



PROTECTING MENTAL HEALTH DURING EPIDEMICS

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I. INTRODUCTION

In his recent remarks to the 46th Directing Council of the Pan American Health Organization in September 2005, Dr. Lee Jong-wook, Director-General of the World Health Organization (WHO) warned all the attending Ministers of Health from the Americas about the risk of a threat with incalculable health, social, and economic consequences, stating that “failure to take this threat [avian influenza pandemic] seriously and prepare appropriately will have catastrophic consequences.” He also called the certainty of a world avian flu pandemic a “critical moment,” an event of enormous consequences in which “no Government, Head of State, or Minister of Health can afford to be caught of guard.” He continued, stating that “every country must also have a communications strategy. It should be ready and able to inform the public about the pandemic, what is happening, and what to do.”

"Humans will have no chance to develop a natural immunity to a new influenza virus," stated Dr. Lee, referring to the highly pathological H5N1 flu virus, which has already sounded many alarms.

The issue has been discussed as a potential microbial disaster. “As human impact on the earth increases exponentially, the chances for unpleasant surprises from the microbial world will also grow.” “The new virus spreads quickly because no one has any significant immunity to the novel strain, and the illness it causes can be unusually severe.”¹

PAHO/WHO authorities have exhorted the countries of the Region to prepare for the possible emergence of a new strain of influenza capable of producing a pandemic. They have been urged to make contingency plans specific to their circumstances and limitations (availability of appropriate vaccines and antiviral drugs, as well as equitable access to them).

The descriptions above are a preamble for emphasizing the need to assess this threat from a behavioral perspective. Indeed, the responses of the affected population groups and how to address them need to be better understood. Also, active community participation is necessary in preparing and implementing epidemic control measures.

Preparations for an epidemic have traditionally emphasized aspects such as the implementation of national plans, epidemiological surveillance, vaccine and drug requirements, improved vaccination coverage among high-risk groups, as well as the economic impact and burden. Psychological and social aspects were absent from programming.

This is the case, even though many of the problems affecting the population as a whole stem from fear and its multiple expressions. Since the problem affects everyone, it

¹ Peters, C.J. “Hurrying Toward Disaster?” In *Perspectives in Health Magazine*, Pan American Health Organization. Special Centennial Edition, Volume 7, Number 2, Washington, 2002.

makes sense to address it with collective activities. Studies conducted in populations facing a threat that generates fear or terror have shown that more than 80% of the people in obvious proximity to the danger show symptoms of fear or panic.

II. PSYCHOSOCIAL VULNERABILITY

Vulnerability, whether born with it and/or acquired as a result of a traumatic threat or event, is the internal state of an individual or group that causes harm due to a dynamic process in which various factors interact.

The high number of people who sicken and die and vast economic losses associated with an epidemic or pandemic lead to a high psychosocial risk. A rational approach to mental health care implies recognition of different types of vulnerability among different population groups, particularly differences related to gender, age, and socioeconomic status. There are also occupational risks--for example, to the members of response teams working during the emergency.

It should be pointed out that the most vulnerable groups are those that have the greatest difficulty rebuilding their means of subsistence and social support networks during and after the catastrophe.

Below is a list of conditions that generally influence vulnerability. Normally, it is not a single one of these conditions that determines the degree of vulnerability, but rather a set of them under certain circumstances. For example, being a member of an indigenous population does not make a person vulnerable, unless it is combined with other factors.

Conditions influencing vulnerability	Population groups
Age and gender	Boys, girls, and adolescents The elderly Women
Ethnicity	Indigenous populations Minority groups
A history of physical and/or psychological illness	Disabled people Psychiatric patients with a long history of illness and previous psychiatric disorders People with chronic diseases
Economic and social conditions	Groups living in poverty and extreme poverty Marginality in large cities Migrants from the countryside to the city Illegal residents
History of traumatic events	Population groups that have been victims of violence in its different forms Communities that are frequently hit by natural disasters

Working conditions in catastrophes. Examples: working with large numbers of patients, handling corpses, witnessing situations that cause pain	Members of institutional and community response teams
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The losses experienced can affect men and women differently. Social and cultural patterns determine how they will react. For example, men tend to repress painful emotions, and expressing them is interpreted as a weakness. Their emotional response may be to drink heavily or become violent. Women tend to communicate with each other more easily, to express their fears, and to seek support and understanding for themselves and their children.

In some communities, the elderly are a source of experience and wisdom and have a historical memory of how, over time, populations have dealt with critical situations. However, some may run the risk of being vulnerable because they suffer from chronic, disabling diseases and because they are isolated and lack family and social support networks.

Children can also be a vulnerable group; they have less understanding of the traumatic event and are limited in their ability to communicate what they feel. Some children go into complete denial or act with indifference when they learn that they have lost one or more members of their family. The emotional impact is so intense that they often do not speak about what they have experienced. Some adults may assume that the child has forgotten, but this is not the case. Children are able to recall and talk about their traumatic experiences once their fear is under control.

Catastrophes like a large-scale epidemic can lead to violations of children's rights (to health, education, nutrition, recreation, protection, the right to live with their parents, etc.). The situation created by an epidemic affects all aspects of child development (physical, psychological, and social), but generally the people responsible for helping children have concentrated on their physical vulnerability without fully taking their losses and fears into account.

III. IMPACT ON MENTAL HEALTH

Epidemics are health emergencies in which human life is threatened and there are significant numbers of sick and dead. Local resources are generally overburdened, and the community's safety and normal functioning are threatened. As a result, outside assistance is urgently needed. But, as with other catastrophic events, epidemics are also real human tragedies, and thus the grief and psychological consequences also need to be addressed.

In terms of mental health, a major epidemic implies a psychosocial disturbance that can exceed the affected population's capacity to handle the situation. It can even be said that the entire population experiences stress and anguish to some extent. Thus, it is estimated that there is an increase in the incidence of psychological disorders (between one-third and one-half of the exposed population may suffer some psychopathological

manifestation, depending on the magnitude of the event and the degree of vulnerability). However, it should be pointed out that not all the psychological and social problems that occur can be described as diseases; the majority are normal reactions to an abnormal situation.

The effects on mental health are usually more marked among populations living under precarious circumstances, who have limited resources and access to social and health services.

Psychological Disturbances among Survivors

At the individual level, many people can experience a crisis, defined as a situation caused by an external life event that exceeds a person's emotional response capacity. Essentially, that person's coping skills are insufficient, and a psychological imbalance or failure to adapt occurs.

Certain feelings and reactions are common in very emotionally significant situations, such as suffering from a serious disease and/or the death of a loved one. Moreover, the memory of what happened will be part of the victims' lives and will never be erased from their memories.

However, while some psychological manifestations are the understandable and transitory response to living through traumatic experiences, they can also be indicators that the person is developing a pathological condition. The assessment should be made in the contexts of the facts, determining whether these manifestations are "normal or expected," or, on the contrary, if they are psychopathological manifestations requiring professional assistance.

Some criteria for determining whether emotional expression is turning into a symptom of something else include:

- Prolonged suffering;
- Intense suffering;
- Associated complications (suicidal behavior, for example); and
- Significant impact on an individual's routine and social functioning.

The most common immediate psychological disturbances among survivors are depression and acute, transitory stress reactions. The risk that these disturbances will appear increases according to the circumstances surrounding the losses and other vulnerability factors. An increase in violent behavior and excessive alcohol consumption has also occasionally been observed in emergencies.

Some of the delayed effects reported include pathological grief, depression, adjustment disorders, manifestations of post-traumatic stress, abuse of alcohol or other addictive substances, and psychosomatic disorders. Patterns of prolonged suffering are also manifested as sadness, generalized fear, and physically expressed anxiety—symptoms that frequently become serious and long-lasting.

Adjustment disorders are characterized by a state of subjective discomfort, emotional alterations affecting social life, and difficulty accepting the changes wrought by the loss.

Post-traumatic stress (or certain symptoms of it) appears later or is a delayed type of disorder brought on by exceptionally threatening or catastrophic events; experiencing a major epidemic, particularly for people who have experienced major losses, can trigger post-traumatic stress symptoms.

Grief

Sadness, suffering, and grief are expected following the death of one or several loved ones. The grieving period is when the person assimilates what has happened, understands it, overcomes it, and rebuilds his or her life. This is a normal process that should not be rushed. Neither should one seek to eliminate it or regard it as a disease.

All societies have rites, standards, and ways of expressing their grief based on their different concepts of life and death. Performing the rituals established by the collective culture is an integral part of the survivors' recovery process.

Grief is experienced as a mixture of sadness, anguish, fear, and anger. At its most critical point, it reaches the extremes of very intense emotional pain and despair. Afterwards, gradual relief comes, and the process ends with expressions of renewed confidence and hope. The grieving process implies:

- Freeing oneself from or leaving behind the relationship with the deceased person;
- Adapting to the world under other conditions; and
- Making efforts to establish new relationships.

Facing the loss and grieving appropriately is closely linked to the following factors:

- The survivor's personality and coping mechanisms;
- The relationship with the deceased person;
- Circumstances in which the death occurred; and
- Social support network (family, friends, and community).

The most frequent psychological manifestations of mourning are: very vivid and repetitive reminders of the deceased and what happened, nervousness, fear, sadness, weeping, desire to die, sleep and appetite disturbances, memory and concentration problems, fatigue, apathy and difficulty resuming normal activities, little motivation and difficulty returning to a normal level of activity, tendency toward isolation, mixed feelings or emotions (such as self-blame, blaming others, frustration, impotence, anger, feeling overwhelmed, etc.), neglect of personal appearance and hygiene, and various nonspecific physical manifestations (such as dizziness, nausea, headache, chest pains, tremors, difficulty breathing, palpitations, and dry mouth).

In a major catastrophe, grieving means dealing with many other losses and implies a broader, more community-oriented feeling. It implies interrupting a life plan that not only has a family dimension, but also a social, economic, and political one.

Complex grieving is grieving that does not progress “naturally” and becomes pathological. It normally leads to a depressive disorder characterized by deep sadness, loss interest and the ability to enjoy things, reduced activity levels, and extreme fatigue. There are other symptoms, such as decreased attention and concentration, loss of self-confidence, feelings of inferiority, guilt, a bleak future outlook, thinking about or attempting suicide, sleep disorders, and loss of appetite.

Many circumstances can make facing the grieving process more difficult, but personal vulnerability and the scope of the loss can be cited among them. Complex mourning frequently leads to the appearance of psychiatric disorders that require more specialized interventions.

In epidemics and situations involving mass fatalities, several authors have described the survivors’ fears and feelings:²

- Grief and distress due to the loss of family members and friends which sometimes coincides with material losses. There are also more subtle and sometimes intangible losses, such as loss of faith in God, loss of the meaning of life, etc.;
- Practical fears: having to assume new roles imposed by the disappearance of a family member (for example, the widow who becomes the head of the household, or the widower who must take charge of the children);
- Recurrent fears that something can happen again or that death will befall other members of the family or community;
- Personal fear of dying: fear of the unknown or fear of facing God;
- Feelings of loneliness and abandonment: it is common for survivors to feel that family members and friends have abandoned them at a difficult time;
- Fear of forgetting or being forgotten;
- Anger toward the deceased, which is taken out on family members or close friends;
- Some degree of guilt for someone’s death; sometimes, what happens after the death of a loved one increases this guilt;
- Shame following the death of a loved one because of circumstances surrounding the death of that person (your behavior, humiliation, etc.); or shame about the conditions in which a family is left following a disaster.

IV. MENTAL HEALTH CARE

² PAHO/WHO. *Management of Dead Bodies in Disaster Situations*. Published by PAHO/WHO. Washington DC, 2002.

Experience shows that mental health plans cannot be limited to expanding and improving the specialized services offered directly to the people affected; rather, the perspective needs to shift toward a much broader area of expertise.

For example, emphasis can be placed on the relationship between mental health services and a broad range of activities, such as:

- Humanitarian and social assistance;
- Counseling for the population and at-risk groups;
- Mass communication.

It has also been recognized that following major catastrophes, prolonged care is needed for the mental health problems of survivors while they face the task of rebuilding their lives. This raises the need for devising medium- and long-term psychosocial recovery plans.

In terms of care, three time periods (before, during, and after the epidemic) can be identified, along with four groups of people:

- The sick;
- Those who had the disease and survived;
- Those who are not sick, but could get sick, and who have experienced major losses (death or illness among family members, friends, or neighbors); and
- Members of the emergency response team.

Mental Health Actions by Time Period

Period: psychological and social manifestations among the population	Mental health actions
<p><u>Before:</u></p> <ul style="list-style-type: none"> - Expectation of the inevitable high level of stress among the population - Over- or under-estimation (denial) of the potential epidemic - Exaggeration of preexisting personality traits (positive and negative) - Anxiety, stress, insecurity, and hyper vigilance for symptoms of the disease 	<ul style="list-style-type: none"> - Communication of risk to the population, emphasizing vulnerable groups. - Sensitization about and information on the subject - Location of competent mental health personnel - raining of mental health teams and PHC workers in this area - Preparation of emotional support and counseling groups - Identification of vulnerable groups from a psychosocial standpoint - Preventive protection: imposed in an authoritarian manner, if necessary - Promotion of community spirit and community participation - Organization of mental health services for adequate response during the emergency, particularly the formation of mobile teams, crisis intervention units, and liaison services in general hospitals - Interinstitutional coordination - Creation of work networks
<p><u>During:</u></p> <ul style="list-style-type: none"> - Fear and a sense of abandonment and vulnerability - Need to survive - Loss of initiative - Spontaneous leadership (positive or negative) - Behaviors that can fluctuate between heroic and horrible, violent and passive, and sharing or selfish - Adaptation to changes in the normal patterns of living: restriction of movement, use of masks, reduction in direct physical contact, temporary schools closures, etc. - Anxiety, depression, grief, peri- 	<ul style="list-style-type: none"> - Rapid evaluation of the psychosocial needs of the population depending on the specific conditions of the location where the epidemic is unfolding - Support for the basic activities of early detection, reporting, care, and control the spread of the disease - Mass communication: Information and recommendations on: what is happening, what is being done, and what people should do; Transmission of: organization, safety, authority, morale, calm, support, and encouragement - Continuation of in situ training during

<p>traumatic stress, emotional and panic crises, group reactions to disturbances, regression to preexisting psychological disorders, and psychologically-based sleep disorders</p>	<p>the emergency</p> <ul style="list-style-type: none"> – Individual and group support and psychosocial care for affected people, families, and communities – Promotion of self-help and mutual assistance mechanisms, including groups and peer assistance – Recovery of initiative and improvement of self-esteem – Helping to control social disorganization – Emotional first aid from nonspecialized personnel (health and humanitarian assistance), especially for grieving families – Psychiatric care for people with defined mental disorders – Specialized services to deal with the pandemic: mobile groups to work in the community and PHC, crisis intervention units in selected sites (such as morgues, large hospitals, etc.) and liaison services in general hospitals
<p><u>After: the pandemic is under control</u></p> <ul style="list-style-type: none"> – Fear of a new epidemic – Aggression and protests against authorities and institutions – Sedition and/or criminal acts – Social and mental health side effects: depression, pathological grieving, post-traumatic stress, alcohol and drug abuse, as well as violence – Start of a slow and gradual recovery process 	<ul style="list-style-type: none"> – Continuation of a good mass communication strategy to promote recovery – Continuous in-service training for teams of recovery workers – Individual and group mental health services for affected people, families, and communities, as part of a medium-term psychosocial recovery plan (6 months at the very least) – Mental health care for those who helped during the crisis (response team) – Rehabilitation is moving forward and hope is reappearing; new life plans should be strengthened – Consolidation of interinstitutional coordination and community organization – Discussion of experiences and lessons learned

There are three basic messages:

1. We should not think only in terms of psychopathology, but also in broad terms about collective problems.
2. The area of expertise of mental health professionals needs to be expanded.
3. The majority of psychosocial problems can and should be addressed by nonspecialized personnel.

Psychological and Social Care

At first, crisis intervention techniques will need to be used for people who are not sick but are experiencing major psychological reactions. The health and humanitarian assistance workers should be trained in basic emotional first aid techniques. It is especially important to have mental health services with crisis intervention capabilities in the main health centers where the sick are being cared for, creating an entity to provide care for family members and companions.

The following are recommendations for survivors and people who have suffered major losses.

- Treat them as active survivors and not as passive victims;
- Do not medicalize care or necessarily treat people as psychiatric patients;
- Assist them and show concern for their physical safety and health;
- Ensure that basic needs are met;
- Provide emotional support and a sense of connection to other people;
- Ensure privacy and confidentiality in communication;
- Help them vent about or tell their stories and express their feelings;
- Develop a responsible, careful, and patient way of listening among those offering psychological assistance; response team members should explore their own ideas and concerns about death and should not impose them on those they are helping;
- Rather than giving advice, allow survivors to reflect on what has happened and how to face the future; the advice given should, then, refer to practical matters and the available channels of assistance;
- Provide as much information as possible and listen to problems to help solve them;
- Encourage a return to daily life, as soon as circumstances permit
- Avoid the intrusiveness of the press or other groups; and
- Know that spiritual or religious support is usually a valuable way to calm family members.

The criteria for referral to a specialist (psychologist or medical psychiatrist) are limited and specific:

- Persistent and/or exacerbated symptoms not alleviated through initial measures;
- Marked difficulties in family, work, or social life;
- Risk of complications, especially suicide;
- Coexisting problems, such as alcoholism or other addictions;
- Major depression, psychosis, and post-traumatic stress disorder are severe psychiatric conditions requiring specialized care.

Drugs should be used only when absolutely necessary and only when prescribed by a physician. Indiscriminate and prolonged use of psychoactive drugs is not recommended. Certain drugs, such as tranquilizers, have major side effects and can lead to addiction.

The vast majority of cases can and should be treated on an outpatient basis within the family and community context. Hospitalization is usually not necessary. Daily life is where psychosocial recovery begins for people after major traumatic events.

The following is recommended for child survivors:

- A flexible and nonspecialized psychosocial care strategy;
- Viewing the school, community, and family as basic therapeutic forums;
- Having teachers, community workers, women's group's, and young people's groups become agents that work with children;
- Strengthening the training, care, and motivation of the personnel who work with children;
- Group techniques that include games and recreational activities as essential instruments for the psychosocial recovery of children;
- Encouraging a return, as soon as possible, to normal life, including a return to school;
- Taking advantage of widely accepted traditions concerning the care and treatment of affected children.

Basic Principles of a National Mental Health Plan in an Epidemic or Pandemic Situation

- The Plan should NOT be centered only on the traumatic impact (the epidemic disease), but should be broad and encompass the individual and his or her context, and should make use of positive coping strategies with an ideological, cultural, and religious (for those holding such beliefs) dimension.
- Objectives should be realistic and objective. The main goal is prevention (to reduce the likelihood of psychosocial damages).
- Short-, medium-, and long-term actions should be defined on the basis of the objectives established. In carrying out each activity, the responsible party, the implementers, and the dates of completion should be clear.
- Psychosocial intervention should be early, fast, and efficient.
- Work methodologies should be expeditious, simple, concrete, and adaptable to ethnic and cultural characteristics.
- At the outset, a rapid evaluation should be made of the psychosocial needs and of situations where vulnerability is higher; this serves as the basis for action during the initial phase.
- Care should not be viewed only in terms of clinical psychiatric care.
- The plan should create safe environments, promote community life, and support family regrouping.
- Active readjustment should be encouraged, represented by the community's resumption of daily activities like work and school in the case of children.
- Community forums should be created for mutual support, expression, sharing, understanding, and listening where the impact is social, in order to reevaluate it and mobilize resources.

- Workers should listen to the demands of people in their own social or informal settings and not expect them to come to the health services.
- Emotional support should be integrated into the daily activities of organized community groups and be part of meeting the population's basic needs.
- Emotional support should be provided for grieving people, emphasizing culturally accepted funerals and rites.
- The gender approach should be incorporated.
- Partnerships should be forged, and various social actors should participate.
- At the operational level, priority should be given to the group and community without prejudice to the family and individual.
- Flexibility is needed; the psychosocial dynamic in emergencies of this nature is varies widely, which means that every plan should be very flexible.
- Actions should be sustainable in the medium and long term; the goal is strengthen existing services and improve mental health care in the country.

Lines of Action

1. Rapid diagnosis of the psychological and social needs of the population;
2. Psychosocial care by nonspecialized personnel;
3. Direct specialized clinical care for people with more complex psychological disorders;
4. Priority care for groups at greater risk;
5. Training;
6. Health promotion and education;
7. Community organization, social participation, and self-reliance;
8. Mass communication; and
9. Intersectoral coordination.

Organization of Services

Services are organized according to the resources and needs of the country or region in question.

Primary Level:

- PHC team with basic training in mental health, enabling them to deal with simple psychosocial support processes (such as emotional first aid) and to identify and/or refer cases that are more complex;
- Emotional support and counseling services; and
- Outpatient mental health teams (Community Mental Health Centers or others) that offer PHC support, care for referrals, and are mobilized according to need when these services are feasible.

Secondary Level:

- Crisis intervention units (specialized) in selected places, such as emergency centers;
- Mental health units in general hospitals where large numbers of influenza patients are hospitalized (liaison services that serve medical offices).

V. MANAGEMENT OF DEAD BODIES

The presence of a large number of dead bodies following a pandemic generates fear in the population because of inaccurate information about the danger they pose. There is also stress and a widespread feeling of grief; the reigning chaos and emotional climate can result in behaviors that are hard to control. This type of situation requires appropriate psychosocial interventions for the individual and community on the part of leaders.

There is an entrenched myth that corpses are dangerous and should be quickly burned or buried. Accurate information needs to be disseminated about the risks that the bodies (deceased as a result of the epidemic) pose to the health of survivors.

Regardless of the responsible authorities' power to manage the emergency and of the epidemiological reasons that could hurry disposal of the mortal remains, measures should be adopted that respect and take into consideration the customs of the population, avoiding the use of mass graves and cremation, which are generally forbidden by law and violate basic human rights.

The management and disposal of corpses is a problem with serious psychological implications for the family and the survivors, and also entails other political, sociocultural, and health considerations.

Notification of Death and Identification of Bodies

Notification of death can take place in the home, health center, hospital, morgue, or another setting. It is a critical moment and is difficult to handle because it can produce strong reactions. The following are some recommendations for providing notification:

- Prior to notification, compile as much information as possible about the deceased and the event (progression of the disease, complications, etc.);
- Obtain information about the people to notify;
- Make sure that the most appropriate adult family member is the first to receive the news;
- Make notification in a direct and personal manner;
- Have two people make the notification, if possible;
- Observe common rules of courtesy and respect;
- Do not take personal effects of the deceased to the interview;
- Invite family members to be seated. The people making the notification should do the same;
- Observe the surroundings carefully in order to prevent any risks, and be prepared to attend to children or others;
- The message should be direct and simple. Most people will realize from the setting that something terrible has happened, and their agony or anxiety should not be prolonged;
- Be prepared to answer questions;
- Help the family members to notify others, if the family requests it; and

- Listen and tend to the immediate needs of the family, as well as reminding them of their rights.

Notification of death should always be done individually (case by case). Giving information of this nature to a group should be avoided. Where necessary, several teams or pairs should divide up the work.

People (sometimes adolescents) faced with the difficult task of notification and identifying the bodies of family members or friends are exposed to a very traumatic situation. Those going to identify or receive the bodies of loved ones can manifest this trauma through expressions of despair, frustration, and occasionally protest or disagreement with the procedures being used, etc.

Medical and mental health services should be as close as possible to the place where identification of the body takes place to provide physical and emotional support to family members.

Family members usually ask to see the body as soon as possible. The following is recommended:

- The mourners should decide among themselves who will view the remains;
- Do not allow family members to enter the viewing area unaccompanied; it is preferable for skilled personnel to provide them some form of emotional support;
- Offer privacy and respect, so that the family can say good-bye, even allowing them to touch the body;
- Respect any type of reaction that the family members might have at that moment;
- It is almost always necessary to transport family members to the location of the body and ensure their return;
- Provide comfortable conditions and guarantee compassionate treatment at the site where the bodies are viewed.

An important element of dealing with grief is the speedy handling of the funeral, which should be free or accessible to low-income people. Delay in handing over the body and uncertainty over how to pay for the funeral can cause even greater anguish and suffering.

Very often, the authorities do not place a great deal of importance on the problem of funeral services, particularly in the chaos created by an epidemic. However, it is very important for family members, and failure to do so can lead to protests and social unrest.

VI. PSYCHOSOCIAL CARE FOR RESPONSE TEAMS WORKING TO PROVIDE CARE DURING THE EPIDEMIC

An especially vulnerable group includes members of the response teams working during the epidemic and the people in charge of handling dead bodies. Also vulnerable are the people responsible for conducting autopsies; they feel overwhelmed and over-extended with the work load when mass fatality situations occur.

Not all workers and volunteers are suited to these tasks; their suitability depends on a variety of factors related to vulnerability and circumstances, such as age, personality, previous experiences, beliefs about death, etc. They should be well-informed about the nature of the tasks they will perform, and people under 21 should not take part in or carry out work with a deep human impact.

There are certain risk factors that increase the likelihood of psychological disorders:

- Prolonged exposure to very traumatic experiences;
- Ethical conflicts;
- Simultaneous exposure to other traumas or recent stressful situations;
- A history of physical or psychological disorders;
- Unfavorable living conditions;
- A lax selection process for professional staff.

It is likely that the members of the response team will experience some difficulties in returning to their daily lives. These problems should not necessarily be regarded as symptomatic of illness and require, above all, family and social support.

There is no type of training or prior preparation for a person working with seriously injured and dead victims that can completely eliminate the possibility that he or she will suffer from post-traumatic stress or other psychological disorders. If major symptoms of psychopathology do appear, the cases should be referred for specialized treatment.

The following are some recommendations for the care of members of response teams:

- Consider the characteristics and the specific behavior patterns of the team. Team members generally feel satisfied about what they have accomplished and develop a spirit of altruism;
- Keeping the team active is a positive thing; it relieves stress and strengthens self-esteem;
- Promote work rotation and fixed working hours; for example, team members who handle dead bodies for a certain period of time should be reassigned to other, less difficult tasks;
- Encourage team members to take care of themselves physically and to rest periodically;
- Those offering emotional support should listen conscientiously and guarantee confidentiality and the ethical handling of personal and work situations;
- Redefine the crises as a potential for growth;
- Include the family in assistance and sensitization processes;
- Reduce stressors and assess underlying emotional states before and during the emergency;
- Create opportunities for reflection, catharsis, and integration of the experience. Recognize that someone's anger is not personal, but an expression of frustration, guilt, or worry;
- Whenever possible, the team involved in the emergency should attend group counseling sessions.

Recommendations for emergency personnel after resuming daily life:

- Return to your routine as soon as possible;
- Do physical and relaxation exercises;
- Seek contact with nature;
- Get enough rest and sleep;
- Eat regular balanced meals;
- Do not try to lessen suffering by using drugs and alcohol;
- Seek company and speak with other people;
- Participate in family and social activities.
- Observe and analyze your own feelings and thoughts; reflect on what you have experienced and its meaning in life.

VII. MASS COMMUNICATION STRATEGIES: THE IMPORTANCE OF TRUTHFUL, APPROPRIATE, AND TIMELY INFORMATION.

The availability of information that is truthful, transparent, appropriate, and timely is vital for the emotional restraint of family members and the general population. This should be provided at various levels:

- Directly to the individual;
- Directly to a group or community;
- Via the media.

The authorities and community leaders should be prepared to provide information directly either to individuals or groups, as well as to respond to questions and be ready to find answers to these questions.

The media have a dual nature: on the one hand they are profit-driven enterprises, and on the other they have an enormous social responsibility for the public service they provide. Information on disasters, like pandemics, can be used to spark and manipulate the public's morbid interest. However, ethical and sensitive reporting about these events should be insisted on; the media should make a responsible contribution to citizens' peace of mind by providing truthful, balanced information.

A common problem is the number of people who go to hospitals, health centers, morgues, and other places in search of family or friends (sick or dead). This creates problems of congestion and disorganization. Solutions to this kind of situation should be found that are adequate, humane, and respectful to these people.

The health sector should coordinate with law enforcement and humanitarian assistance organizations to contain, care for, and control crowds. In most cases, the crowds are not aggressive, but they need to be organized so that they can be given appropriate information. Entry to health facilities also needs to be limited to individuals or small groups.

For these communication tasks, it is important to seek the timely support from neighbors and community organizations that, in addition to human talent, have extensive knowledge about the population and its customs.

It is advisable for authorities and public institutions to have spokespersons who are specifically responsible for managing information and who can call on the population for emotional restraint. It is advisable to have regularly scheduled briefings and to make use of official bulletins, avoiding any ambiguity.

Preparations Should Include Psychosocial Aspects

The Director of the Pan American Health Organization (PAHO), Mirta Roses, recently stated in Valencia that that we should not be alarmed by avian influenza, but we should be alert to it because all indications are that we are very close to a pandemic of major dimensions and serious impact. She felt that the responsible attitude of society and the authorities is to be ready to mitigate any impact that may occur and not to wait for it to happen to regret the results. She also pointed out that this is not the time for panic, but for activity, which is what she believes the world is doing.

Mirta Roses indicated that she would like to see the virus contained, but stressed the importance of bearing in mind that anything that humanity has no memory of--that is, what it has had no contact with, is potentially very serious, adding that humanity still does not have a response ready for this virus.

The Director of PAHO felt that very concentrated efforts are being made by the media, the authorities, and the public.

Informing the public about the possibility of a major pandemic is not an option but a step that should be taken without question. The reasons are clear:

- People can be prepared and can help prepare those around them (family, community, workplace, etc.).
- The community can collaborate with official efforts by the government and other authorities.
- Once the epidemic is under way, informed people can act more appropriately and better protect themselves and their families.

Communicating risk is essential, and the basic strategy is to create an atmosphere of mutual trust among the population, the authorities, and communicators.

The goal of communication before the epidemic breaks out is to reach an intermediate point where accurate information is given about the existing risks and dangers, creating an appropriate level of fear through knowledge, while offering help in addressing the problem and preparing the population. The goal is to avoid extremes, i.e. tepid announcements that do not break through the

population's apathy or, the opposite, alarmist reports that generate great fear and could lead to panic.

Recommendations for communicating risk:³

1. Put yourself in the public's shoes
2. Don't be afraid to frighten people
3. Acknowledge uncertainty
4. Share dilemmas
5. Give people things to do
6. Be willing to speculate responsibly
7. Don't get caught in the numbers game
8. Stress magnitude more than probability
9. Guide the adjustment reaction
10. Inform the public early and aim for total candor and transparency

Communicating risk is vital from a mental health standpoint. A good mass communication strategy is critical to maintaining calm and an appropriate emotional state; a well-informed population can act appropriately, protect itself better, and be less vulnerable in terms of psychosocial aspects.

VIII. FINAL CONSIDERATIONS

Coping with an epidemic emergency that has produced a large number of sick and dead is not only a problem for the health sector; other actors such as government institutions, NGOs, local authorities, and the community itself are involved. The most general immediate measures that help to create a climate of order and emotional calm include the following:

- Ensure a correct and orderly response on the part of authorities;
- Provide truthful and timely information; a good mass communication strategy is essential to maintaining calm and an appropriate emotional state during all phases (before, during, and after);
- Encourage interinstitutional cooperation and community participation;
- Guarantee basic health services, including the psychosocial component;
- Prioritize mental health care for the most vulnerable groups, taking into account gender and age differences;
- Give emotional first aid to the sick and their families, largely through efficient health care and humanitarian support;
- Anticipate an increase in the number of people with symptoms of unresolved grief or psychiatric disorders and facilitate adequate care for them;
- Ensure the careful and ethical handling of bodies, establishing an orderly, individualized system for the notification of deaths;

³ Sandman, P.M., Lanard, J. "Bird Flu: Communicating the Risk" *Perspectives in Health Magazine*. PAHO Vol. 10, No. 2, 2005.

- Avoid cremation or burials in common graves. Support the speedy handing over of remains to family members, so that the population's desires and customs can be respected.

Traumatic experiences as well as losses and grief necessarily take different forms of expression according to the culture. The prevailing concepts of life and death and funeral rites for loved ones are important for the acceptance and understanding of what has occurred.

Mental health plans cannot be limited to improving specialized services and to making them more accessible; rather, the area of expertise needs to be expanded to address the range psychosocial problems and needs in the population.

Mental health services should be organized based on needs in an epidemic situation. At the primary level, the PHC team should have basic training in mental health, so that it can handle simple psychosocial support processes. The provision of emotional support and counseling services also needs to be anticipated, as does outpatient mental health teams that support PHC. At the secondary level, it is important to plan for crisis intervention units in selected areas (such as emergency rooms and morgues) and for mental health services in general hospitals where there are large numbers of influenza patients.

Delayed effects (medium- and long-term) that arise in catastrophic situations should be considered when designing appropriate intervention strategies for their effective prevention and control. However, the most common institutional responses are based on individual psychiatric care and reach only a very limited number of the people affected.

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