

## BRIEF MENTAL HEALTH GUIDELINES<sup>1</sup>

*These guidelines are provided for primary health care workers and relief volunteers helping those affected by the Haiti Earthquake. They focus on the acute phase of the response and are basic principles. The appendices provide some more information on specific approaches to loss and stress responses. Please also use the IASC guidelines on mental health and psychosocial support for more detailed information on the appropriate response in all sectors.*

[http://www.who.int/mental\\_health/emergencies/guidelines\\_iasc\\_mental\\_health\\_psychosocial\\_april\\_2008.pdf](http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_april_2008.pdf)

### ACUTE PHASE: Psychosocial Support for the Affected Population

All earthquake affected individuals and communities can be expected to be suffering from psychological stress, shock and grief. The worst affected will be those who have suffered multiple losses, combined with physical exposure to danger and are now without resources. They will have been terrified by the initial quake and continue to suffer acute anxiety with continuing aftershocks. They are likely to be hungry, tired, exhausted, bewildered, numb, angry, despairing, frustrated as well as suffering all the feelings that follow overwhelming loss. The best way to assist in the first instance is by attending to their **basic needs through social interventions that provide the following:**

- **Shelter, food, water, medical care**
- **Security:** In setting up temporary accommodation particular attention needs to be paid to the protection and safety of women and children and other vulnerable people.
- **An ongoing, reliable flow of credible information on the emergency and associated relief efforts:** People want to know what has happened. What is going to happen next? Where are we going? Who is in charge? Where can I get more information?
  - Access to information is a right and also reduces unnecessary anxiety and distress.
  - Information should be provided on the nature and scale of the emergency; efforts to establish shelter and care for the population; the specific types of relief activities being undertaken by the government, local authorities and aid organizations, and their location.
  - Information should be disseminated according to principles of risk communication: e.g., it should be uncomplicated (understandable to local 12-year olds) and empathic (showing understanding of the situation of the disaster survivor).
- **Family Reunification:**

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<sup>1</sup> These guidelines result from years of IMC experience in rapid-onset emergencies. They also draw upon Sphere standards, <http://www.sphereproject.org/> and WHO guidelines for Mental Health in Emergencies, [http://www.who.int/mental\\_health/prevention/mnhemergencies/en/](http://www.who.int/mental_health/prevention/mnhemergencies/en/)

- Medical evacuations should be arranged with particular attention to maintaining family connections by documenting carefully who is going where and where remaining family are staying. Copies of tracing information should be kept by agency and affected parties.
  - Establish effective accessible systems for tracing missing relatives and friends and reuniting families.
  - Shelters for those displaced should be organized with the aim of keeping family members and communities together.
- **Respectful treatment of the dead:** Including respectful treatment by media. If feasible families should have the option to see the body of a loved one to say goodbye, when culturally appropriate. If possible, unceremonious disposal of the bodies of the deceased should be avoided.
- **Access to appropriate religious and cultural support, including mourning activities.**
- **Rapid reestablishment of normal routines and activities as far as possible, these include:**
- School and recreation for children
  - Meaningful work or concrete, purposeful, common interest activities for adults and adolescents – such as participation in relief efforts
  - Participation and consultation regarding organization of shelters, which should include space for recreation and religious practice
- **Attention to isolated persons:** Separated or orphaned children, widows, widowers, elder persons or others without their families are particularly vulnerable to various abuses and greater adjustment problems. They should be identified, supported and given access to all activities that facilitate their inclusion in social networks.

### **ACUTE PHASE: Psychological and Psychiatric Interventions**

Self-recovery and resilience in the face of disaster are the norm. However a proportion of the population (and some of those involved in the relief effort) will experience **acute mental distress**; many others will be **in the acute stages of grief**. This will limit their ability to function. They should have access to psychological first aid from health care providers or relief workers.

**Psychological first aid** is simple, easily taught and involves a practical and compassionate approach based on the following points:

- Listen
- Convey compassion
- Do not force someone to talk
- Assess needs and ensure that basic needs are met
- Encourage but do not force company from significant others
- Protect from further harm
- Avoid widespread prescription of benzodiazepines because of the risk of dependence

A smaller proportion of the population will be suffering from **acute or chronic psychiatric disorders**. This is a needy and extremely vulnerable group. Particular attention needs to be paid to:

- Those who have been in physical restraints in family homes or institutions of any kind
- Those in institutional care
- Those on long term medication
- Those with previous disorders vulnerable to exacerbation in the current conditions
- Children or adults with developmental disorders or mental retardation

All these groups require access to skilled psychiatric care or the urgent establishment of continuing care that attends to their basic needs, respects their dignity and their human rights. In the absence of specialized mental health care:

- Do not untie or unchain physically restrained patients until they have had a psychiatric assessment and are adequately medicated as required
- Try to ensure physically humane and comfortable conditions. Treat physical wounds and illnesses. Ensure access to food and drink
- Identify a medical care provider with sufficient knowledge to prescribe psychotropic medication if needed
- The sudden discontinuation of psychotropic medication, particularly anti-psychotics, antidepressants and antiepileptic antiseizure medication is harmful, and in some cases potentially fatal and should be avoided. Frontline health care workers and primary health care facilities accessible to the displaced population should ensure a supply a continuing supply of such medications and their inclusion in emergency medical kits
- Children and adults with special needs are sometimes abandoned or separated from their families in disaster situations. They will need special care and protection

### **LONG TERM EFFECTS**

The long term effects on whole affected population depend very much on how the current crisis is handled now. Taking care of people humanely and treating them with dignity and respect is essential. The failure to do this is as traumatizing as the initial earthquake and likely to lead to anger and frustration that will compound and prolong any stress reactions. People are much less likely to need counseling if they are able to meet their basic needs, and helped appropriately on the issues described above as soon as possible.

Longer term interventions with displaced populations should be based on the following and principles:

- An accurate assessment of the specific community's needs and circumstances
- Collaboration with the community in addressing those needs
- Particular attention to minorities and the less empowered within the community
- A focus on interventions that foster the rebuilding of normal life and reintegration into society, whether through return to an original living situation or starting anew elsewhere
- Continuing access to social and psychological services and support as required

## **APPENDIX 1**

### **SOME BRIEF GUIDANCE NOTES ON STRESS, GRIEF AND LOSS FOR FRONT LINE TEAMS AND PRIMARY HEALTH CARE PROVIDERS**

#### **I. COMMUNAL STRESS RESPONSES**

**Normal psychological responses in the immediate aftermath** of community destruction and massive loss include:

- Fear
- Anger
- Despair
- Disorganization
- Confusion
- Denial, numbness
- Exhaustion
- Over activity/under-activity
- Aggression/Passivity
- Hysteria/Agitation

Different people present with different constellations of feelings according to age, culture and personality and life history. Moods can change rapidly from one moment to another. Any who have suffered long periods of being trapped and afraid, are likely to have much stronger reactions.

Such feelings are all normal and likely to resolve with time, especially if relief workers can pay attention to the basic needs with social interventions outlined above.

The majority of people do not become mentally sick just because they have lived through stressful events. See *Appendix 2* for estimated proportions.

#### **Common symptoms and experiences in the first few weeks:**

- Feeling afraid, tense, difficulty sleeping
- Seeing images of the event, especially near reminders
- Nightmares
- Feeling jumpy and very alert
- Feeling numb, dazed, confused, depressed, anxious
- Avoiding reminders
- Sudden changes in mood
- Over-activity or lack of energy

**More severe reactions include:**

- All the above
- Despair
- Withdrawal
- Regression - behaving younger than their age
- Disturbed behavior
- Panic and hyperventilation
- Symptoms can last minutes to a few hours to a few days
- Symptoms can change rapidly from one state to another
- Symptoms resolve rapidly if withdrawn from stressful environment

**In the longer term a small percentage of people (less than 10%-20%) may suffer:**

- Phobias
- Depression and anxiety
- Somatic complaints
- Alcohol or drug problems
- PTSD (Post Traumatic Stress Disorder)

If any person you are seeing has ANY kind of symptoms that appear to get worse or is affecting their ability to function over more than two months, consult a physician.

**Advice on managing stress when living in difficult circumstances:**

- Avoid alcohol, caffeine, drugs
- Needing to talk does not equal weakness
- Not wanting to talk does not equal denial
- Moderate physical exercise
- Organize time: balance sleep and activity
- Extra sleep
- Find productive activities to do
- Find some form of recreation
- Methods of relaxation: massage, yoga
- Make use of your friends and relatives
- Create some kind of personal space

**In children expect any of the following in response to stressful and life threatening events:**

- Under five: regressive behavior, soiling, wetting, clingy, sleeplessness, nightmares, night terrors, loss of new skills, and/or minor illnesses
- Six to twelve: tearfulness and depression, sleep problems, poor concentration, restlessness, anxiety and fear, aches and pains, regression and/or aggression. Repetitive play is very common

- Over twelve: risk taking, withdrawal, apathy, somatic complaints, hopelessness, suicidal ideas, and/or self destructive behavior

## **II. SYMPTOMATIC RELIEF FOR SPECIFIC DIFFICULTIES:**

**Managing acute anxiety and hyperventilation:** This is very common in overcrowded shelters where people are anxious from lack of support and information. It is easily understood. Fear results in the release of adrenalin which leads to:

- Respirations increasing
- Chest breathing
- Too much oxygen going in/too little CO<sub>2</sub> going out (Hypocapnia)
- The chemical imbalance can cause chest pain, choking feeling, pins and needles, in fingers and round mouth, feeling dizzy, spasm in hands (carpopedal spasm)
- Fear of these physical symptoms (am I having a heart attack? am I choking? Am I dying?) leads to more fear and more symptoms

*Treatment:*

- Create quiet space
- Clear excess attendants
- Check no cardiac problems/fits (history)
- Simple explanation based on above and reassurance to sufferers and care givers
- Leave with calming attendant
- Gentle reassurance (in a calm quiet place)
- Encouraging slow quiet breathing with the abdomen
- If necessary have individual rebreathe his/her own CO<sub>2</sub> by holding a paper bag over the mouth

### **Simple symptomatic relief for other problems**

- Unpleasant imagery: distraction techniques such as games, stories, “wipe it clean” and visualization
- Anxiety and tension: abdominal breathing
- Somatic aches and pains: relaxation techniques
- Night terrors: reassurance and explanation,
- Nightmares: dream scripting (children under 10)

## APPENDIX II

### GRIEF AND LOSS

#### *Why do we grieve? Because we love*

*Attachment:* The ability to form strong relationships with others, necessary for survival as human beings

*Loss:* the sense of sadness, fear and insecurity we feel when a loved person is absent. It can also be felt for things and places

#### **Attachment/Separation Behavior**

Observe what happens when you separate a child under 3 from their mother for more than a few hours:

- Protest
- Despair
- Withdrawal
- Detachment
- Anger
- Reengagement

These behaviors can reappear in any of us throughout the life cycle when faced with separation from someone we love. They are the basis of the grief we feel when someone dies or we lose our homes or something we love.

#### **Behavior and emotions experienced after bereavement:**

- Disbelief/numbing
- Sadness/despair
- Yearning
- Anger
- Acceptance

These feelings can come, singly or together, in cycles or recurring after long intervals.

All of the following are possible in normal grief:

- FEELINGS: sadness, anger, numbness, fear, guilt nostalgia, yearning, anxiety
- THOUGHTS: ruminations, intrusive thoughts, unusual ideas, suicidal thoughts
- PERCEPTIONS: flashbacks, hallucination
- BEHAVIOUR: withdrawal, aggression, non-acceptance, identification
- MOTOR: agitation/restlessness, lethargy/apathy
- COGNITIVE: poor memory, poor attention and concentration, disorientation
- BIOLOGICAL: somatic symptoms of all kinds, loss of appetite, sleep disturbance and nightmares

#### **Disasters bring multiple overwhelming losses. These can be divided into:**

- *External:* home, possessions, job, loved ones, friends, physically familiar environment
- *Internal:* sense of security, identity, trust, hope in future, self esteem

Note. It is not only the losses that result from deaths of loved ones that are significant. Affected populations are mourning the loss of their entire lives and their communities.

## **Mourning**

Mourning means culturally appropriate processes that help people to pass through grief. It allows for:

- Acknowledgement and acceptance of the death
- Saying farewell
- Time periods for grieving
- Processes to continue attention towards the dead and to move beyond it and make new attachments

The disaster and subsequent destruction disrupt the possibility of appropriate mourning.

- Uncertainty over missing relatives
- Bodies treated inappropriately or lost
- Normal rituals impossible to carry out

Disrupted mourning can extend and prolong grief. In addition, the presence of multiple people suffering losses from a disaster affected community can inhibit the normal mechanisms of social support. Outsiders and relief workers can play a crucial role in being available to accompany and listen to those suffering from losses.

## **The Best Approach:**

- Attend to basic needs
- Answer questions provide information
- Accompanying
- Available
- Attention to cultural/religious metaphors
- Altruism: provide opportunities
- Avoidance as required. Don't force talking or remembrance

## **III: GRIEF IN CHILDHOOD**

### **Frequently Asked Questions:**

- Do children grieve?
- Are they too young to understand?
- Should we protect them from unpleasantness and distress?
- Will loss in childhood cause later mental illness?

### **Understanding death**

*Under Five Years:*

- No understanding that death is final
- Magical thinking results in misconceptions about causes and effects
- Egocentric view of world can lead to feelings of responsibility. "Mummy won't come back because I was naughty"

- Reactions are similar to those following any separation. The longer the absence the greater the distress
- Detachment, surviving family may think the child does not care

*Over Five Years:*

- Children can understand that death is irreversible, may still not regard it as something that can affect them. May continue to have some magical, concrete and egocentric thinking
- Concepts of good and bad, curious about cause and effect, able to articulate concern for others
- Desire to stay connected to the dead parent
- Reactions are variable. Boys are already learning to suppress feelings

*Ten to adolescence:*

- Growing understanding of abstract concepts: for example that death is universal and inevitable and can affect them personally
- Growing concern with justice and injustice, and an awareness of inconsistencies
- The conflict between the desire for autonomy and need for closeness: resolved by "indifference and detachment", or by identification and nostalgia

**The most common immediate reactions:**

- Shock and disbelief
- Dismay and protest
- Apathy and feeling stunned
- Continuation of usual activities
- Anxiety
- Vivid memories
- Sleep problems
- Sadness and longing
- Anger and acting out behavior
- Guilt, self reproach and shame
- Physical complaints
- School problems
- Physical complaints
- Regressive behavior
- Social isolation
- Fantasies
- Personality changes
- Pessimism about the future
- Rapid maturing

**Guidelines for working with grieving children:**

- Provide consistent, enduring appropriate care
- Reunite children with their families or extended families as soon as possible
- In the absence of family, create enduring family-type networks with a low ratio of caretaker to children

- Consistent care-giving by one or two caretakers, not multiple volunteers is essential to prevent attachment problems particularly in younger children
- The more continuity with the child's previous life the better
- Support the caretakers by attending to basic needs and their own mental states
- Facilitate normal grieving and mourning- with memorials for absent bodies, appropriate religious ceremonies
- Do not hide the truth
- Children need clear, honest, consistent explanations appropriate to their level of development
- They need to accept the reality of the loss, not be protected from it
- Magical thinking should be explored and corrected. What is imagined may be worse than reality and children may be blaming themselves for events beyond their control
- Debriefing may not be therapeutic or appropriate
- Encourage a supportive atmosphere where open communication is possible, difficult questions are answered, and distressing feelings are tolerated
- Allow children to express grief in a manner they find appropriate to a person they most trust, at a time of their own choosing
- Symptomatic relief: help the family to cope with traumatic symptoms if they exist. Provide information as to what to expect and straightforward management advice
- Help the child maintain connection with the lost parents – find mementoes if possible or let the child draw pictures/make objects. Answer the child's questions about the dead relative
- Restart normal educational and play activities as soon as possible

#### **IV: TAKING CARE OF OURSELVES**

- Give yourself time
- Do one task at a time if possible
- Exercise
- Sleep
- Eat regular meals – don't skip them (carry snacks for long hikes)
- Time out with friends
- Not wishing to talk does not equal denial
- Wishing to talk does not equal weakness
- Acknowledge that coping methods differ
- Listen to what your friends and colleagues tell you about how you are doing
- Take a break when appropriate
- Take time out of emergency situation (1 week/8 weeks minimum)

#### **Bad coping methods:**

- Working 24/7
- Alcohol
- Drugs

- Too much caffeine
- Never leaving the field
- Ventilation of feelings on beneficiaries

**APPENDIX III**

The chart below was prepared by WHO Geneva in the aftermath of the Tsunami. The framework may have some relevance to the disaster affected population in Haiti since it provides a good summary of the likely percentages for those suffering severe, moderate and mild distress and a framework for the appropriate response.

**Summary table on psychosocial/mental health assistance to tsunami-affected populations: WHO projections and recommendations.**

Description	BEFORE DISASTER: 12-month prevalence rate (median of World Mental Health Survey 2000 data across countries)	AFTER DISASTER: 12-month prevalence rates (projected)	Type of aid recommended	Sector/agency expertise
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder, etc)	2-3%	3-4%	Make mental health care available through general health services and in community mental health services	Health sector (with WHO assistance)
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including of PTSD)	10%	20% (which over the years reduces to 15% through natural recovery without intervention)	1) Make mental health care available through general health services and in community mental health services. 2) Make social interventions and basic psychological support interventions available in the community	1) Health sector (with WHO assistance)  2) A variety of sectors
Moderate or severe psychological distress that does not meet criteria for disorder, that resolves over time or mild distress that does not resolve over time	No estimate	30-50% (which over the years will reduce to an unknown extent through natural recovery without intervention)	Make social interventions and basic psychological support interventions available in the community	A variety of sectors
Mild psychological distress, which resolves over time	No estimate	20-40% (which will over the years increase as people with severe problems recover)	No specific aid needed	No specific aid needed

*Note:* These rates vary with setting (e.g. sociocultural factors, previous and current disaster exposure) and assessment method but give a very rough indication what WHO expects the extent of morbidity and distress to be.