Mental health in disasters: the psychosocial approach

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Psychosocial and community-based work: some notes on a transversal concept

Regarding mental health work, the psychosocial or community-based model results from two fundamental public health concepts. First, it focuses on improving health rather than on fighting illness; putting the emphasis on preventive medicine and on alleviating conditions which increase people’s vulnerability. Second, it encompasses those situations which increase vulnerability that contributing to community imbalances and strengths. Along these lines, violence (Fournier et al., 1999; Kleinman et al., 1995), disruption of the social bonds, or the economic or political discrimination of certain population groups can be considered to be public health issues. The Pan-American Health Organization describes two possible mental health work models: a clinical model and an epidemiologically-based community model. We can in fact consider these different models, as shown in Figure 1. As these models complement one another, the problem does not so much lie in what model should be chosen. The point is: given the available - usually limited - resources and understanding that the three work models are inseparable and interrelated, where should we put the emphasis? Which one should we start with? e.g. when intervening in a humanitarian emergency situation. Two diagrams can help us understand a clinical approach (Fig 2) and a psychosocial or community-based approach (Fig 3).

Choosing between these two approaches will depend on three criteria. An ideological criteria: How do we understand health and illness and their connection with social issues? A cost-effectiveness criteria: With the available resources to implement a program in a crisis situation, what activities will help us to widen our coverage rate? Which approach will be more beneficial for the population in the short, middle and long term? And a time criteria: probably during
the very first days of a crisis, the number of people feeling shocked and disturbed will lead to an individual psychological intervention targeting affected people as well as organizing activities. The programmes are based on specific, clear guidelines given by leaders or authorities.

Along these lines, psychosocial care should not be understood as a complementary activity to those addressed to assist the victims, but rather as a transversal concept to each and every decision made within a crisis situation.

Disaster as an example

According to Fritz (1961 : 655), a disaster is an event concentrated in a given time and space, in which a society or a relatively self-sufficient part of it lives in severe danger and loss of some of its members and belongings and in which social structures collapse and all or some fundamental services are impaired (Pfieß & al. 1995). Contrary to other definitions which focus on causal agents or on the dimension of the consequences of a disaster, this definition puts an emphasis on disruption in its widest sense. When we refer to disasters, we include from natural phenomena (floods, earthquakes, volcanic eruptions...) to man-made phenomena (nuclear accidents, plane crashes, train derailments, socio-political crisis, war...). The line separating these phenomena is vague, e.g. famine, one of the most important chronic diseases in the XXth century, has a combined origin. The consequences of a disaster are directly linked to the living conditions of the populations that endure them. The same kind of disaster occurring with a similar intensity would provoke 166 dead persons in a country in the South while just 1 in the North.

If we define vulnerability as the proneness of a given community to severe damages as a consequence of a disaster, we can see that most vulnerabilities depend on poverty, but not only depend on poverty (Fig 4). Furthermore if we understand vulnerability not as a static situation but as a dynamic reality in what we call the disaster endemic circuit. A disaster increases vulnerability which, in turn, increases the consequences of new disasters and so on (Fig 5).

This is why, assistance in the aftermath of a disaster requires breaking the vulnerability spiral, acting upon the factors mentioned. Along these lines, the reconstruction process should go hand in hand with

development. By development we understand all factors which increase people’s control over their environment (Escobar 1994). This is why, post-disaster mental health work, to a great extent, consists in analysing the psychosocial factors which enable to develop, promote and keep the control and power people can have over their individual and social environment. As a result, this work seeks to bring about environmental and structural changes to minimize the vulnerability factors in case of new disasters and improve endurance powers when facing adverse events. The psychosocial and community-based approach always puts special emphasis on community participation and development (Montero 1984), the fundamental principles of which are: (a) Self-management on the part of the subjects involved, i.e. health workers and the community in such a way that they participate together and influence each other at all possible moments, (b) all the power is in the hands of the community, (c) the theory is valid when connected to actions. It is within the social changing process itself that the ways to minimize risks and vulnerability factors are discussed and compared.

Stages in the history of natural disasters

The following diagrams (Fig. 6 & 7) display a stage model that we propose to define disasters, based on the notion of risks and problems likely to arise and on the strengths we may count on to fight them, putting an emphasis on the community approach when working in disaster situations. The last table (Fig. 8) is a practical application of the above-mentioned theory and show some elements in the organisation of shelter which usually appear to be “technical”, while in fact entail fundamental psychosocial components. It can be used as a tool to understand the two arguments put forward in this chapter: bearing in mind its transversal dimension, a psychosocial perspective should be included in all the activities carried out by the group or the organisation. In post-disaster work, the clinical model and the public health-community reinforcement model complement each other and are no way exclusive. The question lies in what they are focused on and what actions are given priority. Yet, one cannot be understood without the other.

The features of this model, under normal circumstances, are included in the (bio-behavioral) sector. Additional features corresponding to other intervention programs are given in the dark-shaded box.
Fig 3:

Diagram based on a psychosocial or community-based approach.

The features of this model under normal circumstances are included in the (bicolored)-shaded areas. Additional features corresponding to crisis intervention programs are given in the dark-shaded box.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Depending on priority</th>
<th>Not only depending on priority</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical or clinical</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Social</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Stock-piling capacity</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Intervention</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Cultural</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Default procedure</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

Fig 4:

Vulnerability, poverty, prevention.
Fig 5:
VULNERABILITY SPIRAL (BELTRÁN 2001).
Fig 6: STAGE MODEL, RISKS AND STRENGTHS.
Some examples of situations psychologically relevant not usually taken into consideration when organizing shelters.
Bibliography


Martín Beistianu C. Apoyo psicosocial en causas de enfermedades. AVEPSO. Cuzcas; 2000.

