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Psychological First Aid: A Way of Disaster Management

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Abstract:

"Save the people God will save you"

Disaster always dangerous or harmful for all human being, it may be natural or manmade. Its takes place suddenly and affects people mentally, physically, socially and economically. We should have to save the people in different ways. Psychological first aid is one of them. It is the first thing that helps to think of disaster-affected people. It consists of a set of helping actions which are systematically undertaken in order to reduce initial post-trauma distress and to support short- and long-term adaptive functioning and coping. The programs build the response capacity of people who, in a disaster, will be the family and friends of the survivors; appropriately, they will be the ones to whom survivors and those affected most often turn for psychological support. Psychological First Aid can be implemented by other than mental health professionals. The core skill is active listening, the skill at the heart of most therapeutic techniques, but also the first skill learned in any interpersonal or communication skills programme.

Keywords: Psychological First Aid

Introduction:

The American Psychiatric Association (1994) defines a traumatic event as a psychologically distressing event, outside the range of usual human experience that would be markedly distressing to almost anyone. Every disaster, natural or manmade, results in deaths and injuries, damages and destructions, which are always visible. What are 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. Here psychological first aid could have prevented much such type of agonies.

Immediately after disaster often the numbers that need such counselling are far beyond the capacity of available mental health experts. This has encouraged innovative research and practices on community based psycho-social counselling by which the simple tools and techniques of counselling 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 has to be trained with the concepts, methods and techniques of counseling.

Objectives:

Objectives of Psychological First Aid:

1. To establish human connection in a no intrusive, compassionate manner.

2. To enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. Offer practical assistance and information to address survivors' immediate needs and concerns.

4. Connect survivors to social support networks, including family members, friends, neighbours, and community resources.

5. Support positive coping and empower survivors to take an active role in their own recovery.

6. Provide information to help survivors cope effectively with the psychological impact of disasters.

Disasters:

The word disaster comes from Middle French desastre and that from Old Italian disastro, which in turn arrives from the Greek negative prefix dus-, meaning "bad" and aster, meaning "star". It is a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources. It is seen as the consequence of inappropriately managed risk from a combination of both hazard/s and vulnerability.

Psychological First Aid:

Psychological first aid is conceptualized as supportive actions by the expert person or group for the sake of disrupted people. Most survivors will have transient stress reactions that will remit with time. It aims at reducing the initial distress caused by the trauma, and to foster short- and long-term adaptive functioning. There is no evidence that global interventions for all trauma survivors will serve a function in preventing subsequent psychopathology. There is consensus, however, that providing comfort, information, support, and meeting people immediate practical and emotional needs play useful roles in one's immediate coping with a highly stressful event.

Psychological services

Psychological services" refers to those services which apply specialist psychological skills of a level appropriate to the task, to psychological assessments, diagnoses and interventions in disasters in all their dimensions.

It's needed to help affected people to shift the balance from maladaptive or traumatic responses to adaptive ones, and to preamp later pathology. Psychological services need to be specialised because in disasters responses need to be conceptualized in ways different froms. Further, delivery of service requires special skills and cooperation with others, including informing other services with the psychological perspective.

Established professional and institutional attitudes can be quite unhelpful. People struggling with effects from threats to their lives may resent being seen as "crazy", ill, or "pathological", and experience such judgments as additional stressors.

While physical treatments often take the form of patterned office-based clinical therapies, in disasters social structures and patterns are may be disrupted, there may be a rapid increase in client numbers, and the psychological services may themselves be strained. Therefore service delivery has to be flexible, mobile, creative, extensive, while at the same time being able to prioritise.

The approach is outreach, with all in the affected community contacted. Such coverage can identify the need to prioritise services to the vulnerable and those with established dysfunctions. Secondly, outreach may be able to prevent widespread distress and help prevent dysfunctions by for instance providing information about the nature and sense of common stress responses and what can be done about them. Psychological services should be a special but integral part of other established emergency and recovery services. The logistics of the service delivery is in the context of disaster management as a whole. Special skills are required to "see the bigger picture", communicate along hierarchical lines and across services, liaise with them, integrate into emergency and recovery services as a whole, as well as have consultant and healing roles toward the service network.

Nature of psychological services as integral to Emergency Management:

The planning, management and delivery of emergency services by disaster managers in many areas have the potential to have serious psychological consequences for affected individuals and communities. Positive consequences can be enhanced and negative ones avoided through disaster managers being informed by specialist psychological services of the psychological consequences of their decisions. Indeed, it is critical that the psychological dimension inform understanding, planning, training, assessment, decision making and service delivery components of emergency and recovery management. Lastly, managers may avail themselves of psychological services to deal with secondary stresses within their own sub-system.

Specialist training is required to discern, and appropriately act on the wide range of bio psychosocial stress responses evoked in oneself during assessment and interventions. For instance, intense emotions at the professional level may be used as information for assessment and measured professional intervention rather than instinctive response. Nevertheless, because empathy requires openness to and reverberation with others, monitoring of one's responses by self, peer group and supervisors is necessary.

Different techniques use:

Recognition of who or what group is affected in what way, how and why. Inappropriate current responses and beliefs may make sense when traced back to their biological, psychological and social survival response origins in the disaster context. Psychological support; counter-trauma environment. Its characteristics include a safe space with boundaries within which one can absorb, think, feel, express fully, communicate, and put one's experience in context.

Therapeutic relationship

It includes sensitive empathic listening and tuning into affected people for the purpose of being able to offer skilled help. The relationship is reliable, punctual, objective, and nonjudgmental. It provides a template for hope, trust, bonding, and faith that the world can provide kindness, comfort and reliability.

Relief of specific distress;

Symptomatic treatment:

Intervention may mitigate specific distress and symptoms. This includes creature distress, such as facilitating provision of warmth or toiletries. People may be taught skills in asking for such items by understanding helping networks, and

know how to ask for what, where and how. Human empowerment may also be facilitated by learning physical and mental skills to improve one's environment, while ventilation of feelings and skills to manage tension, anxiety, anger and other intense emotions facilitates taking control over one's internal environment.

Education:

Proper education regarding disaster and its monument can reduce unhealthy situation. Provision of information and clarification are key components which relieve distress. It can provide great relief to have clarified that what people are experiencing is typical of normal people who experienced an abnormal event.

Assimilating the trauma;

. Each response and its ramifications are made sense of in terms of the original context and its ripples, and are contrasted with current less turbulent and hopeful contexts, and appropriate responses to them. Correct understandings of both the disaster circumstances and of the present are merged cognitively and emotionally in a chronological story with new meanings which incorporate both. This facilitates adaptive responses to the present and the future, which include wisdom of past experience. It must be seen that Specific Ethical Principles In Relation to Clients, Patients.

Whatever is best for clients should take primacy. In particular the vulnerability of their traumatized state should not be exploited for financial, academic, organizational or personal rewards. The impulse to help should be balanced by likely benefits and disadvantages to victims.

Collaborative works for clients.

To the degree possible trauma therapy should be collaborative and reciprocal, clients being able to control the occurrence of the therapy and having equal power in it. When clients are approached as part of an outreach process, its rationale should be explained very early and permission to continue be asked for. If clients are unable to give informed consent to therapy, a prime goal should be to help them to be able to do so. The rights as well as special needs of children, the elderly, the ill and ethnically unassimilated should be respected.

Core actions of psychological first aid:

1. Personal Contact: Personal contact varies from person to person and across social groups If you are not familiar with the culture of the survivor, do not: Approach too closely, – Make prolonged eye contact..Get guidance about cultural norms Seek cues from the survivor regarding" personal space" • When working with families, identify the family spokesperson.

2: Supply Safety and Comfort

The goal is to enhance immediate an ongoing safety and provide physical and emotional comfort Ensure immediate physical safety Provide information about disaster response activities and/or services Offer physical comforts Offer social comforts and link to other survivor Protect from additional trauma and potentia trauma reminders.

3. Stabilization:

The goal is to calm and orient emotionally overwhelmed and distraught survivors Steps toward Stabilization.• Respect the survivor's privacy • Give him/her a few minutes without active attempts to intervene • Remain calm, quiet, and present • Tell him/her that you will be available if he/she needs you or that you will check back with him/her in a few minutes.

4: Information Gathering:

The goal is to identify immediate need and concerns, gather additional information, and tailor PFA interventions It is used to determine: Need for immediate referral.

– Need for any additional available ancillary services, which components of PFA may be helpful.

5: Giving Practical Assistance:

Offer practical help to survivors in addressing immediate needs and concerns through

– Identify the most immediate need of the affected person,

– Clarify the need

– Discuss an action response and

– Act to address the need.

6: Connection with Social Support:

The goal is to help establish brief or ongoing contacts with primary support persons, such as family members and friends, and to seek out other sources of Support. Enhance access to primary support persons which can-

• Encourage use of immediately available support persons

• Discuss ways to seek and give support

– Identify possible support persons

– Discuss what to do/talk about

– Explore reluctance to seek support

• Address extreme social isolation or withdrawal

7: Information on Coping:

Provide information about stress reactions and coping to reduce distress and promote adaptive functioning

– Explain what is currently known about the event

– Inform survivors of available resources

– Identify the post-disaster reactions and how to manage them

– Promote and support self-care and family care practices

Role of Psychologist:

Help people to manage other life disasters that might be happening at the same time (e.g. death or illness of a relative not related to the current event).Educate people that it is normal for disaster survivors to have an array of common reactions. Some of these include: fears, memories, nightmares, irritable and/or withdrawn emotions, and confusion. Assure people that it is possible to recover from disaster and to build fulfilling and satisfying lives.

Listen to people's concerns on a variety of issues including their homes, missing family members and pets. Help people to manage their temporary living conditions and to acclimate to shelters located possibly far from their home state and in different environments.

Provide information about available resources for current needs help to facilitate those connections. Advocate for the needs of particular individuals or families as they navigate the systems that have been established to provide aid.

Conclusion and findings:

Disaster nowadays a common phenomena, but in modern civilization we have to know about its affect and rescue work for common people. So we have to mange it through different ways. Psychological first aid is a common and normal way through this way disaster can be reduce much. Education and training programs need to build capacity in these providers to recognize and manage post-disaster psychological morbidity. Brief psychological interventions using cognitive behavioral techniques (such as anxiety management and problem-focused coping) can be made available, as can education, self-help skills resources and, when appropriate, medication if disorders become significant.. The key elements of an assessment to determine other needed psychological support include a review of the experience; determining the patterns of distress; identifying the coping strategies used effectively; checking the ongoing stressors and issues; and assessing the level of distress and functional change as to whether it means that the person needs specialized psychological support. Such support should be provided while taking into account the distress levels, allowing counseling and dealing with the happening in "doses" that the person can tolerate. This must build up a sense of achievement with forward goals for the future, beyond the disaster experience.

References

1.Armstrong K (2000). Multiple stressor debriefi ng as a model for intervention. (pp. 290-304). In. B Raphael and J Wilson (Eds.). Psychological debriefi ng: Theory, practice, practice and evidence. New York: Cambridge University Press.

2. Asukai N & Maekawa, K. (2002). Psychological and physical health effects of the 1995 Sarin attack in the Tokyo subway system. In. Havenaar, Johan M (Ed); Cwikel, Julie G (Ed); et al. (2002). Toxic turmoil.

3. Silove D. (1999) The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. Journal of Nervous & Mental Disease. 187(4):pp. 200-207.

4.Singh B & Raphael B (1981). Post-disaster morbidity of the bereaved: A possible role for preventive psychiatry? Journal of Nervous and Mental Disease, 169, pp.203-12.

5. Sphere Handbook (2004). The Sphere Handbook – Revised edition. Sphere Project:Switzerland.Available: www.redcross.ca/sites/english/sphere/handbook.html

6. Ursano, Fullerton, Vance & Wang (2000) Debriefi ng: its role in the spectrum of prevention and acute management.

7.Crow, L.D and alice Crow, Understanding our behavior, New York,Alfred A. Knoff,1956.

8. Agarwal,J.C, Psychological foundation of education, Vikash publishing house New Delhi-2008.

9.Bhatia and Bhatia: A Textbook of Educational Psychology. Doaba House, Delhi,

10.Hurlock, E.B. : Developmental Psychology, A Life-Span Approach, TATA McGRAW-HILL Publishing Company LTD., New Delhi, 5th Edition,

11. Mangal, Dr. S.K.: Psychological Foundations of Education. Parkash Brothers, Ludhiana,