



International Medical Corps

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COPING IN THE AFTERMATH OF HURRICANE KATRINA: SOME BRIEF GUIDANCE NOTES ON STRESS, GRIEF AND LOSS FOR FRONT LINE TEAMS

These guidance notes on stress, grief and loss have been compiled by IMC's Mental Health Advisor, Dr. Lynne Jones, for organizations working with Hurricane Katrina-affected populations. They represent lessons learned regarding mental health activities from IMC's international experiences in disaster response, including the recent tsunami, as well as summarize best-practices¹ identified by international agency consensus.

I. COMMUNAL STRESS RESPONSES

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

- Fear
- Anger
- Despair
- Disorganisation
- 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.

¹ These guidance notes also draw on the Sphere Project's Minimum Standards in Disaster Response <http://www.sphereproject.org>, and WHO Guidelines for Mental Health in Emergencies, http://www.who.int/mental_health/prevention/mnhemergencies/en/

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 like someone younger
- Disturbed behaviour
- Panic and hyperventilation
- Symptoms can last minutes to few hours to 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- Symptoms resolve rapidly if withdrawn from stressful environment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%) may suffer

- Phobias
- Depression and anxiety
- Somatic complaints
- Alcohol or drug problems
- PTSD

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
- Organise 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 behaviour, soiling, wetting, clingy, sleeplessness, nightmares, night terrors, loss of new skills, minor illnesses
- Six to twelve: tearfulness and depression, sleep problems, poor concentration, restlessness, anxiety and fear, aches and pains, regression, aggression. Repetitive play is very common.
- Over twelve: risk taking, withdrawal, apathy, somatic complaints, hopelessness, suicidal ideas, self destructive behaviour.

Symptomatic relief for specific difficulties:

Managing acute anxiety and hyperventilation. This is 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 CO₂ going out (Hypocapnia)

- The chemical imbalance causes: 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?) leads to more fear and more symptoms

Treatment:

- Create quiet space
- Clear excess attendants
- Check no cardiac problems/fits (history)
- Simple explanation and reassurance
- Leave with calming attendant
- Gentle reassurance (in a calm quiet place)
- Encouraging slow quiet breathing with the abdomen
- If necessary rebreathing one's own CO₂ by holding a paper bag over the mouth

Simple symptomatic relief for other problems

- Unpleasant imagery: Distraction techniques: games, stories, “wipe it clean”, visualisation
- Anxiety and tension: abdominal Breathing
- Somatic aches and pains: Relaxation techniques
- Night terrors: Reassurance and explanation,
- Nightmares: Dream scripting (children under 10)

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 Behaviour

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 behaviours 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 something we love.

Behaviour 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 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. Displaced populations are mourning the loss of their entire lives.

Mourning

Mourning means the 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 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 behaviour
- Guilt, self reproach and shame
- Physical complaints
- School problems
- Physical complaints Regressive behaviour
- Social isolation
- Fantasies
- Personality changes
- Pessimism about the future
- Rapid maturing

Guidelines for 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 carers by attending to basic needs and their own mental states.
- Facilitate normal grieving and mourning- with memorials for absent bodies, appropriate religious ceremonies
- Don't 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 possible, difficult questions answered, and distressing feelings tolerated.
- Allow children to express grief in manner they find appropriate to 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
- Time out with friends
- Not wishing to talk $\neq$ denial
- Wishing to talk $\neq$ weakness
- Coping methods differ
- Listen to what your friends and colleagues tell you re how you are doing
- Take a break when appropriate
- Take time out of emergency situation (1 week/8 week minimum)

Bad coping methods

- Working 24/7
- Alcohol
- Drugs
- Too much caffeine
- Never leaving the field
- Ventilation of feelings on beneficiaries

The best treatment for stress and loss is the company of those we love ...

APPENDIX 1

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 the US and 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.