Trauma-informed approach to Mental Health and Psychosocial Support During Disasters

A Training Manual for Counsellors

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By

RAHBAR, A FIELD ACTION PROJECT OF THE SCHOOL OF HUMAN ECOLOGY, TATA INSTITUTE OF SOCIAL SCIENCES

In Collaboration With

NATIONAL DISASTER MANAGEMENT AUTHORITY

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National Disaster Management Authority
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सत्यमेव जयते

Foreword

In the face of increasing frequency and severity of natural and man-made disasters, the importance of effective mental health and psychosocial support (MHPSS) has never been more evident. India, with its diverse geography and large population, is particularly vulnerable to a range of disaster events, including floods, earthquakes, landslides, and pandemics. Each of these disasters brings not only physical destruction but also profound psychological impact, making the role of mental health professionals crucial in mitigating the long-term effects on affected individuals and communities.

The Indian subcontinent has experienced significant disasters in recent years, each highlighting the urgent need for comprehensive psychosocial support frameworks. From the devastating landslides in Waynad Kerala to the unprecedented challenges posed by the COVID-19 pandemic, the psychological toll on survivors has been immense. These events underscore the necessity for mental health professionals to be equipped with effective, trauma-informed approaches to provide support in such critical times.

In this critical context, this manual stands out as an essential resource. Created through the collaborative efforts of Rahbar and the National Disaster Management Authority (NDMA), this manual marks a significant advancement in our shared mission to improve disaster response and recovery through specialized mental health support.

The partnership between Rahbar, which is a field project by Tata Institute of Social Science (TISS) and NDMA has been crucial in the development and refinement of best practice guidelines for psychosocial support. This manual synthesizes international best practices with practical insights garnered from field experience, providing a trauma-informed framework tailored to the mental health needs of individuals impacted by disasters. It offers a spectrum of interventions designed to address various stages of trauma and specific responses observed in disaster contexts.

This manual is organized into six detailed sections. Each section delivers essential information, ranging from the understanding of trauma and its effects to the effective implementation of trauma-informed MHPSS strategies. It is intended for use by a wide array of mental health professionals, including social workers, psychologists, and psychiatrists, and is applicable across different modalities, whether in-person or remote.

We express our sincere appreciation to the Rahbar team, led by Dr Chetna Duggal and various stakeholders who extended their willing support, cooperation by devoting their expertise to make valuable contributions in shaping this manual. Their steadfast dedication ensures that mental health professionals are thoroughly prepared to deliver compassionate and effective support to those affected during disasters. By adhering to the principles outlined in this manual, we can collectively enhance our efforts to deliver high-quality, trauma-informed care and foster the resilience and recovery of affected individuals and communities.

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First and foremost, we thank Shri. Krishna Vatsa, Member Secretary, NDMA, and Shri. Safi Ahsan Rizvi, IPS, Advisor (Mitigation), NDMA. It is their foresight and vision that brought mental health support to the forefront of disaster management services. Under their leadership, NDMA launched a Psychosocial Care project for the state of Sikkim from which subsequently this manual was developed.

We are grateful to Chancellor and Pro-Vice chancellor Tata Institute of Social Sciences, for extending her support for this collaboration between NDMA and Rahbar, a field action project of TISS.

The volunteer Tele-Manas counsellors from the state of Sikkim associated with NDMA's Psychosocial Reverse Helpline who were a part of the training and supervision sessions carried out by Rahbar contributed significantly to the compilation of this manual. It is through our interaction with them that we gained insights on psychosocial concerns of people affected by disasters and the needs of mental health professionals during this time, which provided the conceptual and practical framework for this manual.

In putting together this manual we drew upon evidence based models and resources developed by various international organizations and practitioners across the world.

We are grateful to the team at the National Institute for the Clinical Application of Behavioral Medicine, Connecticut, United States for granting us permission to use their resources in the manual. We have taken due care to appropriately credit their work in relevant chapters.

The compilation of this manual would not have been possible without Ms. Teju Jhaveri. It is thanks to her artistic expertise that endless pages of text were brought to life through a creative visual layout and design.

We thank all the mental health professionals across India who have been tirelessly working on the frontlines of disasters to provide timely and responsive care to individuals and families impacted by it. This manual is dedicated to their efforts and we hope it serves as an effective resource and guide for all mental health professionals.

Contents

List of Abbreviations

ACEs: Adverse Childhood Experiences

ANS: Autonomic Nervous System

APA: American Psychological Association/ American Psychiatric Association

ASD: Acute Stress Disorder

CAPS-5: Clinician Administered PTSD Scale for DSM-5

CAPS-CA-5: Clinician-Administered PTSD Scale for DSM-5 - Child/Adolescent Version

CBT: Cognitive–behavioral therapies

CPT: Cognitive processing therapy

CSRC: Child Stress Reaction Checklist

DBT: Dialectic Behavioural Therapy

DMA: Disaster Management Act

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

EMDR: Eye Movement Desensitization and Reprocessing

IFS: Internal Family Systems model

ISTSS: International Society for Traumatic Stress Studies

MHPSS: Mental Health and Psychosocial Support

MoHFW: Ministry of Health and Family Welfare, Government of India

NCTSN: National Child Traumatic Stress Network

NDMA: National Disaster Management Authority, Government of India

NICABM: National Institute for the Clinical Application of Behavioral Medicine, Connecticut, United States

NIMHANS: National Institute of Mental Health And NeuroSciences, India

NSESASDSS: National Stressful Events Survey Acute Stress Disorder Short Scale

PDS-5: Posttraumatic Diagnostic Scale

PSS-I-5: PTSD Symptom Scale - Interview for DSM-5

PTG: Post-Traumatic Growth

PTGI: Post-Traumatic Growth Inventory

PTSD: Post-Traumatic Stress Disorder

SAMHSA: Substance Abuse and Mental Health Services Administration

SI-PTSD: Structured Interview for PTSD

SS: Seeking Safety model

STAIR: Skills Training in Affective and Interpersonal Regulation

SUDS: Subjective Units of Distress

TISS: Tata Institute for Social Sciences, India

UNISDR: United Nations International Strategy for Disaster Reduction

WHO: World Health Organization

Author Bios

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is Associate Professor at the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. She has completed her Ph.D. from TISS, Mumbai and her M.Phil. in Clinical Psychology from NIMHANS, Bangalore. She is a psychotherapist with over 20 years of experience and has worked with children, adolescents, couples and families. She teaches courses on psychotherapy and counselling in the Masters programme and supervises trainee counsellors and practitioners. She is the Project Director for Rahbar, an initiative to promote training, supervision and professional development for mental health practitioners in India. She also heads the School Initiative for Mental Health Advocacy (SIMHA), an initiative that endeavours to promote well-being of young people in schools through advocacy, research and capacity building. She is the trustee of Apnishala, an organisation working towards making life skills education accessible to children from underprivileged contexts. She has a keen interest in psychotherapists and counsellors training, supervision and reflective practice, and has conducted research and authored book chapters and papers on the same.

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is a clinical psychologist working as a private practitioner in New Delhi. She has experience of working with individuals with psychiatric difficulties as well as children who are survivors of sexual abuse. Her special interest is in working with individuals with histories of trauma which also aligns with her research interest. She has an MPhil in Clinical Psychology from NIMHANS (Bangalore), an MA in Clinical Psychology from TISS, Mumbai (Silver Medalist) and a BA (Hons.) Psychology from Delhi University (Gold Medalist). Her therapeutic work is a reflection of her beliefs about acknowledging and appreciating the role of social justice, intersectionality and socio-political frameworks in the sphere of mental health.

Introduction

About the Manual

BACKGROUND

This manual has been developed by Rahbar in collaboration with the National Disaster Management Authority (NDMA). Rahbar ('guide' or 'companion' in Urdu) is a field action project of the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. Rahbar was established in 2019 as a platform for promoting training and supervision for mental health practice. Rahbar supports mental health professionals and organisations across India and outside, especially those in resource constrained contexts, to ensure access to quality mental health care for all through supporting professional development of mental health practitioners and developing best practice guidelines and frameworks. Rahbar also offers a flagship Post graduate Diploma in Supervision for Mental Health Practice. The Rahbar team also coordinated mental health and psychosocial support for those affected by the train accident in Balasore, Orissa.

In April 2020 Rahbar launched an initiative to train and supervise mental health professionals supporting those affected by the Covid-19 pandemic. In May 2020 the National Disaster Management Authority collaborated with Rahbar as a training partner to support volunteer counsellors leading NDMA's psychosocial helpline for persons diagnosed with Covid-19. Between June to August 2020, the Rahbar team provided training sessions and sessions pro bono to NDMA's counsellors which aimed at building knowledge, skills and reflective abilities of counsellors in carrying out psychosocial first aid and telephonic support to those affected by the pandemic. In September 2020 Rahbar and NDMA collaborated for continuing supervision sessions for PSC Helpline counsellors as well as developing a training manual. Between September to December 2020 Rahbar provided supervision sessions which covered case discussions, peer de-debriefs, skill building, theoretical discussions and experiential exercises. The discussions informed the development of a training manual titled 'Psychosocial Support during the COVID-19 pandemic:

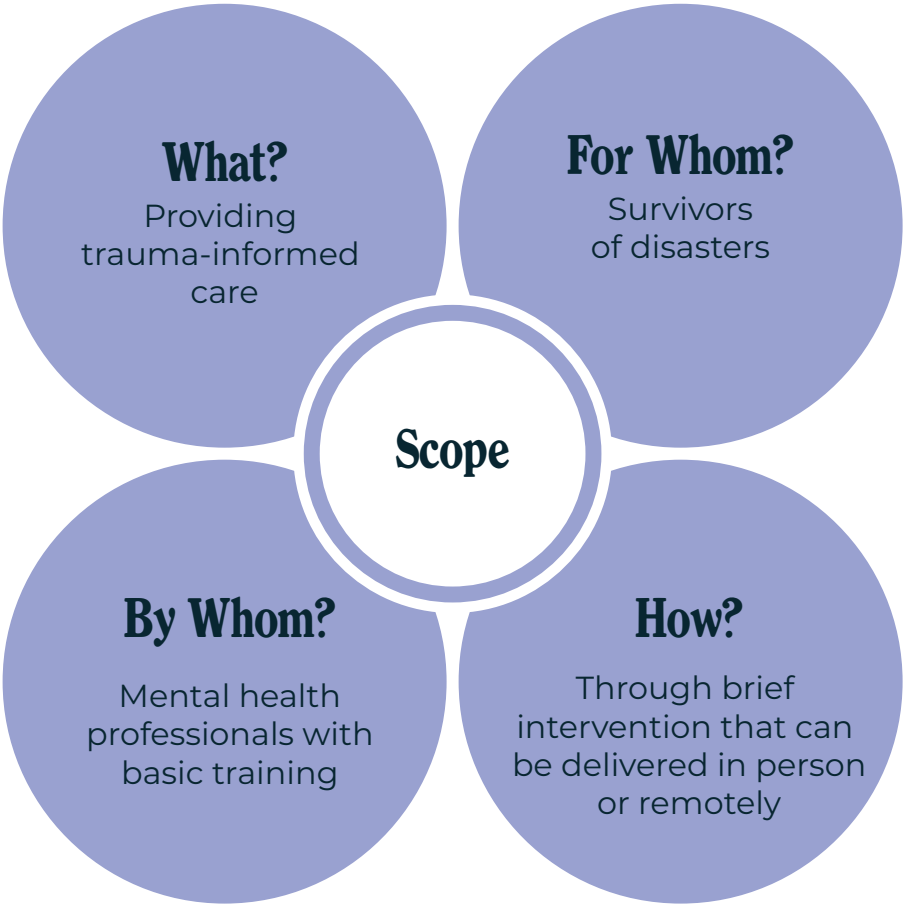
A training manual for counsellors' (https://ndma.gov.in/sites/default/files/PDF/covid/RAHBAR_%20NDMA-manual.pdf). NDMA and Rahbar also documented this work through the research titled 'Psychosocial Support for Individuals Diagnosed with Covid-19: Experiences of Volunteer Counsellors from India' (https://ndma.gov.in/sites/default/files/PDF/covid/Psychosocial-Support-forIndividuals-Diagnosed-with-Covid-19.pdf). After the helpline restarted in 2021, Rahbar supported NDMA through training and supervision sessions. From March to September 2023, Rahbar worked on updating the National Disaster Management Guidelines on Mental health and Psychosocial Support Services in Disasters in keeping with the recent developments in the field of disaster risk reduction and as well as psychosocial care. The updated guidelines would provide a pathway to integrate and mainstream psychosocial care in every stage of the disaster management cycle in view of these developments in the national and international scenario.

The NDMA and Rahbar collaborated once again in November 2023, following the landslide in the state of Sikkim. Rahbar provided support for psychosocial work in the state by creating resources for community sensitization and facilitating awareness programs for school students to identify emotional responses during disasters and sharing strategies for managing distress. Tele-Manas counsellors from the state were trained in trauma-informed practices for working with traumatic responses commonly seen in the aftermath of disasters. A reverse helpline was started in which the counsellors contacted those most severely affected by the landslide to provide psychosocial support. Rahbar provided supervision and debriefing support to the counsellors during this time.

This manual presents a trauma-informed framework of psychosocial support to equip counsellors in addressing the mental health concerns that arise in the context of disasters. Integrating international best practice guidelines with practice-based insights of trainers and supervisors, as well as counsellor education frameworks, the manual aims to be a resource for mental health professionals not only in India, but across the world.

SCOPE

This manual is aimed at helping mental health professionals to provide trauma-informed care to individuals who have survived disasters. The interventions described in this manual can be used by counsellors and other mental health professionals (e.g., social workers, psychologists, psychiatrists etc) who have training in mental health. These brief interventions can be applied in any modality (in-person or remote)



OVERVIEW

This manual is divided into six sections:

SECTION 1: Trauma and Disaster Mental health. This section defines trauma and its typologies with an overview of mental health in disaster settings.

SECTION 2: Trauma responses in disasters. This section highlights the different responses to traumatic events and how these can be identified in disaster settings. It also introduces the concept of post-traumatic growth.

SECTION 3: Trauma-informed Mental health and Psychosocial support (MHPSS) in disasters. This section describes the neurobiology of trauma and its impact on the brain and body.

SECTION 4: Role of Mental health professionals in delivering trauma-informed MHPSS during disasters. This section describes the role that mental health professionals play at different stages of psychosocial support in disaster settings. It also highlights the principles of trauma-informed care and competencies of mental health professionals who are trauma-informed.

SECTION 5: Providing Trauma-informed MHPSS during disasters. This section describes the stages of trauma-informed MHPSS and the interventions that can be carried out at each stage.

SECTION 6: MHPSS for specific trauma responses during disasters. This section describes the interventions that can be carried out for different trauma responses during disasters.

Throughout the manual, exercises for reflective practice and self-care have been woven in to help counsellors to reflect on their work and promote professional development. Additionally, each chapter also has tips for supervisors for carrying out trauma-informed supervision.

Trigger Warning

It is important to note that this manual covers very heavy and triggering topics that may bring up difficult experiences for counsellors either from their own life or those important to them, including their clients. Please feel free to pause and step away from it as and when it becomes overwhelming.

All mental health professionals acknowledge that working with the realities of trauma is an evolving competency. As counselors we are all continuously finding our own ways to make meaning of the pain and suffering that we witness.

If it seems ‘too heavy’, that is because it is. It will become more bearable with time, experience, supervision and support. Using the strategies mentioned in the manual may be beneficial for us too.

CHAPTER 1

1 Trauma and Disaster Mental health

1

DEFINING TRAUMA

Trauma has been defined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), as "exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (DSM 5, APA, 2013). This definition focuses on the traumatic event. The American Psychological Association (APA, 2017) highlights the experience of trauma where it is seen as an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea (APA, 2017). The definition of trauma by Substance Abuse and Mental Health Services Administration (SAMHSA) highlights the effect of the traumatic event on the experience. SAMHSA has specifically defined trauma as resulting "from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014). This definition of trauma is sometimes used to define "psychological trauma" to help differentiate it from other types of trauma such as physical trauma like having a fractured limb or meeting with a road traffic accident. The trauma in psychological trauma is defined in terms of the event, the individual's experience of the event and the adverse long-lasting effects of this experience.

Thus, the 3 Es of trauma are (SAHMSA, 2014):

Events	These are the single, multiple or extended situations and circumstances posing an actual or extreme threat of physical or psychological harm.
Experience	It is the unique and subjective experiences of individuals which determine whether events are perceived as traumatic
Effects	These refer to the temporal nature of the experiences. Effects of the event may be immediate, or delayed; short term, or long term.

2

TYPES OF TRAUMA

Adverse childhood experiences (ACEs) are those experiences occurring before the age of 18 years that can be considered to be traumatic. These include exposure to violence, abuse, or neglect, as well as any situation in the environment that compromises a child's sense of safety and stability including but not limited to parental separation, a family member having substance use difficulties, and so on (SAMHSA, 2014). ACEs tend to have a pervasive and long-range influence on the emotional, cognitive, behavioral, and psychobiological functioning of the child. It may lead to difficulties in managing emotions, processing information, guilt and shame, behavioural difficulties, difficulties in interpersonal relationships and delay in biological development of the child (APA, 2017).

Traumatic events may be interpersonal and noninterpersonal events based on the intentionality to inflict harm (Janoff-Bulman, 1992). Interpersonal traumas are those in which a perpetrator harms another human being with conscious intent. Examples of these events include experiencing or witnessing physical, sexual and emotional abuse, interpersonal violence to name a few. These experiences are associated with dissociation, shame, distress, lowered self-esteem, and changes in beliefs about self, such as negative self-attributions and a decrease in positive view of self; about others such

as they are not trust-worthy and the world such as it is unsafe and unpredictable (Forbes et al., 2014; Ogle, et al., 2013). Noninternpersonal traumas include those events where such an intention is absent. Some common examples of these noninterpersonal traumas are illness, natural disasters and accidents. Noninterpersonal traumatic events may elicit feelings of powerlessness and feelings of loss of control (Lilly et al., 2011).

Experiences of trauma may also be transmitted as a psychological consequence of an injury or attack, poverty, and so forth, from one generation to next. These reactions often include shame, increased anxiety and guilt, a heightened sense of vulnerability and helplessness, low self-esteem, depression, suicidality, substance abuse, dissociation, hypervigilance, intrusive thoughts, difficulty with relationships and attachment to others, difficulty in regulating aggression, and extreme reactivity to stress (APA, 2017).

3 DISASTERS AS TRAUMATIC EVENTS

The United Nations International Strategy for Disaster Reduction [UNISDR] considers disaster as "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" (UNISDR, 2009; pp.13). The Disaster Management Act, 2005 [DMA, 2005] defines disaster as "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or manmade causes or by accident or negligence which result in substantial loss of life or human sufferings or damage to, and destruction of, property or damage to, or degradation of environment and is of such a nature or magnitude as to be beyond the coping capacity of the community of an affected area".

Disasters differ from other types of traumas in significant ways. Thus, it is important to discuss these separately (Watson & Hamblen, 2008). Disasters tend to be collective in nature, that is, a large number of individuals are often affected at the same time. This may lead to better mobilization of support and resources which may not be accessible to individuals otherwise. At the same time, it may lead to minimization of individual needs. It is possible that the resources available may be insufficient. The impact of disasters is widespread and includes

impacts on infrastructure and mental health. Basic needs such as communication, transportation or housing may get adversely impacted. Secondary impacts such as homelessness and joblessness may get exacerbated. The vulnerabilities in the communities may get magnified in the context of disasters. This can be seen in the results of a large-scale study which found that the loss of lives in lower income countries was higher despite experiencing fewer disasters (West et al., 2015). The response to the disaster can also be an important factor to the experience of trauma. If the systemic responses are not attuned to the needs of the people who went through the disaster, it may lead to increased feelings of helplessness, abandonment, and insecurity among affected individuals and communities (Schultz et al, 2005). Across different disasters such as hurricanes, earthquakes and Tsunami, research has shown that lack of timely rescue efforts, breakdown of healthcare systems, difficulties in meeting the basic needs of the people, and insufficient long-term support and recovery planning can prove to be detrimental to the overall recovery of the individuals and communities (Shreshtha et al, 2018).

India is considered to be one of the most disaster-prone countries in the world because of its unique geo-climatic conditions. Within the country, 27 out of the 36 States and Union Territories have been deemed as being prone to disasters (NDMA, 2021). The effects of disasters are further complicated by a large population, the social, economic, and cultural diversity in communities, low literacy levels, high poverty, and inequitable availability and distribution of resources.

4

PHASES OF DISASTERS

The impact of disaster is often widespread and the needs and reactions of individuals and communities change over time. Thus, understanding the way in which post-disaster events unfold is important. This period has often been divided into four phases: impact, immediate, intermediate, and long-term.

4.1 PHASE 1: IMPACT

This phase encompasses the hours, days or weeks following a disaster, depending on the size and scope of the event. The impact phase tends to be longer for events that destroy people's homes and create a housing crisis, like a hurricane, earthquake, flood, or fire. During this phase several stressors may occur such as injury, loss (of loved ones, home, workplace, possessions), dislocation (i.e., separation from loved ones, home, familiar settings, neighborhood, community); even trying to understand the fact that some disasters may be caused by human error, neglect, or malevolence. People may feel a sense of threat, shock, fear, helplessness or powerlessness, guilt, and anxiety. People may also reach out to support each other and prevent loss of life and property.

4.2 PHASE 2: IMMEDIATE - RESCUE

This is the phase in the days and weeks following disaster when people start assessing the extent of damage to home and community. They begin to deal with the physical, emotional, and social impact of injury, loss, and exposure to traumatic stress engendered by the event. The focus is often on survival needs and the restoration of safety and some semblance of order. Once stability is achieved, people may start showing delayed emotional reactions. These reactions depend on the personal history, perceptions, and exposure to the disaster.

4.3 PHASE 3: INTERMEDIATE - RECOVERY

The intermediate phase may last from weeks to months, depending on the size and scope of the event. This phase is the prolonged period of adjustment or return to equilibrium. It begins as rescue is completed and individuals and communities face returning to fulfilling routine tasks and roles. Much of what happens in this phase will depend on the extent of devastation that has occurred, as well as injuries, exposure to traumatic stress, and lives lost. Once the basic safety is restored, other psychosocial needs begin to emerge that had been previously frustrated and unfulfilled.

4.4 PHASE 4: LONG-TERM - RECONSTRUCTION

This phase may last several months or years, as communities rebuild and individuals deal with their

post-event problems. On the one hand, there may be opportunities for positive social consequences if communities collectively respond and rebuild. However, if the community is unable to pull together and overcome fragmentation, there may be increased risk for ongoing stress reactions across the community. This is further complicated by socioeconomic, cultural, racial, and political factors associated with the disaster response. The perception of the event and the meaning assigned to it may also affect long-term psychosocial adjustment. While the majority of affected individuals will see a lessening of distress over time in the long-term phase, vulnerable populations such as those with injury, severe disaster exposure or ongoing adversities, may continue to suffer for years after a large-scale disaster event.

5

IMPACT OF DISASTERS ON MENTAL HEALTH AND WELLBEING

Disasters have a devastating impact on individuals, families, communities, and society as a whole. They have wide-ranging effects on the individual such as loss of life, injury, disability and on the community as a whole such as costs to livelihood, property, purchasing capacity, and financial security. Disasters tend to disturb routines, cut-off social support systems, and lead to forcible displacement of people. Basic needs may not be met as access to water supply may get contaminated or restricted, food supply chains may get obstructed, and services, infrastructure and systems may get damaged especially health services.

These consequences of disasters have cumulative and far-reaching effects on the psychosocial and mental health of people. There is a growing body of research that indicates a surge in mental health concerns and stress-related conditions in the aftermath of disasters, including post-traumatic stress disorder, anxiety, substance misuse, and depression (Makwana, 2019; Fergussson & Boden, 2014). The psychological impact of disasters has led to the development of policies focused on providing psychosocial support and mental health services.

People respond to the immediate aftermath of trauma by showing emotional distress ranging from transient to severe. Emotional distress is defined as a range of negative and/or painful emotions and experiences, both physiological and psychological (APA, 2017). A large scale review summarising findings from 160 studies

showed that nearly 51% of the samples of people who had experienced disaster showed moderate impairment indicating prolonged stress. The more extreme reactions such as minimal or transient impairment were shown by 11% of the sample while severe impairment and very severe impairment indicating clinically significant distress was shown by 21% and 18% respectively on the other hand (Norris & Elrod, 2006). Results from a review conducted in India showed that post disaster mental health difficulties are highly variable, ranging from 5% to as high as 80% (Kar, 2010).

Research in the field of mental health impact of disasters indicate that the most common post-disaster negative reactions are depression, anxiety, posttraumatic stress disorder (with higher incidences of intrusion and arousal reported as compared to avoidance), acute stress disorder, dissociative responses, increases in the use of alcohol and drugs, demoralization, negative affect, perceived stress, physical health problems or somatic concerns, poor sleep quality, and physiological indicators of stress such as increased activation of the autonomic nervous system and hypothalamic-pituitary-adrenal axis (Goldmann & Galea, 2014; Lowe & Galea, 2015; Morganstein et al., 2016). It is indicated that the first 6 to 12 months post disasters are crucial as these reactions are more common during this period irrespective of the nature of the disaster (Pietrzak et al., 2012). Complicated grief which has a combination of symptoms of grief and PTSD tends to cause greater and more prolonged distress (Kristensen et al., 2012). With respect to suicide, the rates vary with severity of the disasters. In large scale disasters, the rates increase three to fouryears later whereas in less severe disasters, the rates decrease as the time moves on (Matsubayashi et al., 2013). With respect to children, distress is often manifested as emotional lability, difficulties in sleep, increased crying, fear and grief especially around anniversaries and somatic complaints which cannot be explained medically (Peek, 2008; Ronan et al., 2008).

In this manual, we are particularly focusing on trauma responses experienced by those affected by the disasters. These include responses such as shock, numbness, hyper-arousal, hypo-arousal, agitation, flashbacks, and disorientation. During disasters, trauma responses are seen in both individuals as well as communities. Individual trauma as already described above, is said

to arise from an event, or a series of events or set of circumstances that are experienced by an individual as being physically or emotionally harmful or life threatening. These tend to have lasting adverse effects on their functioning as well as their mental, physical, social, emotional, or spiritual well-being (SAHMSA, 2014).

Disasters may be experienced as collective trauma by the affected communities. Collective trauma refers to psychological reactions to a traumatic event affecting the society at large. It is not just a historical fact or a recollection that a terrible event happened to a community. It highlights the representation and ongoing reconstruction of the traumatic event in the collective memory of the group so as to make sense of it (Hirschberger, 2018). Communities which have undergone collective trauma are more likely to be passive, mistrustful, silent, dependent and leaderless (Somasundaram, 2014). Other effects of collective trauma may include breakdown in traditional family, and social structures; changes in relationships, and child rearing patterns; or widespread displacement, and disenfranchisement.

6

VULNERABLE GROUPS IN DISASTERS

Mr.R is a 43 year old man residing in a small town near a river. Due to unexpected heavy rains, the river flooded this year. His two-storey house was badly affected as water entered the ground floor. Fortunately, he had heard the warning that the Government was telecasting on the news for two days and had shifted his family members upstairs. He has lost some furniture and a valuable watch that was a gift from his grandfather. He is hoping that once the flood water recedes, he can travel again for business and recover the cost of the furniture. The watch is lost forever though.

Mrs. P is a 24 year old woman residing in the same town in a one-room house in a temporary tenement. When the flood came, they were caught completely off-guard and had to rush home. They were able to reach safely though. Since her house was on the upper floor, there was no property damage but the children were very scared with the running and sudden onslaught of water. They have been crying incessantly and Mrs. P is finding it difficult to comfort them. Her husband is getting very angry about this and is shouting at her and them which is making them even more upset. Along with being

distressed about this situation, she is very worried about the ration as the food supply will end in a day or so. The roads are still closed. She knows hunger makes her husband angrier and more violent.

Reflective Exercise

· Did you notice any difference in MR. R's experience and Mrs. P's experience?

· Who do you think was more vulnerable and why?

Disasters do not affect all individuals equally. Some individuals may be more vulnerable to the experiences of disaster while others may be better protected from their impact. Identity and intersectionality are important contexts to consider. These contexts shape the individual's experiences as traumatic and help in understanding why a particular event may be traumatic for one person and not for the other. It includes the person's historical, caste and class oriented experiences, and other intergenerational experiences which are traumatic. (SAMHSA, 2014). Risk factors or vulnerabilities increase the likelihood of experiencing more intense emotional distress, trauma responses, and mental health concerns during or after a disaster. Protective factors are those variables that are likely to build resilience and protect individuals from the likelihood of experiencing emotional distress, trauma responses, and psychosocial disabilities during or after a disaster.

6.1 PROTECTIVE AND RISK FACTORS

There have been some risk and protective factors that have been consistently associated with disasters. It is important to remember that there is no single factor that puts a person at risk or protects that person; rather a combination or additive total of these risk and protective factors determine the outcome for the individual (Bonanno et al., 2010; Masten & Narayan, 2012). It is seen that most individuals (70-90%) affected by disasters will not require support from mental health professionals (Bonanno et al., 2010). Some unique predictors of resilience include acquiring and maintaining social and emotional resources (Felix & Afifi, 2015), certain personality factors, such as low negative

affectivity, high capacity for optimism, emotional stability, agreeableness, and perceived coping self-efficacy (Bosmans & van der Velden, 2015); and socio-demographic variables such as male gender and higher education level (Bonanno et al., 2010). Among children, resilience is affected by various bio-psycho-social factors such as presence of supportive adults, posseeing problem solving skills, self-regulation and social regulation skills, and having feelings of self-efficacy and hope. This may help them feel safe, connected, and display a sense of agency to make meaning of these experiences (Masten & Narayan, 2012).

CERTAIN RISK FACTORS HAVE BEEN IDENTIFIED IN LITERATURE:

Severity of exposure.
The severity of exposure to the disaster is described in terms of the injury experienced, how much was the threat to life, where was the person with respect to the disaster, the type of disaster that occurred, the displacement that the disaster caused and the severity of loss. Research suggests that it consistently predicts worse outcomes (Gruebner et al., 2015; Viswanath et al., 2013).

1. Ongoing stressors and weak or deteriorating psychosocial resources.
The stresses and adversities faced by the individuals such as loss of employment, financial constraints, and relationship difficulties (Cerdá et al., 2013) along with inadequacy of psychosocial and practical support and resources can pose as significant risk factors (Felix & Afifi, 2015; Goldmann & Galea, 2014; Norris & Elrod, 2006).

2. Demographic factors.
Certain demographic risk factors include female gender; belonging to ethnic minority groups; poverty or low socioeconomic status; and having psychiatric history (Goldmann & Galea, 2014; Norris & Elrod, 2006).

3. Emotional and cognitive factors.
These factors include negative coping strategies, like blaming self or others for negative events (Ehlers et al., 2003; Pietrzak et al., 2013), negative appraisals about the traumatic event, role of self and about the future (Ehlers et al., 2003) and using avoidance as a coping mechanism.

4. Developmental factors.
Risk factors associated with children and adolescents include their age, peer group, reactions of parents towards disasters, separation from a primary caregiver and other factors previously related to severity of exposure (Brymer, et al, 2012; Eisenberg & Silver, 2011). On the other side of the continuum are the older adults who are at greater risk if they have previous health concerns (Parker et al., 2016) along with other previous mentioned factors.

5. Community-level factors.
Certain community level factors such as low community social cohesion may also show worse outcomes (Johns et al., 2012).

There is a need to focus on groups that are especially vulnerable during disasters. The table below describes some vulnerable groups in the Indian context (NDMA, 2023). There may be other groups which may not be covered in this list but may still be vulnerable due to the influence of local power structures and contexts

Table 1.1: Vulnerable Groups in India

Factors	Vulnerable groups
Age	Children (unaccompanied children, orphans, child labourers, children with physical and psychosocial disabilities, children in conflict with law) Older adults (those not cared for in families, living alone and in elderly homes)
Gender and Sexuality	Women (pregnant women, divorced women, widows) Gender minorities (transgender and intersex people) People identifying as lesbian, gay, bisexual, or other sexualities
Occupation	People in vulnerable occupations, informal sector, and those who are unemployed or undocumented (like daily wage workers, bonded labourers, sex workers, mine workers) Disaster responders including first responders, government officials, media personnel, and health care providers

Socio-economic status	People who are socio-economically disadvantaged (families below the poverty line, homeless persons, slum dwellers)
Caste and Tribal communities	Individuals from Scheduled Castes, Scheduled Tribes
Disability	People who have visual impairment, hearing impairment, locomotor disabilities, developmental disabilities (including autism, intellectual disability, speech and language impairments), muscular and neurological disabilities and mental illness
Health	People with chronic medical conditions, immunocompromised status, persons with limited life span, and those in palliative care ; individuals with pre-existing mental health concerns
Trauma	People experiencing or having experienced intimate partner violence, other community or domestic violence, traumatic bereavement, survivors of sexual violence, and other traumatic experiences
Family	Single parent families, families with multiple dependent individuals and caregiving responsibilities
Ethnicity	Indigenous people and people belonging to cultural and linguistic minorities
Displacement	Immigrants, migrants, people who are internally displaced and climate change refugees
Others	Tourists, prisoners

As we have seen that some groups are more vulnerable than others, it is important to understand the unique socio-political and economic context that clients will bring into the sessions. The next chapter will focus on the role that we as mental health professionals play in this context and the challenges that we may face.

Let's avoid...

Understanding trauma as a unidimensional construct. It is important to remember that trauma can be categorised as events, experiences and effects in order to facilitate any help that the clients need.

Trying to generalise the experiences of the client without asking them about it. Trauma responses are varied and depend on a large number of personal, interpersonal and intrapersonal factors and we need to carefully understand the context of the individual before planning any intervention.

Underestimating the influence of the client's unique socio-cultural context on their experience. Clients' experiences occur in their socio-cultural context which may serve as protective or risk factors. Discounting these and locating the distress within the individual does not give a holistic perspective.

Negating the resilient reactions of the clients. Most of the clients show moderate responses to traumatic situations which may recede on their own time. We can look for stories of resilience and identify the protective factors that they display.

Self-care Exercise

Speaking about trauma may bring up some difficult emotions for us. We can try the following self-care strategies.

- Making a list of all coping strategies that help us relax and self-soothe
- Having interests outside of our work.
- Taking up training opportunities to hone our skills
- Taking periodic breaks
- Seeking social support and using strategies that we often teach clients.
- Accessing personal therapy.

Tips for Supervisors

Some general practices that can ensure a good supervisory relationship with the supervisees while working with clients with histories of trauma may be:

- Hold regular supervision at a time and place that works for you both.

- Collaboratively create an agenda. Ask, “What would you like to discuss today?”

- Outside of supervision sessions, transparently explain your availability and boundaries. For example, we can say, “I am involved in other projects on Tuesdays and Thursdays. I do not schedule supervision sessions on those days. But you can email me anytime, and if I’m not available, I’ll get back to you the next day.”

- Listen non-judgmentally, openly, and empathetically. We may want to say, “I know the case would be very difficult for anybody. Would you like to start there?”

- Use humility and self-disclosure to create an emotionally safe environment for supervisees to share.

Specifically in the context of trauma, it may be helpful for supervisors to understand how supervisees conceptualise trauma. We can ask, “What comes to your mind when you think of the word trauma? What do you know about it?”

This chapter helps us in understanding disasters as traumatic events and their impact. The next chapter describes the role of mental health professionals and trauma-informed care in the context of disasters.

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CHAPTER 2

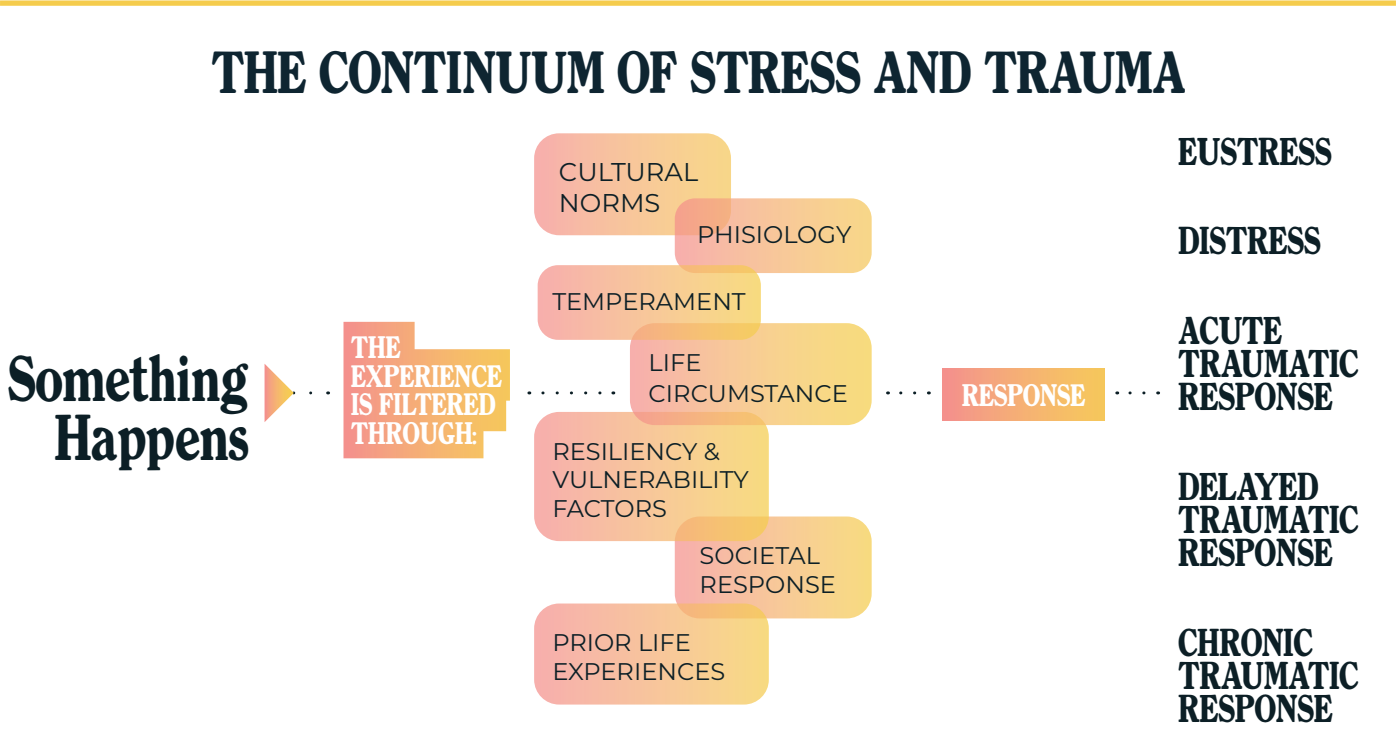
Trauma responses in disasters

1

REACTIONS TO DISASTERS

The manner in which disaster affects a person is mediated by their prior experiences and coping strategies. It is also influenced by the help and support that is offered to them in the aftermath of the disaster and the response of the larger community towards them. People who have survived disasters may react to the traumatic experience with exhaustion and confusion or feeling sad, anxious, agitated, numb, spaced out, or constantly on alert. These responses can be considered normal, socially acceptable and even helpful for them. They may resolve on their own without any long-term repercussions. More severe indicators include prolonged and unremitting distress without any intervening period of calm, feeling as if they are not present in the moment, and intense and intrusive recollections of the disaster situation despite being safe. This may necessitate the intervention of mental health professionals. Sometimes, people show more severe but delayed responses to the disaster. They may persistently be fatigued, experience sleep related difficulties, nightmares, fear that the disaster may reoccur, low mood and avoidance of trauma-related emotions, sensations or associations. A trauma-focused intervention is needed in this situation.

These reactions are summarized in the picture below:



It is important to note that even though some traumas are experienced collectively by a community, people may have their own unique responses to disasters. Traumatic experiences typically feel surreal for the people who experience them and can bring about significant disorientation and disconnection from activities of daily life. Those who survive trauma struggle to feel like a part of their worlds and worry that others might not fully understand their unique experiences. This can bring on a sense of shame towards their own feelings, thoughts, and reactions (SAMHSA, 2014).

2

REACTIONS TO DISASTERS

There are certain common responses that occur following single, multiple or enduring traumatic events. These reactions are considered to be normal but distressing to the person experiencing them. These are not considered indicative of mental health conditions or a disorder. They can be categorised under the following domains:

Emotional

Physical

Cognitive

Behavioral

Social

Developmental

2.1 EMOTIONAL

Traumatic experiences elicit a wide variety of emotional reactions within an individual. The post trauma emotional reactions In a disaster situation, may include feelings of shock, disbelief, anxiety, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, betrayal, depression, emotional numbness (difficulty having feelings, including those of love and intimacy, or taking interest and pleasure in day-to-day activities). In the case of emotional numbing, the person's emotions get detached from thoughts, behaviors, and memories. Emotional numbing may manifest as experiencing a limited range of emotions, not showing any emotional response to an emotion evoking situation or even distancing themselves from expressing any emotions when recounting emotionally charged memories.

The skill to identify, label and manage emotions is called emotion regulation. This skill may get compromised in a disaster situation. Clients may not have the vocabulary to talk about emotions or they may be afraid that talking about them makes them worse or more dangerous. They may also be experiencing a lack of emotions as they may feel a sense of numbness. Traumatic events may lead to two extreme emotional reactions, that is, feeling too much (overwhelmed) or feeling too little (numb) emotion. In these states, it is difficult to manage emotions. The degree to which the skill of emotion regulation is compromised depends on the severity and the duration of the event as well as the age at which a person experiences it. They may experience and express these emotions more intensely. For example, research shows that when the traumatic event occurs in childhood, it is more difficult to regulate emotions such as anger, anxiety, sadness, and shame as compared to when the event happens later in life (van der Kolk, et al, 1993). This may lead to heightened emotional distress for the individual.

Reflective Exercise

Mr. A and Mr. R were both at home when the fire broke out in their building. They got out of the burning building along with their families in time with limited injuries. After two weeks, they received a call from the reverse helpline assessing their mental health.

Mr. A. reported that he has seen that he gets agitated very quickly. He is constantly plagued with the memories of the fire and feels as if he is on the edge. At that time, if someone says anything to him which he disagrees with, he starts shouting uncontrollably. His family remarks that it has become impossible to speak to him. He sounds very agitated as he narrates this and says loudly, "Do you think I am overreacting?"

Mr. R reported that he is doing fine and has seen no change in himself. When asked how he felt about the entire incident, he replied in a monotonous tone, "what is there to feel? It is done now. I don't feel anything about it." When asked about if he wanted to speak further about how he was feeling now, he replied that there was no use feeling about things.

If you were the counsellor on the reverse helpline, how would you respond to Mr. A? What about Mr. R? Is there any difference in the way you respond to them? If yes, what do you think could be the reason?

2.2 PHYSICAL

Many clients may experience physical and physiological responses to traumatic events. Examples of these responses include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders. Many of them may not even consider these as responses to trauma and may not discuss these with their mental health professionals. It may then fall on us as counsellors to enquire about these concerns.

In case of a disaster, the physical (bodily) reactions commonly associated are tension, fatigue, edginess, being startled easily, racing heartbeat, nausea, aches and

pains, worsening health conditions, change in appetite and change in sex drive. These changes often result in a state of hyperarousal (or hypervigilance). Hyperarousal may lead to perceiving and reacting to safe situations as if they were threatening. A consequence of hyperarousal is sleep disturbances characterised as early awakening, restless sleep, difficulty falling asleep, and nightmares.

Some people may express their emotional distress through bodily symptoms or dysfunctions. However they may not be aware of this connection between the physical and emotional distress. This is especially common in cultures in which emotional expression of distress is not encouraged. People in these cultures may focus on bodily complaints as a means of avoiding emotional experiences. Somatization may present as medically unexplained aches and pains, nausea, fatigue, blurred visions, shortness of breath and palpitations (APA, 2015).

Reflective Exercise

In the Indian context, it is seen that often there is no dichotomy between mind and body. Hence people are able to express their somatic concerns without prompting whereas psychological distress is expressed only after the doctor prompts (Raguram et al, 2001). How do you think this affects the way clients who have gone through disasters express their psychological concerns? What could be the possible somatic concerns that we may be on the lookout for when looking for signs of trauma?

2.3  COGNITIVE

Cognitions are affected and altered by traumatic experiences. Trauma challenges the core assumptions which many of us use to navigate daily life (Janoff-Bulman, 1992). Our belief that our efforts and intentions are enough to protect us from bad things helps us traverse life. For example, a person who feels confident while swimming may enjoy the experience. But if during one of the swims, the person gets close to a

site of a flood, they may feel unsafe in any situation where they have to be near a water body. Hence, an enjoyable experience becomes an experience where they have to constantly be vigilant (state of hyperarousal is a physical state described previously). Cognitive reactions which are common during disasters include confusion, disorientation (not knowing the time or date), indecisiveness (inability to decide or follow-through with decisions), worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories (of the disaster), repeated imagery (of the disaster situation) and self-blame (feeling that the person could have done something to prevent the disaster or coped better with it).

Trauma may alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future (Ehlers & Clark, 2000). After an individual experiences a traumatic event such as a disaster, they may start viewing themselves as incompetent or damaged, viewing others and the world as unsafe and unpredictable, and seeing the future as hopeless, that is, they or the situation will never get better. Subsequently, these cognitions drive the clients' sense of efficacy in their ability to use internal resources and external support.

2.4  BEHAVIORAL

People may start engaging in uncharacteristic behaviors in order to manage the aftereffects of disaster People may reduce their stress through avoiding, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g.,high-risk behaviors), and/or self-injurious behaviors. One of the most common behavioural responses is avoidance against anxiety. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances related to the disaster. For example, the person may avoid driving to a part of the town where they were housed following the fire. Initially, it may work to decrease anxiety, but over time, anxiety increases and this leads to more avoidance. It reinforces perceived danger in such a way that the person hesitates to test the danger's validity and may in fact extend this

perception of danger to other aspects of life as well. Children may try to gain control over their experiences by being aggressive or reenacting aspects of the event. For example, a child who was rescued from the rubble after an earthquake may reenact the situation in play by running and hiding under the table and trembling till an adult comes to them. This may be an attempt to create a sense of mastery for the child.

2.5  SOCIAL/INTERPERSONAL

Common interpersonal responses to disaster include feeling like the person needs to depend on others and cannot do anything by themselves, not being able to trust others, irritability in interactions with others, increased conflict, withdrawal and isolation from loved ones, feeling rejected or abandoned by them, being distant, judgmental, or over-controlling in friendships, marriages, family, or other relationships. Significant others may get affected by a loved ones' traumatic experience either through secondary traumatization or by directly experiencing the survivor's stress reactions. In natural disasters, social and community support get severely disrupted. Social support and relationships can be protective factors against traumatic stress as survivors may rely on them. However, when people who go through disasters avoid social support, it can have detrimental effects . Survivors may avoid social support because of many reasons such a belief that people are no longer understanding or trustworthy or they may think that they have become a burden to others or that they may feel ashamed of their stress reactions.

2.6  DEVELOPMENTAL

Each age group is vulnerable in unique ways to the stresses of a traumatic event, with children and the elderly at greatest risk. Young children may show symptoms such as generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomach aches, headaches). Older, school-going children may display symptoms such as aggressive behavior and anger, regression to behavior

seen at younger ages, repetition of traumatic events in play, reduced ability to concentrate, and deteriorating school performance. Adolescents may display more depressive features and social withdrawal, rebellion, increased risky activities, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of substances. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000).

2.6.1 TRAUMA IN CHILDREN

The experience of traumatic events and expression of distress depends on the child's age and level of development. For example when preschool-age children are exposed to disasters, they may have feelings of helplessness, uncertainty about the future and a general sense of being afraid. They may have difficulty verbally describing their fears and emotions but present with a loss of previously acquired developmental skills such as sleeping independently, speech and toilet training. Children may also engage in traumatic play, that is, representing the traumatic event in play, by repeating it in an attempt to change its negative outcome. When school-age children are exposed to disasters, they may experience persistent fears of their own and others' safety. They may experience guilt or shame about their actions during the event and may feel overwhelmed by fear or sadness. They may also experience sleep-related difficulties such as fear of sleeping alone, or frequent nightmares. This may affect their concentration and learning and consequently their academic performance. There may be some somatic concerns such as headaches and stomach aches and behavioural concerns such as increased aggression. Adolescents who have been exposed to a traumatic event may feel concerned about their emotional responses such as fear, vulnerability and may label these as "abnormal". They may also compare their responses to their peers and may withdraw from their family and friends. They may also experience feelings of shame and guilt and express fantasies about revenge and retribution. This may foster a radical shift in their perception of the world and themselves. Increased aggression towards self and others may be a common response of adolescents. Some common experiences of

children are shown in the table below (Recognizing and Treating Child Traumatic Stress, 2023).

Age of the child	Possible responses
Preschool Children	• Fearing separation from parents or caregivers • Crying and/or screaming a lot • Eating poorly and losing weight • Having nightmares
Elementary School Children	• Becoming anxious or fearful • Feeling guilt or shame • Having a hard time concentrating • Having difficulty sleeping
Middle and High School Children	• Feeling depressed or alone • Developing eating disorders and self-harming behaviors • Beginning to abuse alcohol or drugs • Becoming sexually active

Practice Exercise

For each of the domains mentioned above, some sample questions are given below. We can role play and adapt these to our own native tongue and consider using them to elicit reactions to trauma. We can also think of other questions to ask.

Emotions: Ever since the disaster occurred, do you feel that your emotions are all over the place? Do you feel that it is difficult for you to control them? Do they feel more intense? Do you feel that you are not able to feel emotions fully? Do you feel like you do not experience any emotions?

Physical: Have you been experiencing aches and pains in your body? Shortness of breath? Have they started after the traumatic event? Have you shown it to the doctor? What did they say? [as the absence of a physical cause of pain is an important consideration for understanding the reaction as somatization]. How is your sleep? Are you able to sleep at the same time as you used to earlier? Is your sleep interrupted? How do you feel after waking up? Do you feel like you are constantly on alert? Are you finding it difficult to relax?

Cognitive: Has the traumatic event led to a change in the way you see yourself? In the way you see the world? What are your views about the future?

Behavioural: Have you noticed any changes in your behaviours? Any change in consumption of substances? Any change in your eating patterns? Any behaviour which you would usually not do? Is there any risk for harm? Have you been avoiding any person? Any place? Any situation?

Social/Interpersonal: How have your friendships been impacted after the traumatic events? How is your relationship with your family members?

3

SUB-THRESHOLD TRAUMA-RELATED SYMPTOMS

Even when clients are doing well and showing minimal distress, they may show subclinical symptoms or symptoms that do not meet the diagnostic criteria for a disorder (SAMHSA, 2014). These symptoms tend to limit their ability to function normally such as regulating emotions, maintaining and engaging in social and family relationships, working steadily, taking care of the needs of their bodies to name a few. It is possible that these symptoms may be transient and come into play only when triggered. Such sub-threshold symptoms may appear intermittently for a few weeks or months and recede on their own.

4

TRAUMA-RELATED PSYCHOLOGICAL DISORDERS

As mentioned previously, some people may experience more severe and long-lasting and disabling effects. Care must be taken that we consider diagnosing a mental health concern only after the criteria for these have been met. Normal reactions to disasters should not be pathologised (APA, 2008). Post-traumatic Stress Disorder and Acute Stress Disorder are the most common diagnoses associated with trauma. Some other commonly associated mental health concerns include substance use disorders, mood disorders, various anxiety disorders, and personality disorders. For individuals with a predisposition for mental health concerns, a traumatic event may precipitate onset or exacerbate symptoms of pre-existing disorders.

4.1 ACUTE STRESS DISORDER (ASD)

ASD represents symptoms of stress which develop within 4 weeks of the occurrence of a traumatic event. However, it is not a precursor for PTSD as many individuals with ASD do not go on to develop further impairment. It is more commonly associated with the experience of one specific traumatic experience rather than long-term exposure to chronic traumatic stress. An individual with Acute Stress Disorder appears overwhelmed by the traumatic experience; there is a preoccupation with the experience and a need to talk about the event over and over again They may insist on describing in repetitive details about what happened, and may seem like they are constantly trying to make sense of the traumatic experience. They may also not be able to remember the details of the traumatic events and hence repeatedly ask questions to fill in the gaps in their memory. Persons experiencing ASD may seek assurance from others that they could not have prevented the event. Hypervigilance is increased and the person may constantly try to avoid reminders of the event. For instance, a person who was in a train accident may feel anxious if they hear the sound of a train. Symptoms associated with ASD tend to be less severe and transient and resolve about a month after the event. If the symptoms persist after 4 weeks, the diagnosis is changed to PTSD. If early intervention is carried out for ASD, it is possible that the individuals may not develop PTSD or other mental health concerns later.

There are very few well-established and empirically-validated measures to assess ASD (Byrant et al, 2016). The Acute Stress Disorder Structured Interview (Byrant et al, 2016 for review on updating as per DSM-5) and the Acute Stress Disorder Scale (Byrant et al, 2016 for review on updating as per DSM-5) are available for assessment but these require training. One of the freely available measures for ASD is National Stressful Events Survey Acute Stress Disorder Short Scale (NSESASDSS). It is available on the following link: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Severity-of-Acute-Stress-Symptoms-Adult.pdf. The Child Stress Reaction Checklist (CSRC), can be used for children 2 to 18 years old (Saxe et al., 2003).

4.2 POSTTRAUMATIC STRESS DISORDER

The most commonly diagnosed and researched trauma-related disorder is PTSD. PTSD symptoms are seen in

a number of other mental health concerns , including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006).

According to DSM-5 (APA, 2013), there are four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. These reactions occur in response to exposure to actual or threatened death, serious injury, or sexual violence, produce significant distress and persist for more than 4 weeks. These symptoms usually appear within 3 months of a traumatic event, though they may remain dormant for months or years after the event. It is possible that these symptoms appear suddenly especially when triggered by external events. For example, a child who was sexually abused may get triggered years later when they see a movie about the same theme. Similarly, anniversaries of the traumatic event may trigger these responses. Personal characteristics, social support, and the environment's response to aftermath of traumatic events influence the presence of PTSD (Brewin, et al, 2000).These symptoms are similar to the ones listed under Acute Stress Disorder and similar questions can be asked to elicit these.

Experiences of multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships can lead to a unique constellation of reactions, called complex traumatic stress (Herman, 1992). Often, these reactions tend to be more severe than the symptoms of PTSD but may not match the criteria for it. Culture also plays an important role in this context. While PTSD is observed across different cultures (Osterman & de Jong, 2007), it may manifest differently . Culture may affect the presence of somatic and psychological symptoms and beliefs people hold about the cause of traumatic events. Certain religious and spiritual beliefs can also affect the way in which distress is experienced and reported. For example, in societies where disasters are considered acts of God, it is difficult to be angry about the situation.

Interview instruments used to assess PTSD include the Clinician Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013a), PTSD Symptom Scale - Interview for DSM-5 (PSS-I-5; Foa, et al., 2016a), Structured Interview for PTSD (SI-PTSD; Davidson et al., 1990) for adults. Some

self-report measures include PTSD Checklist for DSM-5 (Weathers et al., 2013b), Posttraumatic Diagnostic Scale (PDS-5; Foa, et al., 2016b) for adults. For children, Clinician-Administered PTSD Scale for DSM-5 - Child/Adolescent Version (CAPS-CA-5; Pynoos et al., 2015) can be used.

5

OTHER CO-OCCURRING DISORDERS

There is a considerable overlap between symptoms of PTSD and other mental health concerns such as mood and anxiety disorders, substance use, and personality disorders. Some of these are listed below.

5.1 MOOD AND ANXIETY RELATED DISORDERS

Major Depressive Disorder is the most common co-occurring disorder in people with histories of trauma (SAMHSA, 2014). Research has indicated a causal relationship between stressful events and depression, such that prior history of MDD predicts the occurrence of PTSD after trauma exposure (Foa et al., 2006). This may lead to greater impairment, more severe symptoms and less likelihood of remission of symptoms. PTSD and anxiety disorders share a bidirectional relationship such that PTSD may exacerbate symptoms of anxiety disorder and the pre-existing anxiety symptoms may increase vulnerability to PTSD. Pre-existing anxiety may lead to an increased likelihood of experiencing hyperarousal-related symptoms.*

5.2 PEOPLE WITH SUBSTANCE USE DISORDERS

Research has indicated a correlation between trauma and substance use as well as the presence of PTSD and substance use disorders (SAMHSA, 2014). Substances are often used to manage traumatic stress and specific PTSD symptoms. Sleep disturbances are a common symptom in PTSD and substances are used to manage this symptom. The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases the risk for trauma, and exposure to trauma initiates or escalates substance

* Questions to elicit anxiety and low mood have been mentioned in Section 3; chapters 3 and 4 respectively.

use to manage trauma-related symptoms. Managing PTSD symptoms thus is an important goal in substance use treatment.

In order to elicit substance use we may ask questions regarding the kind of alcohol or drugs that people are consuming, number of times in a day they consume the substance and how they are affected by its consumption. A common questionnaire for asking about substances is the CAGE questionnaire (Ewing, 1984). The CAGE acronym represents keywords present in each question. It stands for: Cut, Annoyed, Guilty and Eye.

The questions represented by the CAGE acronym are:

- Have you ever felt you should "cut" down on your substance use?
- Have people "annoyed" you by criticizing your substance use?
- Have you felt bad or "guilty" about your substance use?
- Have you ever used a substance first thing in the morning to steady your nerves or start the day (an "eye" opener)?

If the answer is yes to 2 or more questions, the likelihood of substance abuse is high.

6

POST-TRAUMATIC GROWTH

People who have undergone stressful or traumatic events also report experiencing the events as 'catalysts' for positive psychological change (Tedeschi & Calhoun, 2004). This phenomenon is known as Post-Traumatic Growth (PTG; Tedeschi & Calhoun, 2004) and is known to be associated with enhanced interpersonal relationships, newer possibilities for a fulfilling life, increased appreciation for life and personal strength and opportunities for spiritual development. It is important to note that PTG is not a linear journey where the pain of the traumatic event is forgotten. Rather, it can be understood as an experience of growth where the capacity to hold what is lost, co-exists with an appreciation of what is gained, bringing forth a deeper connection with life. (Tedechi et al, 2014).

The process of PTG involves engaging with the traumatic events by making attempts to understand why this

event happened and what it means for the person. This engagement is termed as cognitive processing and is associated with higher levels of PTG (Tedeschi et al, 2014). This cognitive processing takes place through a process of slow and intentional inquiry about the traumatic event. It is fostered by sharing or disclosing the internal experience in a safe and supportive environment (Tedeschi et al, 2014). Thus, sharing negative emotions in presence of safe social support promotes PTG (Saltzman, et al, 2018). Positive coping strategies foster positive appraisal of the traumatic event by promoting belief in our ability to adapt to the situation and help find meaning (Henson et al, 2020). Another important mediator for growth is spirituality (Tsai & Pietrzak, 2017). Spirituality promotes meaning-making and increased sense of belongingness (Prati & Pietrantoni, 2009). Reappraising the negative event by construing it in a positive way generates positive changes (Henson et al, 2020). Reappraising the event as a challenge and finding gratitude in being able to survive it may also foster PTG (Tsai & Pietrzak, 2017). Research evidence shows that personality traits such as Agreeableness, altruism (Tsai et al., 2016), Extraversion, Openness (Mattson et al., 2018) and Conscientiousness (Owens, 2016) have been found to be positively correlated to growth. Having hope (Yuen et al, 2014) and a sense of purpose (Reker, 2000) also predicts PTG.

The most commonly used measure for assessing PTG is the Post-Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). It is a self-report inventory to retrospectively assess the growth that a person perceives. It consists of 21 items which assess domains of New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life (Tedeschi & Calhoun, 1996). However, it is not a freely available tool.

7

SALUTOGENESIS

Salutogenesis refers to focusing on human health and well-being and not just on the disease model (Antonovsky 1979). In difficult circumstances such as disasters, salutogenesis is especially important in understanding and promoting well-being of the community. Sense of coherence, an important component of salutogenesis, is associated with helping individuals and communities navigate the challenges of disasters (Antonovsy, 1980). Sense of coherence is

the ability of a person to see life as comprehensible, manageable and meaningful. Comprehensibility refers to the ability to understand the challenges that disaster brought to their life e.g. what caused the disaster and how it affects the daily life of those who have gone through the disaster. Manageability refers to the belief that a person has the resources to deal with the disaster. This includes having access to resources such as food, shelter, social support and personal coping skills. Meaningfulness is the belief that there is purpose to life and that it is important to overcome the challenges that disaster has brought in the lives of people impacted by it. Disasters may be seen as precursors for personal growth and community solidarity and also promote future preparedness (Eriksson & Lindström, 2006).

For example, when the earthquake hit Nepal, a salutogenic approach yielded a community focused approach to managing the disaster (Omer & Fajardo, 2017; Taludhar et al., 2015). In order to promote comprehensibility, various educational programs helped people understand the causes of the earthquake, the expected aftershocks, and how to stay safe which reduced fear and confusion. To help community members increase a sense of manageability, relief efforts focused on providing resources like temporary housing, food supplies, and access to medical care. Community-based initiatives empowered locals to participate in rebuilding efforts, which increased their sense of control. And lastly, to promote meaningfulness, community rituals and ceremonies were organized to honor lost lives and celebrate the survivors. This helped people find meaning and collective purpose in the recovery process. Thus, salutogenesis helped foster resilience and a sense of solidarity among the community members.

Reflective Exercise

Post-traumatic growth is an important construct in understanding the experience of trauma holistically. As a mental health professional, it is imperative for us to understand our conceptions of PTG. We can wonder

- How can we identify PTG in our clients?
- What are the factors associated with PTG in our clients' narratives?
- What can be the consequences of enhancing PTG among our clients?

Let's avoid...

Pathologising the normal responses of people after encountering trauma. It is important to remember that responses to trauma may be normal, socially acceptable and even helpful to the survivors.

Using a one-fit all approach in understanding the trauma responses. An individual's response to trauma is varied and needs to be contextualised in the experiences, coping strategies and the support offered to them by the external environment. It is also influenced by the developmental stage of the client.

Believing that trauma responses manifest as only emotional dysregulation. Trauma responses manifest in various ways including emotional dysregulation but also manifests as numbing, different cognitions, behaviours, and social and interpersonal relationships.

Being unaware of the various trauma-related disorders. Trauma responses may manifest as acute stress disorder, post-traumatic stress disorder, mood and anxiety disorders, substance use disorders to name a few. Identifying and eliciting trauma history may help us make distinctions amongst these categories.

Ignoring narratives of post-traumatic growth in our clients. Post-trauma phenomenology is replete with stories of distress and growth. It is imperative for us as mental health professionals to see our clients as people with these varied experiences and not box them into categories of distress. We need to identify, acknowledge, nurture and honour narratives of growth.

Forcing narratives of post-traumatic growth onto our clients. At the same time, we have to be careful that we do not force these narratives onto clients who may not be ready or willing to engage in this context as this forceful way may be perceived as invalidation of the clients' experiences as well as their agency. Let the clients discover their own meanings of their experiences.

Self-care Exercise

It is imperative to conduct an assessment about ourselves to identify our own concerns. Some questions that we may ask ourselves help us in doing trauma-informed work include (Meichenbaum, 2007):

- **Self-check-ins:** These include questions about how we are doing, what we need and what would we like to change. We can also ask how we take care of ourselves, who our social support networks are and how we respond to their support.
- **Check-in about work:** Questions such as what is the hardest thing about work or what worries us about it, what are our specific goals for the clients and how successful are we in accomplishing them can help us in checking in with our work.
- **Check-in about self at work:** Questions such as how have we changed since we began working, do we like these changes and if not what can we do about it can help understand us in context of work. We can even ask what is our sense of accomplishment at work, how we can ensure that my sense of satisfaction in work persists and how we communicate about our concerns, feelings and rewards of our work to others.

Tips for Supervisors

This chapter helps us in identifying the concerns of the clients. One important consideration that we can look out for is identifying concerns of the supervisees. It is possible that in supervision, a parallel process may be unfolding. Parallel process refers to the process in which the dynamic of the supervisee and supervisor reflects the dynamic between the counsellor (that is the supervisee in this context) and the client (Searles, 1955).

Some signs and indicators that may help us in identifying parallel process includes:

- **Mirroring Interactions:** Noticing if the supervisee's behaviors, emotions, or attitudes towards the supervisor reflect their client's behaviors, emotions, or attitudes towards them.

- **Emotional Resonance:** Paying attention to the emotional climate in the supervision session. Similar emotional patterns might emerge in both the supervision and MHPSS sessions.
- **Similar Themes or Conflicts:** Identifying recurring themes or conflicts that appear both in the sessions and the supervision.
- **Observation:** Analyzing the communication styles and patterns. If there is a noticeable similarity in how the supervisee and their client communicate compared to how the supervisee communicates with the supervisor, this might indicate a parallel process.

We can use techniques such as reflective listening, exploration of feelings, creating a visual or conceptual map of the dynamics between the client and the supervisee and then compare it to the dynamics between the supervisee and the supervisor and role-playing to help identify parallel processes.

This chapter describes the trauma-related concerns that occur in the disaster context. The next chapter will focus on basic concepts that are required to understand trauma-informed therapy.

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CHAPTER 3

Trauma-informed Mental health and Psychosocial support (MHPSS) in disasters

1

AN INTRODUCTION TO NEUROBIOLOGY

The brain is one of the most complex organs in the human body. In order to understand the various functions it performs, it is important to be able to visualise the major parts of the brain. The triune model by Dr. Paul McLean (1998) is a simplified example. In this model, the brain is conceptualised to be divided into three parts:

1. REPTILIAN BRAIN: Consisting of brainstem and cerebellum, it is responsible for functions of our body such as regulating the heartbeat, breathing, and other autonomic processes to ensure survival and smooth functioning of the body. It regulates the autonomic nervous system.

2. MAMMALIAN BRAIN: The subcortical region and limbic system for this brain which is responsible for emotion and memory formation allowing us to learn.

3. PRIMATE/HUMAN BRAIN: Consisting of the neocortex, it is responsible for executive and higher cognitive function such as regulating attention and focus, experiencing empathy, and enabling complex reasoning and abstract thought.

A QUICK AND SIMPLE WAY TO THINK ABOUT THE BRAIN

Paul D. MacLean, MD, developed the concept of the triune brain in *The Triune Brain in Evolution: Role in Paleocerebral Functions*. Rick Hanson, PhD, author of *Hardwiring Happiness: The New Brain Science of Contentment, Calm, and Confidence* built on this original concept.

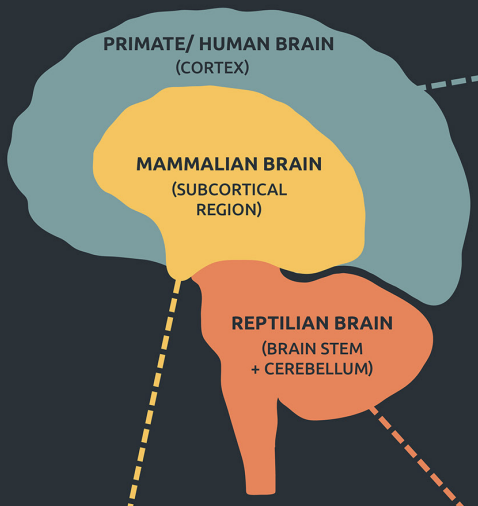
In many ways, the brain is considered the most complex of human organs.
But complex doesn't have to mean complicated. Especially when we're trying to explain the brain's different but necessary functions.

Our brain structure can be divided into three layers – the brain stem, the subcortical region, and the cortex. And each layer can be loosely associated with the reptile, mammal, and primate/human phases of evolution, respectively.

So, if you think about it, it's almost as we're carrying a little lizard, a little mouse, and a little monkey inside our brains.

And as the brain evolved, so did its capacity to meet the three fundamental needs of any animal . . . Safety, satisfaction, and connection.

Here's a visual . . .



PRIMATE/ HUMAN BRAIN
(CORTEX)

The cortex is larger and more sophisticated than the other two layers – thus, we link this part of the brain to primate and human evolution. (In fact, the human cortex has roughly tripled in volume over the last three million years of evolution).

RESPONSIBLE FOR:	Higher mental functions
CORE FUNCTIONS:	Regulating attention, feelings, and desires, complex reasoning, abstract thoughts, imagination, language, empathy
BASIC "NEED":	Connection and attachment to others
WHEN NEED IS MET:	We feel LOVE
WHEN NEED IS *NOT* MET:	We experience HEARTACHE

MAMMALIAN BRAIN
(SUBCORTICAL REGION)

The subcortical region is associated with mammalian evolution – we might think of it as the little mouse part of the brain.

RESPONSIBLE FOR:	Feelings and memory formation
CORE FUNCTIONS:	Emotions, learning and memory, reward/motivation
BASIC "NEED":	Satisfaction and approaching rewards
WHEN NEED IS MET:	We feel CONTENTMENT
WHEN NEED IS *NOT* MET:	We experience FRUSTRATION

REPTILIAN BRAIN
(BRAIN STEM + CEREBELLUM)

The brain stem is the most ancient part of the brain. This brain structure shares a similar function to the brain found in simple creatures, like crabs or lizards.

RESPONSIBLE FOR:	Survival and maintenance
CORE FUNCTIONS:	Regulating heartbeat, breathing, and other vital organs
BASIC "NEED":	Safety and avoiding harm
WHEN NEED IS MET:	We feel PEACE
WHEN NEED IS *NOT* MET:	We experience FEAR

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This model can be represented as the 'hand model of the brain' (Siegel, 2012) and offers us a simple way to represent the brain in the form of a fist. The fist is formed by tucking the thumb inside it. The wrist represents the spinal cord, the thumb represents the limbic system and the fingers that cover the thumb are representing the cortices (frontal cortex particularly).
When there is no threat, these parts of the brain perform their functions seamlessly, that is, the brainstem regulates our heartbeat and breathing, our limbic system is responsible for making us curious about the world and learn about it and our prefrontal cortex allows us to process the information around us and make sense of it. The prefrontal cortex regulates the limbic system. However, it is different when the brain perceives a threat.

Reflective Exercise

Neurobiology is often complicated and difficult to understand. However, a good understanding of how the brain works can help in understanding trauma and sharing this understanding with clients.

- We may want to see how we can make this process interesting and easy to comprehend for ourselves. For example, we can use some memory techniques to remember this information. This will help us in explaining these concepts to our clients as well.
- We may also want to translate these constructs and concepts in our local languages.

2

NEUROBIOLOGY IN TRAUMA

Trauma is a psychobiological experience; its presence in childhood may lead to detrimental effects even later in adulthood (Cassiers et al. 2018).

When we first encounter trauma, a helpful emergency response system built by nature to help us survive a major threat. It is deployed immediately and does not require thinking (it is automatic) and is carried out by the autonomic nervous system (ANS). This part of the nervous system controls rapid, unconscious responses such as reflexes. This includes carrying out a series of

involuntary responses and physiological changes that allow the person to handle this situation and manage the danger. The ANS can send messages that tell the body to prepare for danger in different ways such as:

1. TO THE BRAINSTEM: increasing breathing and heart rate to send more oxygenated blood to the muscles and brain, redirect blood to key areas, and keeping them away from others such as face or salivary glands, tensing muscles which may cause shaking or trembling, constricted feeling in the throat, and dilated pupils to allow more light into the eyes, which allows someone to see better and observe their surroundings.

2. TO THE LIMBIC SYSTEM: In efforts to ensure safety for the future, the amygdala encodes all the sensory information associated with the threatening event to form implicit memory. Implicit memory includes all the d non-verbal experiences of the memory such as the most significant part (worst image), conclusions/meanings made about self, others, and world, emotions experienced in the event and body sensations, when the event happened. The amygdala will encode the implicit memory and anything moving forward which seems the same or similar (anything that brings up the worst part, cognitions, emotions, and/or body sensations) to the original event will trigger the same responses.

3. TO THE PREFRONTAL CORTEX: This part of the brain supports the other parts but does not receive or interpret new information.

This can be represented in the hand-model described above. In this scenario, the prefrontal cortex is no longer regulating the limbic system. Thus, the activity of the limbic system overrules the prefrontal cortex. Or we simply say, the lid is off.

When we are exposed to extreme threats, these short term, adaptive responses become chronic and long term such that even when we transition into a safe environment, the primitive brain does not turn off. We are stuck in the survival brain, very little information can get passed up to the higher parts of their brain. Whilst we are stuck here, we find it difficult to feel safe, form secure attachments; manage emotions or behaviour,

think, learn or reflect because we are simply trying to stay alive in a world that we feel is highly dangerous. In this scenario, certain changes occur in the brain.

Predominant among these are:

1. INCREASE IN AMYGDALA ACTIVITY: The amygdala which acts as an alarm signal for stressful events and helps protect us from danger, becomes overactive due to extreme exposure to trauma. This can lead to feelings of anxiety or being in danger.

2. REDUCTION IN HIPPOCAMPAL VOLUME: The hippocampus which assists with learning and memory storage, also stores cues for remembering safety and danger. When it detects safety, it helps calm the amygdala. However, exposure to trauma can cause the hippocampus to shrink thereby weakening the cues to calm the amygdala which may lead to flashbacks or confusion around the trauma memory.

3. SHRINKING OF THE PREFRONTAL CORTEX: The prefrontal cortex which is responsible for managing thoughts, behavior, and regulating our emotional response to events, t helps us decide that a situation is okay. Trauma can lead to weakening of these signals which may lead to negative emotions from the trauma memory taking over the prefrontal cortex's reasoning ability.

3

TRAUMA RESPONSES IN THE BODY

The autonomic nervous system (ANS) regulates the stress response (Sapolsky, 1998). It is divided into two categories, the sympathetic and the parasympathetic nervous systems. The sympathetic nervous system activation is characterised by increased heart rate, and sweat production. Parasympathetic nervous system activation, on the other hand, is linked to slowing of the heart, reduced stimulation of salivary glands, and other relaxation responses (Thayer et al, 2012).

In order to understand the responses to trauma, we have to understand the concept of defense cascade (Lang et al, 1997) – a term used to describe progressive defense/ fear responses in humans (Kozlowska, et al. 2015). These responses are evolutionary patterns of motor-

autonomic-sensory responses which get automatically activated in the presence of danger. These responses are suddenly activated and perceived to be out of conscious control. Five defensive strategies emerge in the context of danger: freeze-alert, fight, flight, freeze-fright and collapse; each having distinct effects on the body (Bracha, 2004). First, we will explore the body state when a person is safe and then the manner in which these states differ from these states will be described (Baldwin, 2013).

3.1 SAFETY

This is characterized by parasympathetic ventral vagal dominance. This means that the person will be able to carry out their activities of daily living, engage socially and acts opposite to the sympathetic activation described above. This is reflected in a relaxed state, face and eyes are animated, eye contact is maintained and heart rate is robust. Capacity for speech, laughter, play and tears is present. They are able to self-soothe and seek social support (Porges & Furman, 2011).

3.2 FREEZE-ALERT (STILLNESS)

The shift to freeze-alert state almost starts when the threat is first detected. It is assumed to be outside of our coping. The body starts to relinquish parasympathetic control which is manifested as wariness, quickening of heart rate, almost as if in preparation of defense. This is manifested as a still body, fixed eyes, stiff and tense muscles, tightening of throat, and difficulty in breathing. The person seems to be assessing the threat of the seemingly dangerous situation, is alert, watchful and waiting.

3.3 FLIGHT AND FIGHT

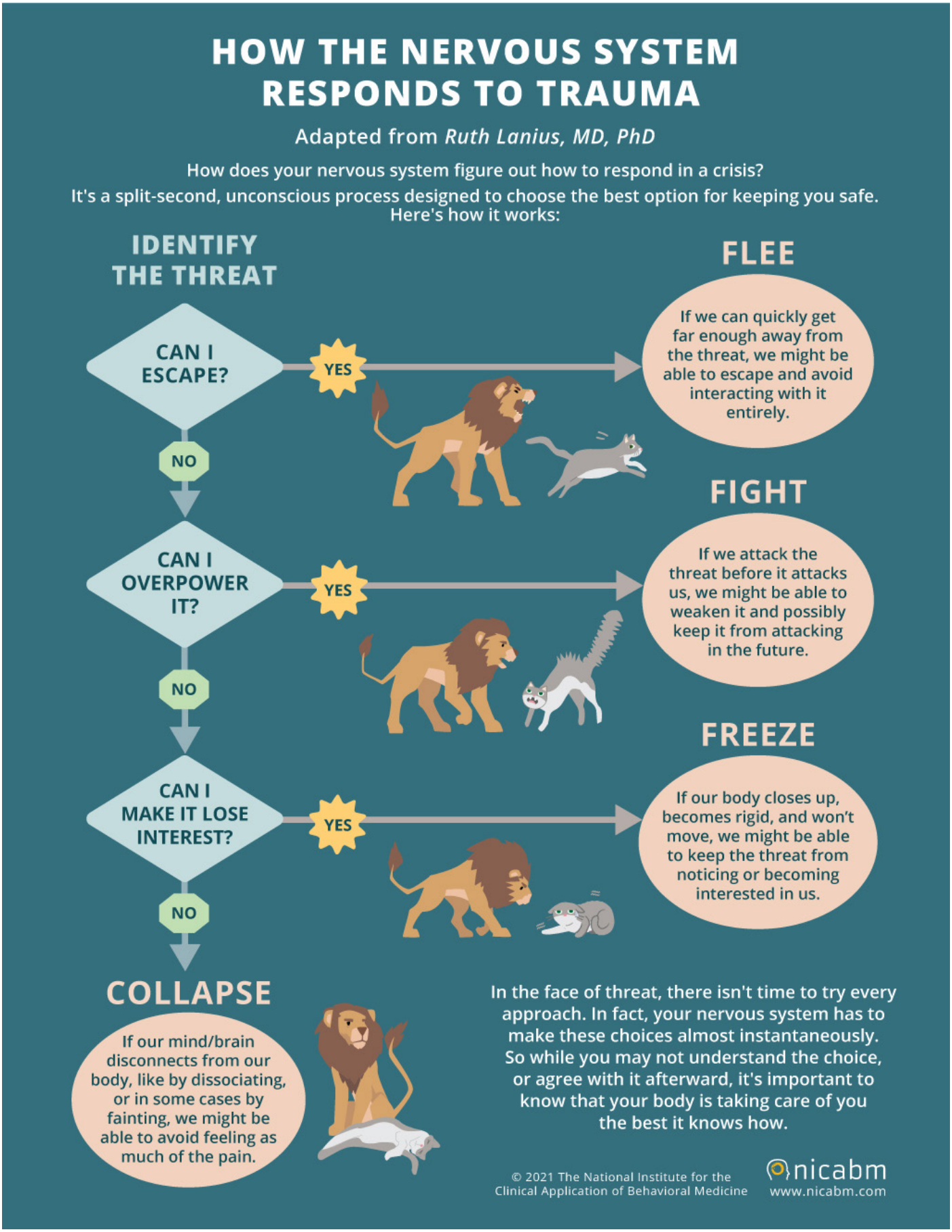
In both these states, the sympathetic nervous system gets activated. The flight response is characterized by increased blood flow to legs, respiration, heart rate and sweating and decrease in digestion. The person feels panicked, afraid, having cold hands and an impulse to run or warn others. In fight response, shoulders, arm, hand and jaw get tensed and clenched. Respiration, sweating and blood flow are increased. Hands are warm, impulses of hitting, kicking or screaming may also be present.

3.4 FREEZE-FRIGHT RESPONSE

Freeze-fright response occurs when the body is unsure or undecided about the use of other defense responses even though the situation has been appraised as being dire. Because of this indecision, there is simultaneous activation of the sympathetic and parasympathetic dorsal activity resulting in this state (Zhang et al., 2004). In this state, the person appears to be immobile, tense and ready to move but this movement is inhibited, making them feel 'frozen'. The stomach gets clenched,the heart is pounding and breathing becomes fast and shallow. This response strengthens heart contractions, increasing blood flow while slightly decreasing heart rate relative to flight or fight. The person feels paralyzed and scared stiff.

3.5 COLLAPSE

Finally, when it seems to the body that all states have not yielded any results, the body enters a state of collapse. In this situation of extreme threat (i.e., inescapable or life-threatening), the sympathetic activity recedes and the parasympathetic dorsal vagal starts dominating the body responses. This result in sharply decreased heart rate and a flaccid immobility ("playing dead") almost as a sense of giving up. Breath is shallow, feeling hopeless, detached and numb.



https://www.nicabm.com/how-the-nervous-system-responds-to-trauma/

Reflective Exercise

Listening to traumatic experiences may also elicit some of these responses in us. It is important for us to recognise our responses to trauma stimuli as well. We can identify our own bodily responses to trauma narratives.

4

WINDOW OF TOLERANCE

Window of tolerance is a model of autonomic arousal (Seigel, 1999) that helps to understand the fluctuations in various trauma responses described above. This model suggests that there are two extreme reactions in trauma- the (sympathetic) hyperarousal and the (parasympathetic) hypoarousal. Between these two states rests a window or a zone where emotions are tolerated, experienced, regulated and integrated (Corrigan et al, 2011). This zone thus, allows the person to have an internal sense of safety and a willingness to engage socially and learn (Boon et al, 2011). With flexibility in this zone, the person is able to experience various intensities of arousal (both emotional and physical) without the entire system becoming disrupted (Seigel, 1999). This model describes all the responses in the defense cascade.

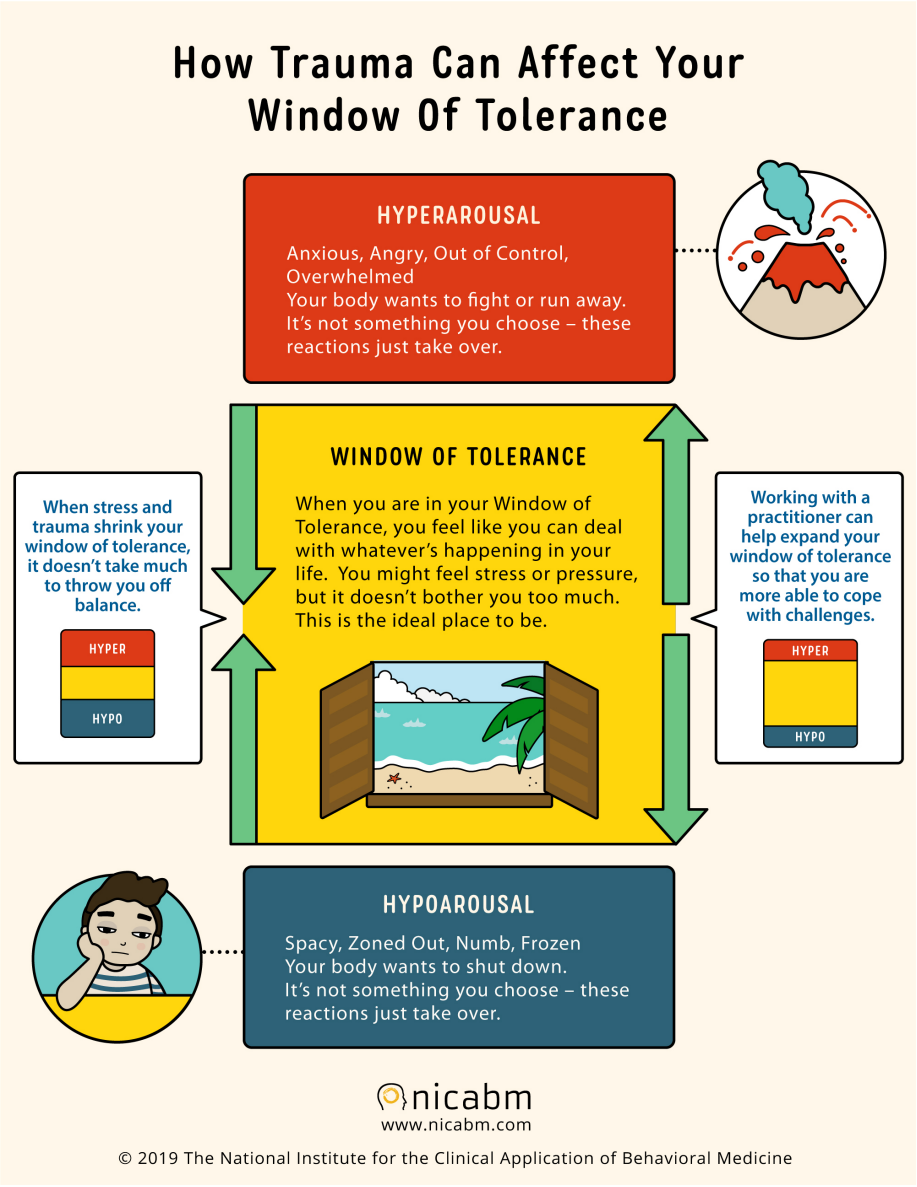
The hyperarousal state is dominated by the activation of the sympathetic nervous system. This is associated with increased reactivity, impulsivity, hypervigilance, intrusive images, flashbacks, nightmares, racing thoughts and engaging in high-risk behaviours (Ogden, et al 2006; Seigel, 1999).

In the hypoarousal state, activation of the parasympathetic nervous system dominates the experience of the individual. In this state, the affect is flat, numbness, emptiness and feelings of collapse dominate. The person feels helpless, hopeless and unable to think (Ogden, et al, 2006; Seigel, 1999).

The window of tolerance is unique for all individuals and is determined by our temperament, physiological reactivity and experiences (Boon et al, 2011). The ‘width’ of this window will influence the ability to process

information (Ogden et al., 2006). People who have wider windows of tolerance will be able to manage a wide range of arousal and process complex information efficiently and simultaneously whereas if the window is narrow, any change in arousal will be experienced as overwhelming and push us into hypo or hyperarousal.

Coming back into the window of tolerance is done by regulating with self and others. Interactive regulation refers to regulating and soothing the self with others (Schore, 2001). Examples of interactive regulation is calling friends when we are upset or even using the therapeutic space to gain different perspectives about our situation. Autoregulation refers to self-soothing practices to regulate oneself (Schore, 2001). It involves reassuring ourselves, pausing and reflecting on ourselves, doing activities that help us feel differently.



https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/

Let's avoid...

Not knowing the neurobiological underpinnings of trauma. Trauma experiences are inherently psychobiological in nature and have a profound impact on the body and mind. Ignoring the impact of one in favour of the other will not lead to holistic recovery.

Not knowing and identifying trauma responses. Individuals behave in characteristic ways when triggered by reminders of their traumatic stimuli. Mental health professionals who do not recognise these triggers or responses for what they are, will be at a risk for misdiagnosing and misinterpreting these responses. This will increase their risk for retraumatization and will be an ethical violation for us as well.

Paying attention to the clients' narratives without engaging in reflection about our own window of tolerance. Being in our own window of tolerance serves two functions: It helps the clients regulate interactively with us as well as not trigger the clients further. Clients with histories of trauma often are sensitive to the arousal levels of others. If the client experiences us as being outside of our window of tolerance, they may be at risk for getting triggered even further.

Self-care Exercise

Being in our own window of tolerance when working with clients with histories of trauma is very important as we can use our own sense of calm for interactive regulation. In order to do this, we can think of taking the following steps to understand our window of tolerance:

- How do we identify the states of hyperarousal, hypoarousal and window of tolerance?
- What are our potential triggers that push us outside of our window of tolerance?
- What strategies help us to return to our window of tolerance?
- What strategies may help us to expand our window of tolerance?

Self-reflection and observing ourselves can aid our own regulation. A key exercise that we can also practise for ourselves is a mindfulness-based exercise.

Practice Exercise

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is adapted from the SAMHSA's Trauma-Informed Care in Behavioral Health Services. It inculcates the ability to stand back and observe thoughts rather than get caught up in them.

We can do this for ourselves. Let us say, "Thoughts are just thoughts; they come and go like water flowing down a stream. We don't need to react to the thoughts. Instead, we can just notice them. We can do this by imagining ourselves sitting next to a stream. Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

We can use the following questions to facilitate this process:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

Tips for Supervisors

It is important to recognise signs of a triggered nervous system in a supervisee. We may want to look out for the following key signs:

- Anger or Irritability – Key to identify: disproportionate reactions
- Mood – Key to identify: unexplained changes in mood
- Dissociation – Key to identify: the mind's distance from the body

Fogginess, confusion, losing track of conversation, memory gaps, looking into nothing, hunched posture, rapid changes in breathing, discussing event as if they were "there"-flashback

Anxiety – Key to identify: evaluation and control

Hyperarousal, repeating same worries, rushed speech, intellectualization, jumpiness

Once there is a presence of such triggers, we can:

- Remain calm ourselves –nervous system to nervous system regulation
- Help the supervisee come back to the present- grounding and stabilization (discussed in the next chapters)
- Empathy can also be a trigger is some instances- maintain a clear, even tone
- Check in with the supervisee once it seems that they are somewhat stable- how are they doing? –preferably do not reinitiate a discussion about feelings about the incident or event
- Check if they would like to step away for a bit
- Debrief- We can say, "I noticed…." Then educate them on trauma triggers (if supervisee is in a place to discuss then)

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CHAPTER 4

Role of Mental health professionals in delivering trauma-informed MHPSS during disasters

1

AN INTRODUCTION TO TRAUMA INFORMED CARE

Trauma-informed care is an umbrella term referring to a service delivery approach where the focus is on understanding and responding to the impact that a traumatic event has on the individual. It is aimed at improving outcomes of care by focusing on ensuring physical, psychological, and emotional safety. This is achieved by empowering people to understand and work towards defining their needs and goals and exercising choices about the kind of care and services they receive. Trauma-informed approach focuses on increasing awareness about trauma and encouraging service providers to work actively to discourage processes and practices that have the potential to re-traumatize survivors.

"Trauma-focused services" and "trauma-informed care" are occasionally thought to be the same as they are therapies oriented towards providing care for those with histories of traumatic stress. However, these are different. Trauma-specific services refer to the clinical interventions which may be directed towards individual and group therapies intended to prevent or intervene for trauma-related symptoms, PTSD and other co-occurring disorders. Trauma-informed care on the other hand, is aimed at creating a universal framework for helping counsellors develop awareness, knowledge, and skills to provide a supportive environment for survivors of trauma (Hopper et al., 2010). Thus, trauma-informed care includes trauma-specific assessment, treatment and building support systems for recovery.

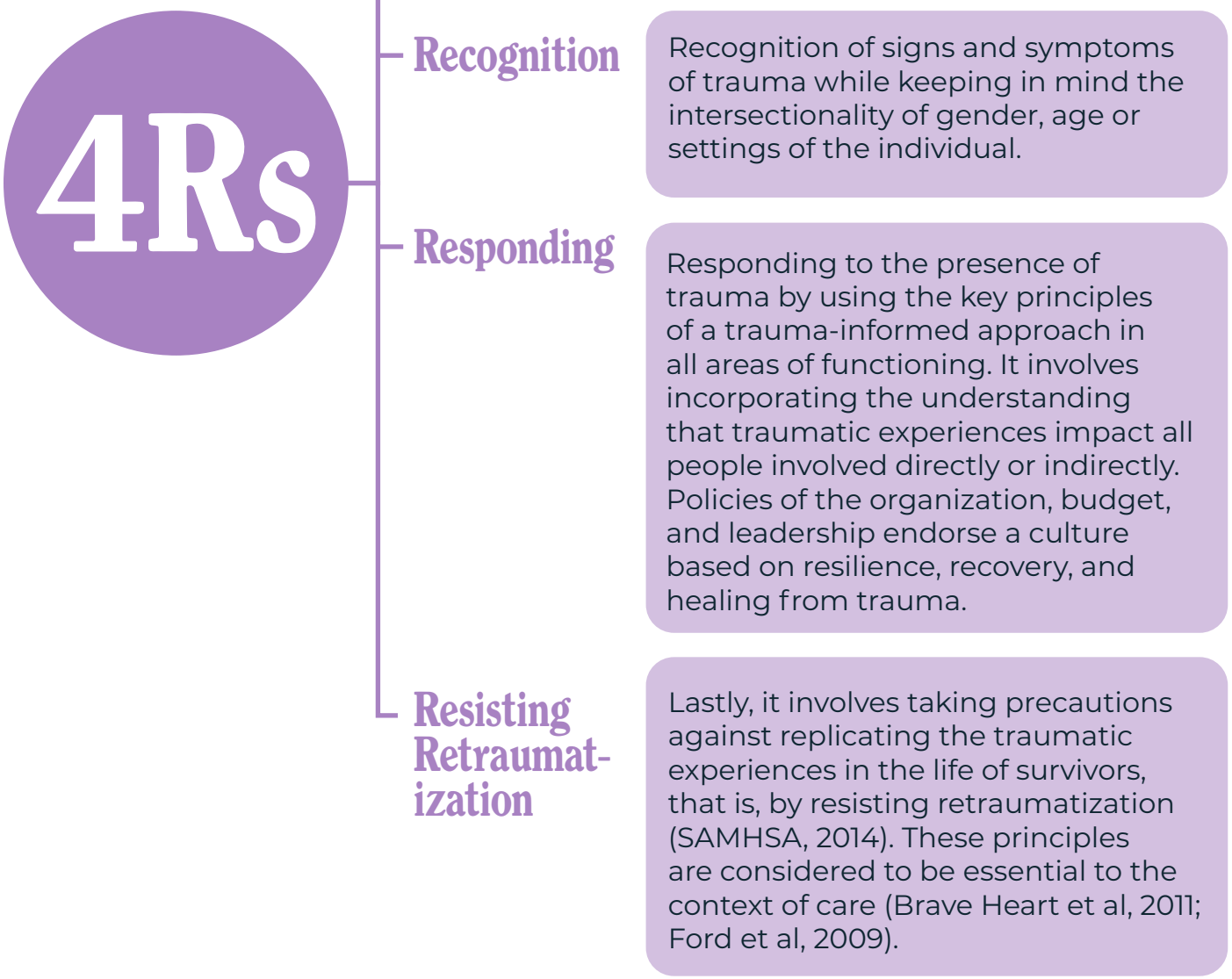
2

KEY ASSUMPTIONS AND PRINCIPLES OF TRAUMA INFORMED APPROACH

The concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles to guide the context of care.

2.1 KEY ASSUMPTIONS

The key principles in this approach are captured by 4Rs. These are:



2.2 PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach is guided by six key principles. These principles can be generalized across different settings and adapted to become setting or sector-specific. These key principles are crucial in linking and promoting resilience and recovery of individuals or families affected by trauma (Elliot et al., 2005; Harris & Fallot, 2001).

Safety

Trustworthiness and transparency

Peer support

Collaboration and Mutuality

Empowerment, Voice and Choice

Cultural, Historical and Gender Issues

2.2.1 SAFETY

It is imperative that anyone associated with trauma-informed care, including the counsellor and client feel safe. This can be reflected in a physically safe setting. It is also reflected in interactions which promote psychological safety in the relationship. This safety is defined and understood from the client's perspective. Establishing safe spaces in disaster settings where individuals can feel secure and supported is important in its aftermath (National Child Traumatic Stress Network & National Center for PTSD, [NCTS], 2006). This may start with physical safety (for example, settling in relief camps, away from the site of disaster) and then extend to psychological safety (providing interventions to bring the people back to the present following a disaster).

2.2.2 TRUSTWORTHINESS & TRANSPARENCY

The aim is to build a relationship based on trust and transparency. This involves creating a system of honesty, honouring the commitments made by people providing

trauma-informed care and maintaining an atmosphere of trust between the client and counsellor. We can try to establish trustworthiness by actively listening to and amplifying community voices. This can be done by engaging people from the community to facilitate communication and deliver messages to other members of the community. This may also help convey respect for the community. Lastly, candidly acknowledging limitations of the counsellors in the disaster situation may help people connect to us better (Rosenberg et al, 2022)

2.2.3 PEER SUPPORT

It is important to provide and receive support from peers in trauma work to gain valuable insights and knowledge in the context of trauma. It is not possible that one individual will have complete knowledge and understanding of the various ways in which trauma manifests. Peers help in providing understanding and newer perceptions that may get missed otherwise. They also help in building hope, creating safety and promoting healing. In the disaster context, people may be able to connect better to a person who is a part of their community. Thus, community engagement can be actively encouraged by promoting local resources by partnering with local practitioners on projects, and with mental health providers and public health practitioners (Rosenberg et al, 2022).

2.2.4 COLLABORATION & MUTUALITY

Collaboration with the client is a key component of trauma-informed care. There is an active effort to recognise power differences and reduce them between the client and the counsellor. It helps demonstrate that healing in trauma is possible when power and decision-making are shared, thereby increasing agency and control that clients have in their paths of recovery. For those who are recovering from disasters, having local leaders from the community actively encouraged to take ownership and control may promote a sense of empowerment and choice. These local leaders may help to increase participation and direction by providing meaningful alternatives in accessible language (Rosenberg et al, 2022).

2.2.5 EMPOWERMENT, VOICE & CHOICE

This principle highlights the importance of recognising and celebrating the strengths of clients and keeping them central in all our endeavours. This translates into believing in the resilience of clients and trusting in their ability to heal. It also involves sharing decision-making processes with them, finding out and bringing client choices in the foreground and keeping their goals as the priority of the work. The aim is to nurture within us the importance of the primacy of the clients, their resilience and their ability to set goals for their healing journey. This promotes self-advocacy and agency of the clients. For communities affected by disaster, helping them understand the vision for short-term and long-term recovery by sharing these in local, simple and accessible language may help in implementing them better. Communities may have specific recommendations based on their local knowledge and expertise and honoring these may help in tailor-making the intervention plans (Rosenberg, et al, 2022). Fostering a sense of control and autonomy among survivors by offering choices and respecting individual preferences and boundaries also helps in empowerment (Kaniasty & Norris, 2008). This may include asking for permission to speak to those affected by disasters, checking about the comfortable time for them to speak and ensuring that any intervention that is carried out is only after taking consent from them.

2.2.6 CULTURAL, HISTORICAL & GENDER ISSUES

It is important to acknowledge the unique socio-cultural, historical and gender backgrounds of the clients and respond to these through the cultural and intersectional lens. It involves understanding and honouring these aspects of the client and offering culturally competent responses. At the same time it is imperative that we keep away our own stereotypes and biases. In the context of disaster this may translate as identifying community history with traumatic events; creating space for other cultural/historic issues (e.g., caste or class tensions, land use, immigration, etc.); finding out the potential points of conflict with government/authority; and, fostering community strength and pride. We can also promote outreach for historically vulnerable or marginalized populations, creating processes to ensure that they receive the requisite access and are able to participate in decision-making processes (Rosenberg et al, 2022).

Reflective Exercise

- Which key assumption is the most difficult to follow in your understanding?
- What should we do if we unknowingly do not follow the key assumptions?
- Which principle is the most important according to you?

3

TRAUMA INFORMED COUNSELLOR COMPETENCIES

Counsellors are said to be 'trauma-informed' when they can demonstrate certain skills in their work. This group of skills or 'competencies' are specific to trauma and can be acquired through training and supervision (Hoge et al, 2007). They include:

1. planning using a person-centered approach
2. displaying culturally competent care
3. focusing on developing a therapeutic alliance
4. ensuring decision-making is a shared responsibility,
5. displaying collaboration while developing recovery plans
6. practicing evidence-based interventions
7. providing care oriented towards recovery and resilience
8. recognising the importance of providing interdisciplinary care, willingness to work in multidisciplinary teams and promoting client advocacy.

In addition to these competencies, counselors also need to focus on the following processes while working with clients with histories of trauma:

1. Effectively screening and assessing for a history of trauma and the mental health concerns which may accompany it, such as mood and anxiety disorders. It also involves understanding the bidirectional relationship between trauma and mental health difficulties.
2. Acknowledging the differences between trauma-informed and trauma-specific services

3. Keeping the tenets of person-centered approach in mind while carrying out the counselling process
4. Advanced training in trauma-informed and trauma-specific interventions, particularly those which are evidence-based, to focus on symptom reduction and client well-being
5. Being committed towards self-care practices that prevent burnout and help to reduce the impact of secondary traumatization on counsellors.

The 'Task Force on International Trauma Training' published consensus-based recommendations for trauma training (The International Society for Traumatic Stress Studies (ISTSS), 2002) which include:

1. Training for competence in listening to the client
2. Training in appropriate methods of assessment which identify psychosocial problems that accompany experiences of trauma
3. Training for evidence-based interventions specific to their client population
4. Promoting knowledge about the local context of the client which includes their help-seeking expectations, expected duration and cost-effectiveness of interventions, and community and family attitudes toward intervention
5. Training in specific strategies for problem-solving at individual, family, and community levels
6. Training in and awareness of interventions for medically unexplained somatic pain
7. Training in collaborating with and building capacities for local resources (e.g., traditional healers, informal leaders etc.).
8. Self-care components for counsellors (Weine et al., 2002).

This is especially useful in the context of disaster where disaster-specific assessments and interventions are needed (Hobfoll, et al, 2007). A thorough understanding of the effect of disaster on mental health, especially common responses is beneficial in providing tailor-made interventions (Norris et al, 2002). Given the diverse populations affected by disasters, counsellors must be culturally sensitive and aware of how cultural factors influence coping mechanisms, help-seeking behaviors, and healing practices (Schwartz & Sendor, 1999). counsellors working in disaster settings need to be flexible and adaptable to changing circumstances,

such as limited resources, logistical challenges, and the evolving needs of survivors (Ursano et al, 2003) as well as being engaged in community-related work. Given the demanding and potentially stressful nature of disaster response work, counsellors must prioritize their own self-care and resilience to prevent burnout and secondary traumatic stress (Brymer et al, 2006).

Reflective Exercise

- Make a list of all the competencies mentioned in the above paragraphs. It may be useful to explore which competencies we have already and which ones we would like to enhance further.
- We can also explore additional checklists which are already available on the internet to understand our level of competence in trauma-informed care.

4

SPECIAL ETHICAL CONSIDERATIONS WHILE WORKING WITH TRAUMA

All ethical practices that are followed in MHPSS, (e.g. beneficence and non-malificence, fidelity and responsibility, integrity, justice and respect for people's rights and dignity) must be incorporated when working with trauma. In addition to these, there are certain ethical considerations that are particularly important to keep in mind.

Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

RESPECT FOR THE DIGNITY OF CLIENTS

Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

RESPONSIBLE CARING

- Take the utmost care to ensure that interventions do no harm.
- Ensure a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can be extremely stressful on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

INTEGRITY IN RELATIONSHIPS

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

RESPONSIBILITY TO SOCIETY

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about y our expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.

- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

CLIENTS' UNIVERSAL RIGHTS

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.
- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

PROCEDURES FOR INTRODUCING CLIENTS TO TREATMENT

- Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:
- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

REACHING COUNSELING GOALS THROUGH CONSENSUS

- Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

- Informing clients about the healing process
- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

LEVEL OF FUNCTIONING

1. Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
2. Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: SAMHSA (2014).

In disaster-like situations, it is possible that the guidelines or codes of ethics may not be followed strictly or to the letter. Ethical codes are often open to interpretation and bound by the context in which they operate. Certain boundary crossings may happen. For example, we as counsellors may be operating in the same context as the clients during a disaster and may share contacts of associations that have helped us. We may not do so in other contexts though. Similarly, we may decide to contribute monetarily to a cause that our client may be involved with because it is helpful to our community. However, it is important to distinguish it from boundary violations which will still not be acceptable. Boundary crossing can be referred to as deviating from the usual

psychological, physical, or social norms in the counselling context in a way that is harmless, is not exploitative, and may actually help in advancing therapy (Gutheil & Brodsky, 2008). An example can be self-disclosure of a counsellor's recovery from trauma to offer hope to the client. But this is not done to express unprocessed trauma memory, rather, it should be done judiciously without going into details of the trauma story and with the express purpose of building hope. Boundary violation, on the other hand, is unsolicited, harmful and exploitative (Gutheil & Brodsky, 2008). These are distinguished from boundary crossing in their intent and or the effect that they have has on the client. Intent is when the violation is done for the extra therapeutic gratification of the counsellor and not for the client's well-being. The detrimental effect is when the action brings about harm rather than help to the client. One of the key areas where counsellors working with trauma commonly encounter ethical dilemmas is boundaries in therapeutic relationships. It is possible that clients with histories of trauma may require additional support in understanding the roles and responsibilities of counsellors and clients. For example, since they may not be trusting of many individuals around them, they may not understand or appreciate why their counsellors cannot share their personal numbers with them and may perceive it as a rejection or the counsellor not caring for them. Clients with histories of trauma may also not realise boundary violations by the counsellors. For example, they may be more tolerant of counsellors who may show inconsistencies such as forgetting sessions, not ending on time or even self-disclosure which is not therapeutic. Supervision can be an important area where such boundary violations may be discussed.

Practice Exercise

Consider the following example. We can reflect if this is a boundary crossing or a boundary violation.

Mrs T is a counsellor with 12 years of experience at an in-patient hospital set-up. Two years ago, she and her daughter had met with an accident. She had escaped with a few scrapes but her daughter had suffered a major arm injury

and had to undergo an extensive rehabilitation to preserve the use of her arm. She made full recovery but it took a toll on Mrs. T. She was very supportive of her daughter but felt very guilty about the entire process as she had survived with very little impact. Her daughter tried to reassure her but she was not convinced.

Four months ago, she started working with Ms. B who had undergone a traumatic brain injury after a train accident. While working with her, Mrs T started extending her sessions feeling that Ms. B should not feel pressured to speak fast (Ms. B had slurred speech). She also started meeting her more frequently, finding herself checking with Ms B before her day started and after her last session. During these times, she would often help Ms. B convey her wants to the staff because they had some difficulty in understanding her. Recently, they have started exploring how Ms. B is making meaning of her experience. Mrs. T found herself asking Ms. B about attribution of blame. She questioned her if she blamed her parents for sending her on the train or not. In the last session, she gave Ms. B a hypothetical situation, asking, "if this was a car instead of train, would you blame the person driving the car? What if it was your mother?"

Ms. B felt very uncomfortable answering this question. This discomfort was noticed by her nurse who asked her about it. Ms. B felt compelled to protect Mrs. T after all the kindness she had shown to her. So she answered that she had no problem with Mrs. T. Mrs. T continued to work with Ms. B but sometimes she asked her this question again and again.

- What were the instances of boundary crossings in this vignette?
- What were the instances of boundary violations?
- How did you make the distinction between boundary violation and boundary crossing? (The key is to consider the context, intent and effect of the actions of the counsellor)
- How do you think Ms. B feels in this situation?
- How do you think we can help Ms B in this context?
- If you were in the position of Mrs T and a supervisor helped you understand the difference between boundary violation and crossing, what steps could you take to redress this situation?

5

ROLE AS MENTAL HEALTH PROFESSIONALS IN PROVIDING TRAUMA-INFORMED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT DURING DISASTERS

Mental health professionals (MHPs) play a crucial role in managing trauma responses to disasters. We bring our unique competencies such as managing stress and developing coping strategies to the disaster situation (APA, 2021). The NDMA (2023) has prepared guidelines to help understand our role as counsellors in the disaster context.

1. For example, prior to the occurrence of the disaster, that is in the preparedness phase, our role can be:
2. Carrying out assessment of vulnerabilities such as understanding the pre-existing psychosocial problems of the individuals and communities in the disaster-prone area as well as the resources available to them including trained personnel keeping the key principles of trauma-informed care at the forefront. This assessment can inform the actions taken during the disaster phase.
3. Building the capacities of stakeholders such as citizens, disaster responders, community level workers, local, state and central government personnels, health and allied health professionals, NGO personnels and media. These training can be on topics such as psychosocial considerations in the context of disasters, trauma-informed MHPSS< community awareness, and psychosocial care and support during disasters.
4. Building technological support such as a centralized portal to identify, consolidate, and provide access to disaster mental health and psychosocial support resources available containing IEC (Information, Education and Communication), self-help guides, information for help-seeking, to name a few.
5. Providing support through research endeavors by participating in trauma-informed disaster mental health research on topics such as intervention, ethics, to name a few.

The next phases are the early phases of disasters which last from one week till 8 weeks post disaster. counsellors are engaged in planning and preventive roles during these early phases of disasters such as:

1. Participating in a multi-disciplinary relief team

2. Carrying out rapid assessment which focuses on:

. Nature of the hazard
. Social determinants of mental health
. Mental health and psychosocial context including prevalence of trauma responses, psychosocial responses of those affected by the disaster
. Social and community based resources
. Formal resources available for the community such as number of trained personnels, technological resources, healthcare institutions to name a few
. Socio-cultural beliefs and attitudes towards mental health

3. Providing capacity building services to understand disaster and its responses for the community members through IEC material and self-help strategies and carrying out community awareness programs promoting help-seeking behaviours

4. Providing psychosocial support such as psychological first-aid, and other specialised mental health services addressing trauma responses, emotions distress, and other responses.

The next phase of disasters is the disillusionment phase starting after the end of the earlier phases (from two months) and can last for the next three years. counsellors are engaged in more curative roles including:

- Interventions for those with significant mental health concerns
- Attending to the referrals for specialised care
- Spreading the scope of capacity building activities
- Training and hand holding community members such as private physicians/doctors, primary health care staff, paramedical staffs, school teachers, anganwadi workers, alternative complementary medicine personnel, religious leaders, spiritual leaders and faith healers for better outreach of services
- Participating in community outreach camps
- Assessing the efficacy of interventions and developing a feedback mechanism

Lastly, the phase of restoration starts where counsellors are involved in the preparedness phase once again. This cycle shows the crucial role that counsellors have in every phase of disaster management.

The scope of this work is covered more in detail in the NDMA guidelines (2023). The World Health Organization (WHO) is one of the many organisations that advocates for integrating trauma-informed care into general mental healthcare systems (Van Ommeren, & Wessells, 2007). This chapter will focus on introducing the idea of trauma-informed care, discussing its principles and lastly, unique ethical considerations that may form a part of trauma-informed care.

Reflective Exercise

The above paragraph describes different roles that counsellors play.

- Which one of these roles do you find most meaningful?
- Which one of these roles may be most challenging for you?
- Which one of these roles do you think will be most impacted if you were also a part of the community that was affected by the disaster?

Let's avoid...

Not knowing the limits of our role as mental health professionals in the context of disaster. Disaster situations may make us feel compelled to rescue clients to avoid feeling helpless in the situation. It is important to understand our role in this context and work in multidisciplinary teams so as not to get overwhelmed by the situation.

Not differentiating between trauma-informed practice and trauma-specific services. Trauma-informed practices are an overarching framework whereas trauma-specific services are evidence-based clinical interventions used to assess and treat PTSD and other trauma-related symptoms.

Believing that key assumptions and principles of trauma-informed care is only applicable within the therapy session. Trauma-informed care is a set of universal frameworks that is applicable in all our interactions with clients.

Engaging in boundary violations. Trauma histories of clients may make us want to go the extra mile for them. However, it is important that we engage in self-reflection about the reasons for our actions. We can keep the context of our practice, our intent is crossing boundaries and the possible effect on the client in mind while making such a decision.

Self-care Exercise

Drawing a comprehensive self-care plan involves assessing ourselves on our current available coping skills and strategies and planning for a holistic and all-inclusive routine that addresses these four domains (SAMHSA, 2014):

- Physical self-care (having a healthy and relaxed body)
- Psychological self-care (includes cognitive/mental aspects for building bigger perspectives, working towards them, countering negative self-talk and beliefs and becoming more self-reflective)
- Emotional self-care (includes relational aspects, feelings of connectedness and groundedness)
- Spiritual self-care (involves meaning, hope and working towards something greater)

Tips for Supervisors

This chapter discusses the key concepts of trauma-informed practice. Supervision can also draw parallels with these principles. A trauma-informed supervision incorporates exercising safety, trustworthiness, choice, collaboration, and empowerment in the supervision space (Berger & Quiros, 2014). We can reflect in the following directions for supervision:

- How can we make supervision trauma-informed?
- As a supervisor, what are our expectations from our supervisees?
- If we are a part of a peer supervisor group, how can we keep it trauma-informed?

This chapter helps us in understanding our role as mental health professionals in the context of disasters. It also helps us in understanding the basics of trauma-informed care. The next chapter focuses on discussing ways of carrying out the process of trauma-informed mental health and psychosocial support.

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CHAPTER 5

Providing Trauma-informed MHPSS during disasters

1

PLANNING AND DELIVERING INTERVENTIONS

Interventions aimed at working with traumatic events such as disasters focus on promoting healing and recovery by addressing the psychological, emotional, and social consequences of disaster. We help individuals and communities to focus on experiencing safety and stability, and integrate the traumatic experience in our lives. Acknowledging and validating the experience of the individual and the community is an integral part of this process. It is important to recognize that recovery from trauma is not a linear process, and there might be setbacks, challenges, and fluctuations in progress. Experiences of disaster are not to be simply forgotten or moved on; not necessarily returning to the way things were before the disaster, but rather about finding new ways of living and thriving in spite of this experience.

We need to be in our own window of tolerance for facilitating trauma-informed work. It is important for us to use the strategies discussed in the chapter with ourselves first. We can then use the strategies with our clients as well.

2

STAGES OF RECOVERY

Recovery unfolds in three stages (Herman, 1998).

The central task of the first stage is the **establishment of safety.**

The central task of the second stage is **remembrance and mourning.**

The central task of the third stage is **reconnection with ordinary life.**

We must make sure that the strategies we suggest for the clients are timed appropriately to their stage of recovery. It is important to note that these stages are not linear. The clients may move back and forth on these stages. For example, a client who might have started reconnecting with their ordinary life, may once again feel anxious and panicked. In this case, it is important to understand what could have triggered the clients and what can we do to restore safety and stablise them. We have to be attuned to the client's reactions and keep track of their processes.

It is important to understand the triggers that clients may face. A **trigger** is a stimulus or a sensory reminder such as noise, smell, temperature, physical sensation or visual scene that sets off a memory of a trauma or a specific portion of a traumatic experience (SAMHSA, 2014). For example, a person who was at a hill station during a flood may get triggered by the sound of running water, or the feel of wet clothes and may experience increased heartbeat or an urge to escape or run. While some triggers may be easy to identify and anticipate, others may be more subtle and inconspicuous. For example, being triggered by the time of the day at which the disaster occurred. These triggers may catch the client off-guard. Triggers can generalize to any characteristic that resembles or represents a previous trauma. These triggers elicit a strong emotional reaction and need to be managed by using coping strategies. Triggers may lead to flashbacks, intrusive thoughts or nightmares. Triggers are important because they are the doorway into post traumatic flashbacks etc and people go to extreme lengths to restrict their lives to avoid being triggered.

2.1 ESTABLISHING SAFETY AND STABILIZATION

Disasters can shake the sense of safety that one experiences in an environment. People may get displaced from their homes, not be able to access the support that they may have and even have to experience loss of homes, people and their livelihood. As we have seen previously in chapter 3, the body also starts showing responses which the client may not completely understand. Thus, the first task of recovery is to establish the client's safety. No further work can be done without securing safety for the client. This stage may last for a short duration such as a few sessions or may last for a much longer duration based on the severity, duration,

and early onset of the trauma experienced by the client. This stage can be addressed in relief camps, for both individually and in groups.

2.1.1 SAFETY

An important step in establishing safety is to focus on helping our clients regain **control of the body** as **well as establishing some control of the environment.** Regaining control of the environment involves restoration of basic needs. This involves helping clients and communities have access to safe living spaces, food and water.* We can explore the strategies for helping clients with basic needs in the Section 3 chapter 1 (addressing basic needs). Feeling unsafe in the body is expressed as a permanent sense of looming danger and feeling out of control with respect to emotions and thoughts. It may also be expressed as difficulty paying attention to the basic needs such as sleep, food, and exercise. Helping clients re-establish their relationship with their emotions, thoughts and attending to their basic needs will help in establishing control over their lives. **Establishing control over the environment** includes having a safe living situation, financial security, mobility, and a plan for self-protection against any threat. It requires building awareness of their own resources for practical and emotional support to build self-regulation and provide a sense of competence and resilience.

Clients also need to feel safe in their body. For establishing safety within the body we need to help clients understand what happens in the body during traumatic events, and then proceed to discuss specific tools for restoring safety. This process is called stabilization.

2.1.2 STABILIZATION

Stabilization is the process of restoring safety and increasing a sense of control over trauma responses (Curtois & Ford, 2009). In case we feel the client is getting triggered, stabilizing the client becomes important. Some important strategies that we may use are (a detailed discussion of these techniques is done in the next chapter):

Grounding Techniques: Grounding techniques help clients feel more present and connected to the present moment, rather than being overwhelmed by distressing memories or emotions.

Coping Skills: Teaching certain techniques such as relaxation techniques, self-soothing activities, and grounding exercises can help the clients.

Somatic Techniques: Somatic approaches such as body awareness, gentle movement, or grounding exercises that focus on bodily sensations can help regulate the nervous system and reduce the intensity of trauma-related symptoms.

Psychoeducation: Providing information about trauma reactions and the physiological response to triggers can help normalize the client's experience and reduce feelings of shame. Educating clients about the fight-flight-freeze response and how triggers can affect the body and mind can help them feel more in control. Some scripts for psychoeducation that we may use to enhance a sense of safety include:

1. **About disaster.** We can start by asking the client how they felt during the disaster. They may reply with emotions of fear and uncertainty. We can use that as a window to start psychodeducating the clients about the impact of disasters,

> *"Disasters tend to affect us profoundly because they make us feel as if our lives are unpredictable and that we are not in control of our own lives. Once we have such an experience, we may find it difficult to feel safe or to trust others. We might also lose trust in ourselves and our judgments. We may feel scared, on edge and uncertain about things."*

   We can pause then ask, if they felt this way as well. We can then ask them if they would like to understand what happens to the brain during this time.

2. **About how the brain deals with disasters.** We can explain the neurobiology of trauma by saying,

> *"In everyday life, our reasoning center called the prefrontal cortex or PFC is active and our emotional centre or the amygdala is quietly observing the situation. Thus, we tend to respond to situations rationally, rather than emotionally. During events that threaten our safety such as a disaster, the amygdala gets activated. We can think of the amygdala as an alert watchman looking out for our safety. As soon as the amygdala feels that there is*

a threat to us, it starts sending signals to activate emotions such as fear and anger. At the same time, the PFC becomes quiet. We can imagine the PFC to be like the reasoning head of the family. Just like in case of a robbery, the members of the house stay quiet and let the watchman take charge of the situation, when the amygdala is active, the PFC becomes quiet. This means that our reasoning centers are less active and emotions take charge of the responses. PFC and amygdala work like a see-saw; when one part is active, the other is quiet. In order for things to go back to usual, the PFC has to become active and amygdala has to be quiet. If the situation is too frightening, it is possible that the PFC becomes too quiet, and thus, the message to the amygdala to stop becomes slower and becoming calm takes more time."

Another way of explaining this is when we use the hand model described in chapter 3. We can say,

"The brain is one of the most complex organs in the human body. We can think of the major parts of the brain as being divided into three parts:

1. Lower part of the brain which is responsible for functions of our body such as regulating the heartbeat, breathing, etc.

2. Emotional Brain which is responsible for emotion and forming memories, thereby helping us learn.

3. Rational Brain which is responsible for thinking and reasoning.

We can imagine the brain to be like a fist formed by tucking the thumb inside it. The wrist represents the lower part of the brain, the thumb represents the emotional brain and the fingers that cover the thumb are representing the rational brain. This means that the rational brain takes charge of the other parts. When there is no threat, all functions are performed seamlessly. However, it is different when the brain perceives a threat. In case of threat, the fingers no longer cover the thumb. The thumb takes over. The rational brain is no longer regulating the emotional brain. Thus, the activity of the emotional

brain overrules the rational brain. Often these are short-term changes. When the threat is removed the rational brain once again takes over the emotional brain.

When we are exposed to extreme threats this short term, adaptive response becomes chronic and long term such that even when we transition into a safe environment, the emotional brain does not turn off. We are stuck in the survival system. Thus, very little information gets passed up to the higher, rational parts of their brain. Whilst we are stuck here, we find it difficult to feel safe, form secure attachments; manage emotions or behaviour, think, learn or reflect because we are simply trying to stay alive in a world that we feel is highly dangerous."

3. **About trauma responses.** We can focus on helping clients understand various ways that people respond after trauma. It is important that we do not overwhelm the client with the information as this conversation is heavy.

   First, we can start by validating the clients' experience. We may say,

   "if someone went through what you did, they are also likely to experience similar responses. Our brain and body are designed for survival; we tend to store any threatening information. The body, thus, starts to be in a state of vigilance, looking out for and predicting danger. But this strategy that helps us survive when the danger is active, becomes painful and exhausting once the threat has passed".

   The next step will be to describe the fight-flight-freeze response. We begin by helping clients understand the physiological alarm state. We can say,

   "When the body starts feeling threatened, it starts some changes in the body and brain. These changes are very rapid and affect the entire body. During this time, our heart rate increases, muscles become tense, and our breathing becomes shallow. Alongside, our emotions are also activated. In case we start feeling angry, the body prepares itself to fight. If we feel afraid, our body may start preparing to run away or flee. If the fear becomes too much and the body feels neither fight or flight will help, it goes into a freeze

mode. This freeze response may be one of two types. One, we may freeze if we want to orient ourselves to the situation to understand the threat, take stock of what is happening and decide what to do. In the other type, we feel immobilized and dissociated (that is, feeling lost and not present in the here and now)."

Once we have explained the fight-flight-freeze response, we can take a pause and ask the clients if they felt any of these responses. It is important to once again validate and normalise their response. We can say,

"In life-threatening situations, becoming highly aroused (no sleep, constant state of anxiety) or danger-focused (not concentrating on other things) or numb (feeling no pain) are all adaptive to survive. It is only when these states continue in the absence of the threatening situation, these feelings of anger, anxiety or arousal or being numb may seem to be coming out of the blue. It is our mind's way of making sense of what has happened".

We can then explain the concept of trigger. We may say,

"Even though these responses seem to come out of the blue, most of these are actually reactive. We have to identify triggers. Triggers are reminders of the traumatic event. It is often tied to our senses – something you may have seen, heard, touched, smelled or tasted while the disaster occurred. For example, many people like you who had experienced floods, become triggered by the sound of water dripping. People who have survived fire may get triggered by the sensation of heat and people coughing".

4. **About the window of tolerance.** The concept of window of tolerance (Seigel, 1999) proposes that between the extremes of hyperarousal and hypoarousal is a 'window' or range of optimal arousal states where emotions are felt as tolerable and our experiences can be integrated. We can explain this to our clients by saying,

"Window of tolerance is the zone where we are able to process intense emotional arousal in a healthy way, allowing us to function and react to stress or

> *anxiety effectively. We feel like we can deal with the situations in our lives. Even if we feel stressed we are not bothered. However, when we feel anxious, angry, overwhelmed and out of control, we may feel like fighting or running away. This is the state of hyperarousal. On the other hand, when we feel spaced out, zoned out, numb or frozen, we may feel like shutting down. This is the state of hypoarousal. Traumatic situations shrink our window of tolerance such that we spend more time in hyper or hypoarousal; rather than window of tolerance."* Working with trauma in the first stage of recovery means working with expanding the clients' window of tolerance; helping them to manage states of hyperarousal and hypoarousal.

We can also notice signs of hyperarousal in the session (e.g., tension, shallow breath, rapid speech). In this situation, we must interrupt the client's narrative gently. We can ask the client to move away from their narrative and focus towards their body. The signs of arousal can be identified and managed using strategies such as diaphragmatic breathing, progressive relaxation, mindfulness based exercise to name a few. These have been discussed in the next chapter. Conversely, when the client seems hypoaroused (e.g. when it feels like they are not listening, lost, inattentive in our conversation), we may redirect their attention to the environment especially towards objects in the present environment. This may help the client to pause thinking about the past and come back to the present. Some important strategies that can be used are grounding, movement such as asking the clients to push down on the ground with their feet, pushing the back against the wall, orienting clients to the present by reminding them of the date and their safety, etc. These strategies are described in more detail in the next chapter.

By utilizing these techniques, counsellors can help clients regain a sense of safety, stability, and control after experiencing triggers, thus facilitating a more secure foundation for further therapeutic work. Working on safety and stabilization is a continuous process in trauma-informed care to ensure that the client should not get overwhelmed. Keeping a balance of using techniques and checking in with the client is very important.

To prevent overwhelming the client and reducing the possibility of retraumatization, we have to pace our sessions. This technique is called titration (Levine, 1997). In order to understand **titration**, we can think of working with trauma as drinking a very strong drink. Instead of drinking it all at once and overwhelming our sensation, we need to drink it slowly to get used to its taste. Similarly, any work with trauma stimuli has to be done slowly, step-by-step. We need to start with a trauma response by working with the least amount of discomfort. Allow the client to feel discomfort but not so much that it overwhelms them. We can then ask them to come back to the window of tolerance. Once the discomfort disappears, we can move on to the next stimuli. Another important construct to be kept in mind is **pendulation** (Levine, 1997). It means swinging between discomfort associated with trauma memories and feelings of safety. Before we begin with any technique, we have to review the concept of safety with the client. Once this feeling is identified in the body, we can ask the client to swing between this feeling and then move on to feeling the distress. Just like when a child starts swinging, they start slowly and come back to keep their feet on the ground, and then start gaining momentum later, the process of working with trauma will also be undertaken with the same precaution.

Tool Box for Safety and Stabilization

GROUNDING helps in managing reminders of trauma memories. These techniques using senses to bring the mind back to the present, focusing on breath and using imagery to make the mind and body feel safe.

- Common grounding techniques such as smelling essential oils, drinking fragrant tea, mindfully eating crunchy food, doing yoga and stretching and other such techniques described above may be helpful.
- Another technique is the 54321. We ask clients to look around and see 5 objects they can see, 4 things they are touching, 3 sounds they can hear, 2 things we can smell and 1 thing they can taste.
- Another helpful grounding technique is playing a favourite song, paying attention to its melody and music and singing it aloud.

We can also grounding statements such as

> *"It seems like you are overwhelmed by the repeating experience of past memories or emotions. Let us try to bring you back to the present. Take a deep breath, relax your body; let the tension seep out of your body towards your feet which touch the ground. Imagine walking out of the past and into the present. Look around you and tell me what you can see presently?"*

SAFE OBJECT TECHNIQUE may also help clients feel a sense of safety and regulate their emotions. We can ask clients to find a physical object that can anchor them. This object is something that has personal significance to them like a toy or a piece of cloth or jewellery or a photograph that can be carried around. We can ask them to imagine feeling safe with the comfort that this object may bring. We can also ask them to carry it around so that they can use it whenever they want.

Some **SOMATIC TECHNIQUES** may also help in bringing the person back to the present. **Drop three** (Lynch et al, 2015) is one such technique. It includes asking the client to drop first the jaw, shoulders and stomach. We can say

> *"First drop your jaw by making your tongue fall to the bottom of your mouth. Then drop your shoulders, release them and let them fall. And lastly, drop your stomach. Just let it go without holding it tightly. Notice how you feel."*

We can also clients to include the **SELF-STATEMENTS FOR SAFETY** such as:

- What is it that I would like to do?
- What can I do in this situation? What is in my control?
- I am in control of my reactions.
- I am not in danger. I am safe now.
- I am triggered right now but I will be okay. This flashback will pass. I am safe now. I have survived this. I am trying to be healthy and happy now

SAFE SPACE VISUALIZATION with the client especially after they feel overwhelmed. A script adapted from Lynch et al (2015) reads

> *"Sit comfortably, relaxed and at ease, by keeping your hands empty and your feet on the ground. Start by taking three breaths, long, slow and deep breaths. Focus on it, the way it changes as you become aware of it. Let it stay calm and relaxed and move on to your heart beat. Let it stay rhythmic, warm and relaxed. Let go of the tension with each breath and the beat of your heart. Now, think of a place where you feel safe and secure. It can be a real place or a place in your imagination. Let it come to you. Whatever it is, a beach, a lake, a mountain, anywhere; just picture it in your mind. Imagine now you have entered this safe space. You are inside this safe place. Look at the objects around you in this safe place... Notice what they are, their colors, their shapes. Look around... And now, listen to the sounds in your safe place, anything you can hear, maybe birds, animals, sound of nature, wind, etc. As you look*

around and listen to your surroundings allow yourself to feel safe, warm and comfortable. Now, pay attention to the smells in your safe place. What are the smells that you are noticing? They could smell of nature, maybe your favourite food, any flower? Enjoy the smells as you breathe in deeply... Allow yourself to feel safe in this space surrounded by the smells, Now, walk around this space in your mind. Notice the objects and pick them up. Touch these objects and observe their textures. Are they soft or rough? Warm or cold? Soft or hard? Continue to walk around and keep on touching these objects. Spend some time in your safe place, while relaxing and enjoying it... (pause one minute). And when you are ready, come back into the present, knowing that your safe space is within you and you can return there at any time. It will always be there for you."

CREATING COPING CARDS may also help. Coping cards refer to a card or a piece of paper that has all the strategies that a client has learnt so far. In times of crisis, it is possible that they may not remember these strategies. It might be helpful to simply have written reminders for them. They can supplement this list by writing down the situations and scenarios where the specific coping strategies on the card can be used.

Reflective Exercise

- What could be the reason for establishing safety and stabilization as the first step of recovery according to you?
- Some of these constructs may be easy for us to understand and psychoeducate about in English. How can we ease this process in our local languages?

2.2 REMEMBRANCE AND MOURNING

Once the client feels safe and can trust us, we can gently proceed to the second stage of recovery. This involves reconstruction of the traumatic memory to integrate it into the client's life (Mollica, 1988). It is based on the principle of empowerment (Herman, 1992). The role of the counsellor is to be a witness to the story and be an ally in recovery. This allows the client to reconstruct the fragmented story of the traumatic events in an organized, detailed, and verbal account, which is centered in the client's timeline and context, incorporating their emotional responses.

Throughout this process, the strategies learnt in the first phase of recovery must be actively used to access safety internally, so that traumatic memories can be worked with without clients feeling 'flooded'. . This helps to maintain the balance between avoidance of the traumatic memories and the feeling of overwhelm they may bring. The other consideration is the pacing and timing of the reconstruction of the trauma narrative. It also includes the acceptance that the memories are reconstructed and change as they are filtered by new experience, which means that we may not be able to uncover a 'complete' picture of the client's story. This tolerance to uncertainty and ambiguity must be learnt. It also involves examining moral questions of guilt, responsibility and the belief in justness of the world. Engaging in this process along with the client may make us question our beliefs as well. Our stance cannot be neutral; rather it is to express our solidarity with their process (Agger & Jensen, 1990).

A major task for this stage is grief and mourning about what has been lost from the clients. It is different for different experiences of trauma. Once the client is able to navigate this grief they may start realising that trauma is a part of their life, not their entire life. At this time, they may feel hope and a desire to engage with life.

One of the ways of helping clients at this stage is to help them **write their narratives.** We can ask them to think about one of their traumatic experiences. For the first time, we ask them to select an event that is not very triggering. Once we understand how to proceed, we can take on more distressing events. The format that can be used is :

DEAR SELF (Reutter, 2019). The acronym stands for **Describe, Express and empathize, Assert, appreciate and apologise and reinforce.**

It can be described as:

D-Describe. In the first part of the letter, we ask the client to describe a traumatic event that happened to them. We ask them to retell the specific order of events including details of the information gathered from our senses such as what they saw, what they heard, what they smelled, what they tasted and what they felt.

E-Express and Empathize. We can ask them to express all the emotions they felt as the traumatic event unfolded. We also ask them to express their emotions after the experience ends. It can also be useful to have clients identify emotions that became frozen, numb, or stuck after the traumatic event. We will ask them to show empathy towards themselves that they never received.

A-Assert, Appreciate, Apologize. The next step is to assert to their traumatized self that what happened to them was wrong and was not their fault, no matter what people say to them. Try to balance their thinking when any cognitive distortions arise (see section 3; chapter 5). We will then help the clients verbalize their appreciation to their traumatized self for how strong and brave they have been to have survived this trauma. We will remind them to elaborate on all of their positive qualities that helped them survive the trauma. Lastly, we will ask them to write the apology that they never received or that they wish they could have received. It is important to reiterate that they are not apologizing for their own trauma. Rather, the apology is for the fact that the trauma happened to them in the first place.

R-Reinforce. We will help the clients reinforce their belief to strengthen their relationship to themselves as well as increase their dedication to the healing process. Many R words can be used: remind, reassure, recall, recommit, reflect, redeem, repurpose, redefine, and reenvision their lives. We can remind them that the trauma is now over; they can reassure themselves that they are safe. They can practise and recall all the skills they have learned along the way and recommit to practicing these. We will help the clients to reflect on what they have learned from the trauma, and even find ways to redeem or repurpose their suffering. We can help them by asking questions such as: How can their trauma be used to help others? What insights have they learned from this trauma that they could not have learned otherwise? How can they use this trauma to help transform themselves, others, and the world? We can also help them redefine their goals, plans, and dreams moving forward. What future can they re-envision that is no longer defined by their trauma? What is their plan to live, love, and laugh as they have not done before?.

Another technique is **COMPASSIONATE LETTER WRITING** (Lee & James, 2013). It includes the following steps like identifying their motivation for writing this letter, getting into the right mindset, experiencing safety, and checking if they are ready to start writing as the compassionate 'self' which understands, validates, empathizes with, and supports the client unconditionally. The next step is to help clients recognise their wisdom, courage, strength, and resilience, adding empathy and understanding to their experience and the unintended consequences of the ways they coped, accepting that it is not their fault, but it is their responsibility to work through the trauma, describing what they need to help them cope with their memories and release their final statement of courage and commitment to a future without suffering.

As disasters affect communities, we can integrate community strengths and resilience in this stage. We can ask communities to regularly get-together in a safe environment where we can facilitate the group. We can use these groups to disseminate information about disasters and recovery, create rituals and ceremonies to honour the lives and livelihoods that were lost, share stories, memories and feelings about the disaster, exploring themes of loss and meaning and build on stories of resilience (Dembert & Simmer, 2000).

Example of community exercise

Hosting events where community members can share stories and memories of those who have been lost can foster a collective remembrance.

We can organize

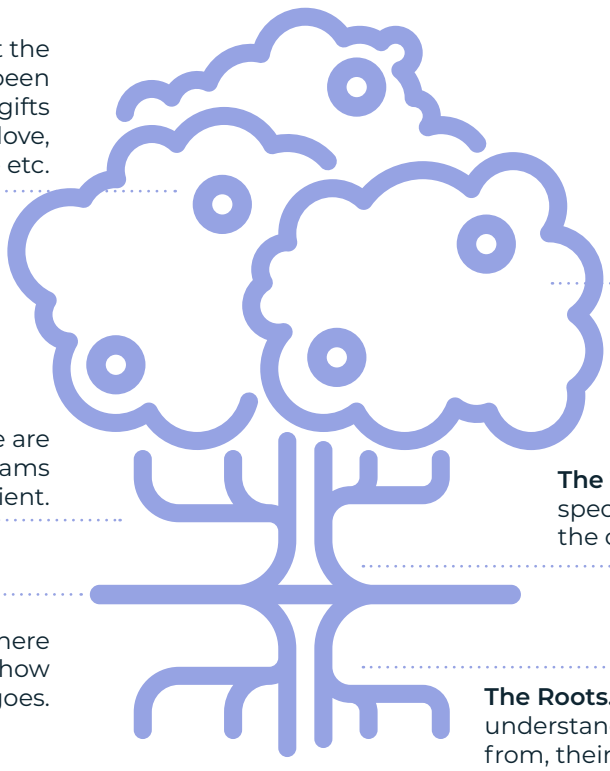
- **Story Circles:** Organize small groups where individuals can share personal stories and memories in a supportive and respectful setting.
- **Digital Memory Archives:** Create online platforms where community members can contribute stories, photos, and videos to preserve the memories of loved ones.

In the aftermath of the Grenfell Tower fire in London, community events were organized where survivors and relatives shared their memories of the victims, helping to keep their stories alive and fostering community solidarity (BBC News, 2018).

2.3 RECONNECTION

The last stage is accompanied with a state of trust, feeling in charge of our own self and staying connected with others. It helps them maintain and respect the boundaries of others (Herman, 1992). This allows clients to deepen their relationship with others by drawing upon their own initiative, energy, and resourcefulness. Many clients may also want to transcend their relationships and engage in social action. While most clients at this stage may not require our help, we can still consider the following strategy to help them transverse this stage.

The **TREE OF LIFE METAPHOR** (Ncube, 2006) includes the following parts:



The Fruits. These represent the gifts that the client has been given, including material gifts as well as acts of kindness, love, care etc.

The Leaves. These are the significant people in the client's life.

The Branches. These are representative of the hopes, dreams and wishes of the client.

The Trunk. This represents the special and precious memories of the client.

The Ground. This represents where the client is at present and how their daily life goes.

The Roots. This prompt helps in understanding where the client comes from, their family, their origins etc.

For communities and groups, we can focus on exploring new collective identity and strengths by helping members identify shared values, cultural traditions, and some resilience stories which serve as sources of support and solidarity (Kaniasty & Norris, 2008). We can also foster a sense of empowerment and agency by encouraging them to take on advocacy roles to address systemic issues and promote positive change. For example, communities can be mobilized to advocate for better disaster preparedness in their area.

Reflective Exercise

- What are the unique challenges for stages 2 and 3 that we can envision?
- What could be our markers or indicators for understanding when the client may need to review strategies for the first stage?
- How do you think the stages 1, 2 and 3 of recovery may be experienced by the counsellor?
- What unique skills and requirements may be asked of the counsellors in each of these stages?

3

POST-TRAUMATIC GROWTH (PTG)

Evidence for personal growth during suffering or following adversity have been found in philosophical, existential and psychological literature. Post-traumatic growth (PTG) is one such positive transformational change that some individuals experience after a major life crisis or traumatic event. PTG has been defined as "positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life circumstances" (Tedeschi & Calhoun, 2004). It may occur in a variety of areas such as finding new opportunities and possibilities for personal development and relational capacities that were not present before the crisis. For example, people may feel that they have become closer to people they care about or have an increased sense of connection to others who have gone through deep suffering. They may also feel a renewed sense of their own strength and appreciation for life in general. Some individuals may also find growth in their religious or spiritual beliefs.

We as mental health professionals may facilitate this process by asking strengths-based questions (discussed in Section -3; chapter 11). We may also ask clients to engage with their values. Values are freely-chosen ideas that can give us purpose and direction in life; they act as a compass for guiding our actions and decisions (Plumb et al., 2009). We may want to check with the clients, the

values they live by. A question that may help can be, “Which value do you identify with the most? How can you remember this at all times?” Helping clients live a life aligned with their values help in promoting a sense of purpose and meaning in their life.

Reflective Exercise

- What are some of the values that we espouse in our personal and professional identities?
- How can we facilitate the process of vicarious post-traumatic growth for us as counsellors?

Let’s avoid...

Working with clients in a triggered state ourselves. It is important to remember that trauma work is guided by regulation of the counsellor themselves. If we are in a triggered state we cannot be present for our clients and may risk re-traumatizing them.

Hurrying through the stage of safety and stabilization. The first stage of trauma work, that is, safety and stabilization remains the most crucial stage and sets up the work for further intervention. Missing out on this stage or not rooting it firmly in the intervention plan places the client at risk for worsening of their condition.

Considering stages as being separate instead of continuous. The presentation of the client’s difficulties requires us to astute in our observations as well as flexible in our approach to work with them. It may require us to go back to reviewing strategies in the first stage even when the work has started for grief and mourning.

Not nurturing the growth narratives of the clients. Identifying pathways of resilience and growth are important considerations for us as counsellors. We must be vigilant to these narratives and expand on them. However, care must be taken that we do not consider post-traumatic growth as an expected outcome for the clients and force its presence in client narratives.

Self-care Exercise

The counsellor who commits to trauma work also commits to an ongoing contention with self. They must be able to access interpersonal and intrapersonal resources. Sublimation, altruism, and humor can be used to be more present in trauma work to engage an enriched life by appreciating life more fully, taking it more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of their clients' courage, determination, and hope. We can use a compassion tool-box which may consist of:

- Compassionate scent, for example, a bottle of perfume or a scent soaked cloth
- Compassionate objects such as stones or shells
- Drawing of a perfect nurturer
- Something in their favorite color
- Copy of new compassionate version of themselves exercise
- Pictures of loved ones smiling
- Important letters
- Copy of compassionate story of their lives
- Compassionate letter to themselves

Tips for Supervisors

Working with trauma means that we have to be careful with understanding our own style of supervision. It may be helpful to keep the following considerations in mind:

- **Establishing trustworthiness:** Transparent decision making and supervisee inclusion in process by having regular, open and honest communication.
- **Encouraging collaboration and mutuality:** Reducing power differences between clients and staff and between staff members/employees by collaboratively discussing the plan of action instead of didactically telling them what to do.
- **Fostering empowerment:** Acknowledging survivors voice and strength in determining choices by listening to supervisee feedback and encouraging and supporting supervisees

This chapter provides an overview of the process of intervention in trauma-informed care. The various modalities of trauma-focused interventions and stages of recovery as well as the strategies were discussed. The next chapter will focus on the specific strategies that will help alleviate trauma-related symptoms.

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CHAPTER 6

6 Mental Health and Psychosocial Interventions for specific trauma responses during disasters.

In the previous chapter, the phases of working with trauma were discussed. In this chapter the focus is on interventions that can be carried out with specific responses that individuals with histories of trauma may present with. It is important to note that while there are a lot of interventions listed here, we need to use our own discretion in using them. As we have explained to clients, the reasoning part of the brain, the PFC goes offline when threat is present (real or perceived), and the emotional brain takes over (see the detailed explanation in chapters 3 and 5), the first focus will be on helping clients feel safe and getting them back in their window of tolerance. Thus, we will use the techniques to regulate arousal first before using other techniques which require us to work with our rational mind.

The list of these responses is not exhaustive and it is possible that counsellors may come across certain responses that are not discussed in this chapter. Supervision and further training may be helpful in understanding working with these responses.

1 REMINDERS OF TRAUMA MEMORIES

Memories, images, smells, sounds, and feelings associated with the traumatic event may come back to the individuals and makes it difficult for them to stay in the present. These may present as unwanted, frequent, distressing visuals, memories or nightmares of the traumatic event. People may feel as though the events were happening again (flashbacks) and become highly distressed. It is possible that physical signs such as sweating, heart racing, and muscle tension may be present. This may lead to other emotions such as grief, guilt, fear or anger.

In order to assess the presence of reminders of trauma memories, we may ask, “Do you remember …. (using the language of the client for the traumatic event) repeatedly?”; further we can ask, “Do you have dreams about the event?”. In order to understand flashbacks better, we may want to say, ““Do you feel that event comes back to you as if you are re-experiencing it? or as if it plays as a movie in front of you?”. This can be followed up by another question like, “Do you feel that when the event is mentioned, you feel very distressed and it is difficult for you to come back from it?”

In order to help clients regain a sense of control or mastery, we can use the following interventions:

1. **Psychoeducation** helps clients understand concepts such as flashbacks. We may say, *"Intrusive thoughts or feelings may appear to us as flashbacks, dreams, or memories of the trauma. They may come to us when we do not want them and upset us. The reason these memories make appearances is to allow the mind to process the traumatic event by going over them again and again. This is the mind's way of understanding and resolving these important experiences. Even though this may seem strange to us, it is quite useful in helping us learn about our experiences and to sort through them."*

2. Having nightmares may disturb sleep. For sleeping well, we can develop a **"sleep kit"** (Boon et al, 2011) with the client. It is a real or imagined box which we can ask the client to fill with those items that help them to relax and calm down and bring them back to the bed. It can be used before going to sleep or during the night if the client gets up feeling anxious or triggered. It can consist of relaxing and soothing music or sounds (stored in a playlist), anchoring items such as a special pillow or blanket, favorite pieces of clothing, a toy stuffed animal, a book that the client enjoys, photographs of people who are important to them, or of safe places which may relax them and a list of people they can call if needed during an emergency. It can also contain a guide with prompts that include:

- Describing what helps them unwind and prepare for bed.
- Listing activities that need to be avoided before bedtime.
- Bed-time routine to be followed.
- Checking in with oneself about what is needed before going to sleep.
- Obstacles and the ways to manage them.

Practice Exercise

Mrs R comes to us at relief centre for people who went through the earthquake. She says that she gets nightmares of that night. She reports that she is not able to sleep once she has the nightmare, which happens at least two to three times in a week. Due to these, she is starting to feel scared to fall asleep. She has not been able to sleep properly.

- What do you think is the reason for Mrs. R's nightmares? How would you explain it to her?
- Which strategy would you like to use with Mrs. R?
- How would you introduce the strategy to her?

2

ANY AVOIDANCE BEHAVIOUR

Memories and reminders of traumatic events can be very distressing and unpleasant and thus, people with histories of trauma often avoid situations, people, or events that serve as reminders. They try not to think about, or talk about, what happened, and even avoid their feelings about the traumatic event. This may result in withdrawal from their families, friends and society as well. They may not be willing to take part in activities they used to enjoy earlier for the fear of being confronted with triggers. They may feel even more isolated. They may also start feeling unmotivated to do things and feel hopeless about the future for this fear. This fear also maintains avoidance as the more the fear, the more is the avoidance. Overcoming this fear will be important for helping clients re-experience their life fully.

> *In order to assess avoidance, we may want to ask questions such as, "Do you feel that you are constantly avoiding some experiences? For example ; thoughts, memories, feelings or even people or places that remind you of the traumatic event?"*

Once the client begins to recognize avoidance, we can offer them the following interventions:

1. **Psychoeducating about avoidance**. In order to help clients understand what is avoidance and why it occurs with respect to trauma memories, we may say,

> *"A common experience is avoidance of all thoughts and reminders of the traumatic event. We often want to put those things aside which are distressing to us. We may feel momentarily better because we are distracting ourselves from this distress. However such avoidance actually prevents us from getting over the experience."*

We can highlight how avoidance ultimately leads to increased distress. We may say,

> *"When people go through difficult times, they tend to avoid thinking about them. It may help them feel less distressed. It is understandable why they would avoid thinking about this. But, it is not very helpful in the long run. Avoiding traumatic memories or reminders prevents us from understanding and processing these memories. Avoidant information tends to come back to us in distressing ways, such as nightmares or flashback memories. Let us do an experiment to verify this. Please sit back, and close your eyes. Try to imagine a pink elephant. Can you see it in your mind? Now please try to stop this image. Do not think of the pink elephant. Do not let it enter your mind. What happened? Were you able to suppress it? This is what happens to traumatic memories as well. Hence we will focus on these memories."*

Here we can ask about some instances from their lives where exposure has helped them in their daily lives. We can say,

> *"Have you ever confronted something you feared? What happened then?" We can continue our psychoeducation then and say, "We are going to tackle them head on. We will have to do this again and again so that our mind gets used to this? Have you put your hand in warm water? When you first put it inside, it feels very hot. But if you keep it in the water, our hand gets used to it and feels comfortable. Similarly, by focusing attention on our memories, we will get used to them and they will*

> *not be so distressing. It is possible that this may still sound scary. It is like exercising, we will not be able to understand the experience till we do not do it. To use another example, imagine when you first wake up from sleep to a room full of light. At first the light is very bright and we are not able to see anything. But after a few moments, we are able to see well. It's the same with memories. When we first think about them, they will be distressing, but after we stay with them for a while, we get used to them and feel less overwhelmed."*

2. Traumatic stimuli may be avoided even before the fear that they may generate is registered in the body. An important step will be helping the clients in identifying the bodily sensations associated with fear so that they can plan for further interventions. Many **body scan meditations** are freely available online. This script is adapted from the one available on the website va.gov. We may say:

> *The body scan practice helps you become more aware of how all parts of your body are feeling. When you first start this practice, it may be helpful to go to a quiet location. Find a comfortable position, lying on your back with your eyes closed. Take five breaths, feeling your stomach expand as you breathe in and relax as you breathe out. Now notice how your body feels as a whole, try to understand what information is your body giving you? Is there any area of tension overall? Now begin to focus on each part of your body in order. We can start with the toes of your left foot. What do you feel? Cool air? A bed sheet? Your socks or shoes? It is possible that we may not feel anything; it is OK. Take a deep breath and end your focus on your toes. Next step is to move to the sole of your left foot. Again, what do you feel? When you are ready, take a deep breath, and now shift your focus from your foot to the next part of your body. We will then go to the left ankle. Repeat the process. Focus and allow yourself to hear your body. Take a deep breath and move to the left shin; then to the left calf; left knee; left thigh; left hip; pelvis; repeating all the steps. Now shift your attention to your right foot and leg (as you did the left) and then once again return to your pelvis. Next we move to the belly and then the back--lower, middle, and upper; moving to your chest and then to our hands. Notice your left fingers, your left hand, wrist, forearm, upper arm, shoulder. Move*

> *to the right hand and arm (as you did the left). We will then move to your neck, face, scalp and top of the head. During this process, when your mind wanders, be gentle with yourself, knowing that this is what minds do. Take a breath and refocus where you left off. End the practice by returning to your breath. Take five breaths, noting the rise and fall of your belly.*

3. We can also focus on **identifying emotions related to avoidance** (Cucu-Ciuhan, 2015). Identifying and labelling emotions may help us in addressing them. Common examples of emotions which lead to avoidance include anxiety, anger, guilt, and shame. For anxiety, we may want to label anxiety and validate their fears. We may also help them understand that anxiety is external to them; the anxiety is the problem, the person is not. Additionally, acknowledging the contextual factors that might be responsible for maintaining anxiety is important. Similarly, for anger, understanding and validating the anger is important. We can also try to identify secondary emotions, that is, emotions which may be accompanying the angry response such as guilt.

4. Identifying and labeling guilt and shame can help clients understand their emotions. Considering trauma tends to make clients feel out of control, one of the ways of taking control is self-blame and shame. Shame and self-blame are natural human tendencies especially when confronted with relationships where we both fear and are dependent on the person (Lee & James, 2013). It helps in seeing the world as meaningful and finding some reason for bad things to happen in life. **Validating and psychoeducating about the function of guilt** can help clients contain it.* For psychoeducating about the role of shame and guilt, we may say,

> *"We may try to understand why the disaster happened to us and our community, and how to prevent it from happening in the future. This may evoke feelings of self-blame, guilt or shame which is different from the emotions such as fear, anger, or sadness which come naturally in disasters. Shame and guilt help us in trying to find some reason for*

*Some strategies for containing anxiety (chapter 4), regulating anger (chapter 6) and assuaging guilt (chapter 7) are found in the manual at xxx.

> *this disaster. However, this process does not provide us complete information as inherently disasters are outside of our control".*

5. For shame, using a compassion-focused approach may be helpful. An example of using compassion-focused intervention can be helping the client understand that avoidance, shaming and blaming self actually aids our suffering rather than alleviating it (Lee & James, 2013). We can ask the client what they think is the **function of the shame.** We may ask,

> *"If I could take away this emotion, what do you think will happen?"*

This may elicit the function of the emotion (Gilbert & Procter, 2006). Once this function has been established, we may then ask the client to take an imagery exercise. One way of doing this is to create a perfect nurturer. We can **create a perfect nurturer** by asking our clients certain questions like:

- How does your perfect nurturer look? Describing the physical attributes of the perfect nurturer.
- How would they sound? If the client cannot come up with a response, we may suggest some prompts: calm, soothing, strong
- How do they smell? Does this smell feel familiar to you? Can you identify it in your surroundings?
- How can your perfect nurturer comfort you? Some prompts can be: by offering unconditional acceptance? Non-judgmentality? Warmth, care, kindness? Strength and wisdom? Hope?
- What does the perfect nurturer want for you?

Practice Exercise

As a result, Mrs R has been avoiding sleeping. She tries to keep herself busy throughout the day and tires herself so much that she should directly fall asleep. She avoids her bedroom and prefers to sleep on the floor in the kitchen. She has also been avoiding seeing her children at the time of sleeping so that it does not start reminding her of how desperate she was while searching for them. Her children miss her and often cry. In order to avoid hearing their cries, she puts on her earphones something she feels very guilty about.

- What do you think is the reason for Mrs. R's avoidance? How would you explain it to her?
- Which strategy would you like to use with Mrs. R?
- How would you introduce the strategy to her?

3 HYPOAROUSAL

It is possible that clients may feel a sense of hypoarousal, that is when they feel like they are not able to listen, feel lost, unable to pay attention to conversations. We may assess different ways in which hypoarousal by asking questions related to

1. Decreased interest in activities that were once enjoyable to the client. We may ask,

> *"What do you enjoy these days? [if the client says nothing, we may further ask] What did you enjoy before the event occurred? Do you still enjoy it?"*

2. Feelings of alienation, estrangement, or detachment from others. It may be helpful to start with an open-ended question such as

> *"how would you describe your relationships with your loved ones currently?"* on further probing, we may ask, *"do you feel connected to them?"*

3. Persistent inability to experience a positive emotion such as happiness, satisfaction, or love. We can assess this by asking,

> *"are you able to feel happy? Do you feel a sense of achievement when you succeed at something? Are you able to feel love?"*

We can help clients who seem hypoaroused by:

1. **Identifying and labelling emotions** is the most important part of the intervention. Along with managing the emotions described above, it is important for us to address the need to create opportunities for generating positive emotions. It is important for us to provide warmth and kindness to inner experience. In this context, we can use the **loving kindness meditation** (Shapiro & Carlson, 2009). It is freely available online. One such example that can be shared with the clients is given below:

> *"Begin by getting yourself comfortable and connecting with your body and bring your attention to your breathing. Follow your breath as it comes in, and then out of your body, without trying to change it. Simply be aware of it, and any feelings associated with it. Give full attention to each in breath and then to each out breath. Being total here in each moment with each breath. If distracting thoughts arise, acknowledge them without becoming involved and return to the practice. Take a moment now to consciously set an intention for this practice, some examples are: "to cultivate loving-kindness", Bring to mind a person whom you are happy to see and have deep feelings of love for. Imagine this person sitting in front of you and notice the feelings you have for them arise in your body. It may be a smile that spreads across your face, it may be a warmth in your body. Whatever it is, allow it to be felt. Let go of this person and continue to keep in awareness the feelings that have arisen. Bring to mind now, and see if you can offer loving kindness to yourself, by letting these words become your words: May I be safe, May I be happy, May I be healthy, May I live in peace, no matter what I am given, May my heart be filled with love and kindness. Notice the feelings and sensations that arise and let them be".*

2. An important intervention for working with dissociation is understanding the dissociative part, derived from the Internal Family Systems model (IFS; Schwartz, 1995). In this system, we understand that we are all comprised of different 'parts', wherein each part has its own feelings, experiences and a role to perform, just like a team or family. We can think of the Self as a wise, compassionate and calm presence which has the ability to understand all other parts just like a leader or a captain. We can help clients in identifying these parts and strengthen their connection to the Self. When dissociation happens, it is because some part has shut down in the face of pain. We can help clients identify these parts, approach them with a sense of curiosity about their roles, rather than fear or judgment. We can try to understand why these parts are behaving in this way. Once we learn their role, we may be able to show some compassion to them. We can for example, thank the dissociative part for protecting the client from the pain and assure the part that we now have the resources to deal with the pain. Hence the part can stop protecting us from the pain. Questions that can be asked after **psychoeducating about the protective role of dissociation** (Lynch et al., 2015).

- What emotions do you numb or not feel?
- What makes it easier not to feel these emotions?
- What do you think would happen if you had to feel these emotions? (can be anger, sadness and even joy)
- How do you think this affects your relationships? What emotions would you like to feel again?

3. Maintain an **emotion expression diary** may also help clients identify emotions. This means that we use prompts for sadness, happiness, anger and fear and ask the client to fill the diary with instances when they felt these emotions over the course of the week.

4. **Healthy mind platter** (Rock et al, 2012) is a metaphor to imagine the needs of a healthy mind. It includes the following components:

- **Sleep:** Sleep and rest help to consolidate learning and recover from the experiences of the day. It helps in improving concentration, emotional wellbeing, learning and behaviour.

- **Physical time:** Movement strengthens the brain in many ways. Exercising improves mood, reduces stress and anxiety and increases focus.
- **Focus time:** Focusing on interesting tasks such as solving problems, journaling, reading and taking on challenges help in making deep connections in the brain.
- **Play time:** This involves engagement in spontaneous and creative experiences such as joking, being silly and having fun also helps us in promoting positive emotions.
- **Connecting time:** This includes connecting with other people, or taking the time to appreciate connection to the world around by expressing gratitude and a sense of contributing to the world.
- **Down time:** This involves engaging in activities without any focus or specific goal, and letting the mind wander or simply relax
- **Time in:** This involves internal reflection that is, focusing on inner sensations, images, feelings and thoughts, through mindfulness and self-awareness activities.

Reflective Exercise

As her guilt and avoidance increases, Mrs. R finds herself feeling low and agitated with herself. She feels very ashamed about the way in which she has been behaving in the aftermath of the earthquake but finds herself unable to change anything. She feels more and more hopeless and believes that this is how she will be for the rest of her life now.

- What do you think is the reason for Mrs. R is feeling the way she is? How would you explain it to her?
- Which strategy would you like to use with Mrs. R?
- How would you introduce the strategy to her?

4

HYPERAROUSAL

Clients may also show hyperarousal responses such as persistent physical sensations of tension: tenseness, agitation, restlessness, impatience, and feeling constantly on the alert. It also includes jumpiness, easily startled, and hypersensitivity to what is going on around you, irritability, outbursts of anger or rage, emotional outbursts, serious difficulty falling asleep or frequent waking and concentration and attention problems.

Any perception of threat by our bodies and minds results in some changes in the body. We increase some body responses and decrease the others. For example, digestion is slowed down while heart rate and breathing increase. We are shifting from a "normal, everyday" state where our tasks are to love, learn, work, and play, to another state of high alertness where we are hypervigilant and looking out for threats and preparing for the fight, flight, and/or freeze response. These lead to a state of hyperarousal.

In order to assess these changes in reactivity, we can questions such as:

> *"Are you experiencing any difficulty in sleeping? Are you able to sleep on time? Do you find yourself waking up while sleeping? Do you feel fresh after waking up?"*
>
> *"Do you feel like you have been getting angry more often? Does it feel like you get angry for no reason?"*
>
> *"Do you feel like you are constantly alert? Do you find it difficult to relax?"*
>
> *"Do you find it difficult to concentrate? Do you get distracted easily?"*
>
> *"Are you getting startled easily? Do you feel that you are on edge all the time?"*

We can help reduce hyperarousal through the following means:

1. **Psychoeducating about hyperarousal.** We may say,

> *"Many people may report sleep, and concentration related difficulties, feeling restless and irritable, or being very preoccupied with the future. These problems reflect the body's state of heightened*

> *arousal where the body is constantly trying to be aware of threat. This interferes with daily functioning as the body still thinks it is under threat."*

2. We can another strategy called the **opposite action** (MacKay, et al, 2007). This means that we ask the client to do the opposite of what they would like to do. We explain the wave metaphor of emotions. We can say,

> *"Emotions are like waves in that they rise in intensity, peak and eventually crash. They ebb and flow in their intensity. If we do not act on them or do anything to aggravate them further, they subside in time".*

   We can then ask the client to do the opposite action to these emotions, so that they can subside in the meantime. For example if the client says that they are so angry, they would like to shout at someone, we explain the wave metaphor and ask them to do an action opposite to that, such as asking them to sit quietly and focus on their breath. It is important not to invalidate the client's emotions at that time.

3. Another strategy is a mindfulness exercise called the **RAIN Dance** (Reutter, 2019). RAIN is an acronym for Recognize, Allow, Investigate, and Nurture. The first task is to recognise the emotion. It can be recognised by physiological reactions for example, anger may be experienced in the body as clenched fists. The next step is to allow the emotion. This means that instead of judging or fighting the emotion, we allow it to come. Emotions can be imagined as waves; just like waves they come and go. The next is to investigate the context of the emotion. Showing curiosity towards, what made us angry? What could have triggered us? Am I more upset than usual? And lastly, we can use some of the coping strategies discussed in chapters 4 and 6 to work with anxiety and anger.

Reflective Exercise

Due to the lack of sleep and the constant need to avoid her guilt by avoiding her children, she feels on the edge. She feels like she has no energy to do anything but when her children call for her and ask her to do things with them, she gets very angry with them. it is as if they cannot see how tired she is and how she does not have the strength to help them. At the same time, she also feels very anxious when she feels that her children will be distant from her. She does not know what to do further.

- What do you think is the reason for Mrs. R's anger? How would you explain it to her?
- Which strategy would you like to use with Mrs. R?
- How would you introduce the strategy to her?

It is important to note that we may have to provide referrals to clients who continue to show significant distress and impairment after some time has elapsed post disaster. We can use the checklists provided in Chapter 2 to assess if the client has symptoms of a diagnosable disorder. We can then refer them to therapists who are trained in trauma-focused therapy for further assessment and interventions.

Let's avoid...

Considering ourselves the expert of the client's life circumstances. It is important to remember that trauma manifests in different ways and we cannot predict how the client is expected to react.

Trying to offer strategies for the experiences of the client without asking them about it. It is important to first hear the client, assess the symptoms and then link it to the intervention.

Underestimating the influence of the client's unique strengths for managing their experiences. Clients may have tried a number of strategies to cope and it is important for us to check in with them about the strategies that they may have tried before we suggest other strategies to them.

Negating our internal experience. Working with trauma is difficult. It is important for us to be aware of our internal experience and cater to our needs before we help others. If we are experiencing hypervigilance, we cannot co-regulate with the client. If we are dissociated, we cannot be present with the client.

Self-care Exercise

We can use any of these strategies mentioned in the chapter to take care of ourselves. Another way of taking care of ourselves is to develop a compassionate version of ourselves (Lee & James, 2013). We can ask ourselves the following questions:

- If I were compassionate to myself...
- How would I think about myself?
- How would I think about others?
- How would I behave towards myself if I was struggling?
- How would I behave in my life in general?
- What would I have in life?
- What would I want for my future?

Tips for Supervisors

This chapter discusses the key interventions for working with specific aftermaths of trauma experience. Sometimes, it is important to reignite meaning in the work. We may want to help the supervisee to reflect on the following:

- Why did I choose this work?
- What have I gained and/or learned from my clients?
- What has changed in my life since becoming a counselor?
- What are my strengths as a counselor?
- How have I changed as a result of my work with clients?

Specializing in trauma-focused therapy

The APA has suggested the following trainings with strong and conditional evidence for treating PTSD when there is a need to work with clients with histories of trauma long-term therapy:

Cognitive–behavioral therapies (CBT)

Cognitive processing therapy (CPT)

Exposure therapy

Eye movement desensitization and reprocessing (EMDR)

Narrative therapy

Skills training in affective and interpersonal regulation (STAIR)

Dialectic Behavioural Therapy (DBT)

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Thank you!