING IS POSSIBLE



TOWARDS RECONCILIATION



Suggested Programme Schedule

5-day ToT Course on Psychosocial Care in Disaster Management

DAY ONE 2nd February 2009

	Session	Methodology	Time
1	Registration – personal profile elicitation		10.00
2	Inauguration and introduction Pre –assessment	Talk Presentation Sharing of personal profile Questionnaire administration	10.45
Tea 11.30-11.45			
4	Disaster Opinion Questionnaire	Questionnaire administration	11.45
5	Basic concept of DM	Film & presentation	12.30
Lunch 13.00-14.00			
6	Orientation on DPSC: Indian initiatives	Talk and presentation	1400
7	Develop a need spreadsheet of care	Exercise	1530
8	Experience of Survivors	Exercise	1615
Tea 16.15-16.30			
9	Disasters Experience Sharing	Group /individual sharing	1630
10	Energizer	Game	1700
11	Feedback session	Activity	17.15
	Reading material and homework ● Administer the family schedule ● Administer the impact of event scale ● Read manual one		

DAY TWO

3rd February 2009

	Session	Methodology	Time
1	Review of day one	Group sharing	09.30
2	Impact of Disasters	Group work	10.00
3	Gr. Presentations	Continues.....	10.30
Tea 11.00-11.15			
4	Understanding the concept of loss	Group activity	11.15
5	Visibility vs. invisibility of problems	Group work	11.45
6.	Understanding experience of stress	Group activity	12.15
7	Energizer	Game	12.45
Lunch 13.00-14.00			
9	Normalcy and abnormalcy of reactions	Presentation & Illustration	14.00
10	Life events and family life cycles coping abilities	Presentation & Group sharing	14.30
11.	7 basic techniques of PSC	Card presentation with illustration and talk	15.00
12.	Spectrum of care	Lecture-Discussion	16.30
13.	Energizer	Game	16.50
10	Manual for individuals	Group Presentation	1700
11	Feedback session	Activity	17.30
	Reading material and homework ● Administer the self- reporting questionnaire ● Read Tsunami manual		

DAY THREE
4th February 2009

	Session	Methodology	Time
1	Review of day two	Group sharing	0900
2.	Internalization of Basic techniques of DPSC	Role play Exercises and activities	9.30-11.30
Tea 11.30-11.45			
3.	Understanding special needs of women in disasters	Free listing and making a final list on the flip chart/computer	11.45
4	Women in disasters	Presentation	12.05
5.	Importance of Psychosocial care	Talk	12.40
	Energizer	Game	13.00
Lunch 13.05-14.00			
6.	Understanding Children Needs	Free listing and making a final list on the flip chart/computer	14.00
7	Understanding emotional reactions of children	Group Discussion	14.20
8	Children Life experience	Regression	15.05
Tea 15.50-16.00			
9	Working with Children in Disasters	Presentation	16.00
10.	Review of Tsunami manual	Group presentation	16.15
11.	Self care	Yoga & mediation	16.45
12.	Feedback	Relaxation exercise	17.30
Reading material and homework ● Read manual for women and children ● Disability assessment schedule			

DAY FOUR

5th February 2009

	Session	Methodology	Time
1	Review of day three	Group sharing	09.30
2	Stress management	Group activity Experiments Demonstration Group relaxation exercise	10.00
Lunch 13.00-14.00			
3	Burn out in Disaster situations		14.00
4.	Mediums to work with children	Psychometric Group test	14.30
Tea 16.00-16.15			
5.	Energizer	16.15	
6.	Review of Women & Children manual		16.30
7.	Feedback/photo session	Group	17.00
Reading material and homework ● Read manual 3 (children) ● Quality of life determination			

DAY FIVE
6th February 2009

	Session	Methodology	Time
1	Review of day four	Group sharing	09.30
2.	Energizer: Resource crunch	Activity & game	10.00
3.	Working with Women	Body mapping Ppt Open house discussion	10:30
4.	Working with PWD	Ppt Game	11:30
5.	Working with other groups	Ppt Gr. discussion	12:00
6.	Tree of sustenance	Activity	12:30
Lunch 13.00-14.00			
7.	Referrals	Talk Group work	14:00
8.	Psychosocial need asses sment	Interactive ppt	14:30
9.	Understanding scale administration	Working on scales	15:00
10.	Post-training assessment	Questionnaire administration	15:30
Tea 16.15-16.30			
11.	Ethics and confidentiality	Exercise	16:30
	Feedback session	Open House	17:00
	Valediction		

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Guidance for New Module Writers

The beginners in this field may find the following steps useful for writing a module:

- Identifying your expertise area of training/subject of specialization.
- Gather all your experience on that particular subject of training –need/feedback analysis
- Finalize target audience and sessions essential and absolutely useful for that group
- Develop a training design brief as per the existing template
- Do a thorough survey of all module or manuals or course materials available in this subject
- Develop your own format to write the module, sub-module and learning units or follow some specific format that suits the selected area of training/subject
- Start writing from any sub-module or learning unit your are most comfortable with
- Maintain the uniformity in the style and format through out all units and sub-module
- However, depending on the demand of the unit even if you deviate from the said format, it hardly makes any difference, but it should be justified enough.
- After finishing each unit take a break of 2-3 days and after finishing a sub-module, take a break of 7 days.
- Whenever, you are stuck, pls. discuss it with a college even if s/he does not belong to your field of expertise
- The process might take a minimum of 3 months depending on the no. of learning units
- Submit it to the higher authority for inputs and approval
- Incorporate the inputs received from both
- Find a minimum of five outside potential experts who could give their inputs/ reviews in time
- Incorporate
- Submit again for approval and to begin the process of sending for the English editing.
- Submitting for final approval
- Proof reading
- Designing & Printing.....



Towards a disaster free India

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