REPORT WITH DATA AND TESTIMONIES

April 2017

Caritas Italiana
organismo pastorale della CEI

Nepal

An Earthquake Inside

The effects of natural disasters on psychological health

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The effects of natural disasters on people's psychological health

Caritas Italiana
organismo pastorale della CEI

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Introduction

*«The development We speak of here cannot be restricted to economic growth alone. To be authentic, it must be well rounded; it must foster the development of each man and of the whole man.» (*Populorum Progressio*, 14)*

The message of the encyclical *Populorum Progressio* endorses all efforts towards "the development of the whole man". This concept was further reaffirmed with the recent creation of the Dicastery for Promoting Integral Human Development, aimed at combining the work of a number of offices that were previously responsible for the advancement in the fields of justice, peace, health, migrations and charity. The idea of a «whole man» is clearly related to his or her physical and mental health. However, although the afflictions caused by physical pain can readily attract people's sympathies, mental suffering often affects human beings in a more subtle and yet equally intrusive way as well as carries additional burdens with it: a stigma and an overall pressure from the community, which places one's grief in a "social" dimension that makes it even harder to withstand.

This is not the first time that the Caritas Italiana deals with issues related to mental health[1]. In this occasion, this topic will be addressed from a peculiar perspective, analysing the way in which natural catastrophes cause both physical and mental distress. As a matter of fact, feelings such as anguish, loneliness, frustration and the perception of being uprooted from one's community are not only familiar for most victims of typhoons, floods or earthquakes, but also by those close to them.

In the aftermath of natural disasters, alongside more tangible issues such as the response and reaction to the calamity, the community's buoyancy and the reconstruction, there is a whole area of intervention that is rarely considered with the right amount of care. Right away, the psychological and mental pain that follows a major traumatic event is not so apparent. However, in the long run, it is perhaps even more devastating: it breaks human bonds, deprives people of hope, destroys their roots and tends to transform them from "active subjects" into "recipients", passively benefitting from aid projects. These outcomes could have a disastrous impact on the physical, social and economical reconstruction of the local communities; on the other hand, such dreadful experiences could also give rise to a renewed self awareness and open up to new beginnings.

Hence, this dossier is going to tackle the following questions: how do single people and whole communities react to natural events that turn their lives upside down? How do these disasters affect their mental and psychological wellness? What kinds of resources are they able to gather to fight back?

We are going to talk about "the whole man", focusing on the victims' psychological wellness following natural calamities, but we will also be paying attention to "each man". The experience of the Nepalese community hit by the earthquake in 2015 will be compared to the equally terrible emergency caused by the recent earthquake in central Italy

We are going to talk about "the whole man", focusing on the victims' psychological wellness following natural calamities, but we will also be paying attention to "each man". In fact, the experience of the Nepalese community hit by the destructive earthquake in April and May 2015 will be compared to the equally terrible – and for many people still present – emergency caused by the recent earthquake in central Italy.

1. The issue: psychological balance and the importance of mental well-being

In the Constitution of the World Health Organization, health is defined as «a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity»[1]. This definition has not changed for almost seventy years and it is supported by even older reference frames; in fact, the ideas of an interrelation between all the components of a human being and of the unbreakable interdependence between them can be found in several ancient medicines, and especially in Buddhist teachings.

What is more, the WHO defines mental health as «a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community»[2]. The elements that influence people's psychological health or bring about a mental disorder are not only individual traits, such as the ability to deal with thoughts and emotions and to handle one's behaviour and the relationship with other people; the social, cultural, economic, political and environmental circumstances are also crucial, especially with reference to the policies implemented on a national level and the social safeguard, standard of living, working conditions and social support provided by the community.

According to the overall context in which they live in, some individuals and social circles are highly more likely than others to suffer from mental issues. These vulnerable groups may (but do not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, prisoners and people exposed to conflict, natural disasters or other humanitarian emergencies[3].

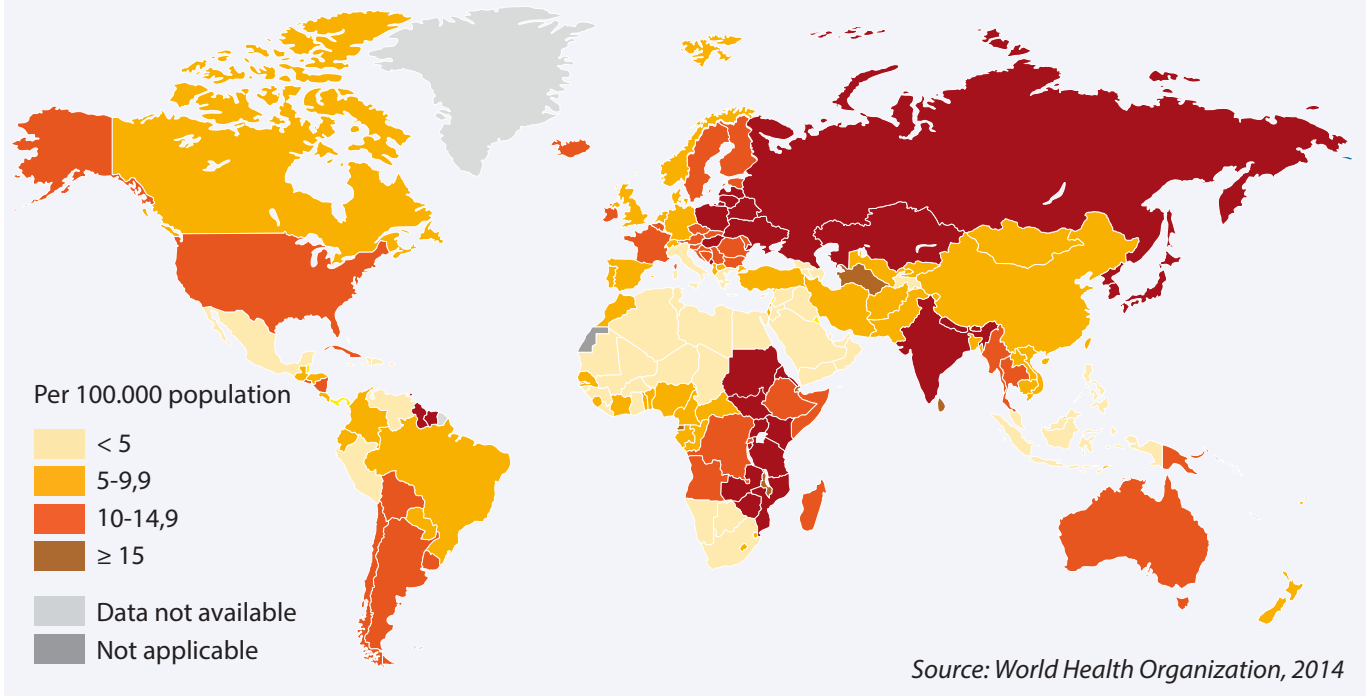
People with mental disorders have disability and mortality rates that by far exceed the average. As a matter of fact, those suffering from major depressive disorder and schizophrenia have a 40-60% higher chance to die prematurely due to problems related to their physical health, which occurs when issues such as cancer, cardiovascular diseases, diabetes or HIV-related infections are not treated properly. The combined data of 22 scientific studies conducted on 825.754 patients affected by various dysfunctions or subject to acute coronary events have shown that the people who were also suffering from psychiatric disorders would receive 14% less lifesaving emergency treatments, compared to those who did not have mental issues; as a result, their mortality rate was 11% higher than that of the rest of the sample group[4]. Besides, it has been demonstrated that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression[5].

Combining this information with the fact that, in case of heart diseases, psychiatric patients receive less treatment, it becomes utterly clear how vulnerable this class of people is and how mental well-being should be taken more care of. Moreover, mental disorders can even have an impact on other issues, such as cancer and HIV or AIDS-related infections, but also on suicide rates[6].

People with mental disorders have disability and mortality rates that by far exceed the average. As a matter of fact, those suffering from major depressive disorder and schizophrenia have a 40-60% higher chance to die prematurely due to problems related to their physical health, which occurs when issues such as cancer, cardiovascular diseases, diabetes or HIV-related infections are not treated properly

The map on the following page displays the suicide rates throughout the world. The peak in the Asian region is due to a number of environmental, cultural, economic and social reasons, but is at one time in the area most at risk of natural disasters, which affect the victims' psychological balance and have an impact on the increase of psychiatric illnesses or mental disorders.

SUICIDE RATE



Source: World Health Organization, 2014

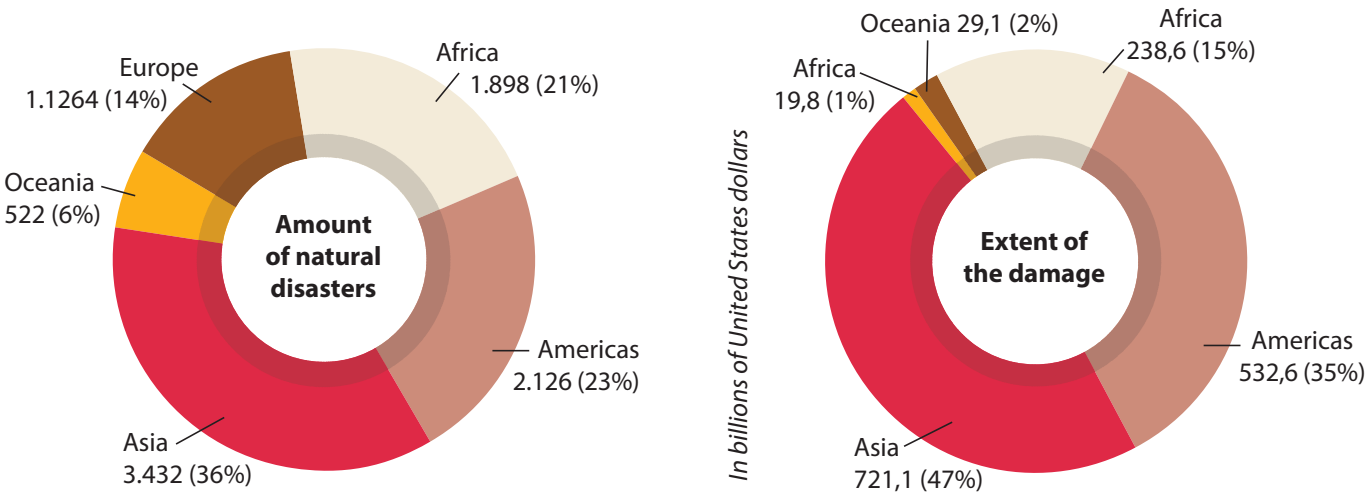
As confirmed by the data, the regions with the highest environmental risks are also those with the most severe suicidal rates[7]; therefore, interventions in favour of the victims' mental health should be priorities both for the governments and for the humanitarian organisations involved.

2. Natural disasters and their impact on human health

Source: EM-DAT International Disaster Database www.emdat.be & Reliefweb-reliefweb.int/disaster (Accessed 23 February 2016)

To this day, natural disasters and calamities are an everyday occurrence all over the world and their numbers seem to be escalating dramatically. It is true that global communication makes it possible to receive information about far away catastrophes in real time; as a result, most events that once would have gone unnoticed or that used to reach international attention after a long time are now immediately covered by the news. On the other hand, climate agents such as global warming or cyclical climatic oscillations – together with other factors resulting from human activity like pollution, overbuilding and deforestation – have contributed to an actual increase of devastating events.

As already mentioned, the Asian continent is in these regards one of the most affected regions. The graph below illustrates how the area at issue, in fact, pays the highest price in terms of human losses, damages and economic and sanitary costs.

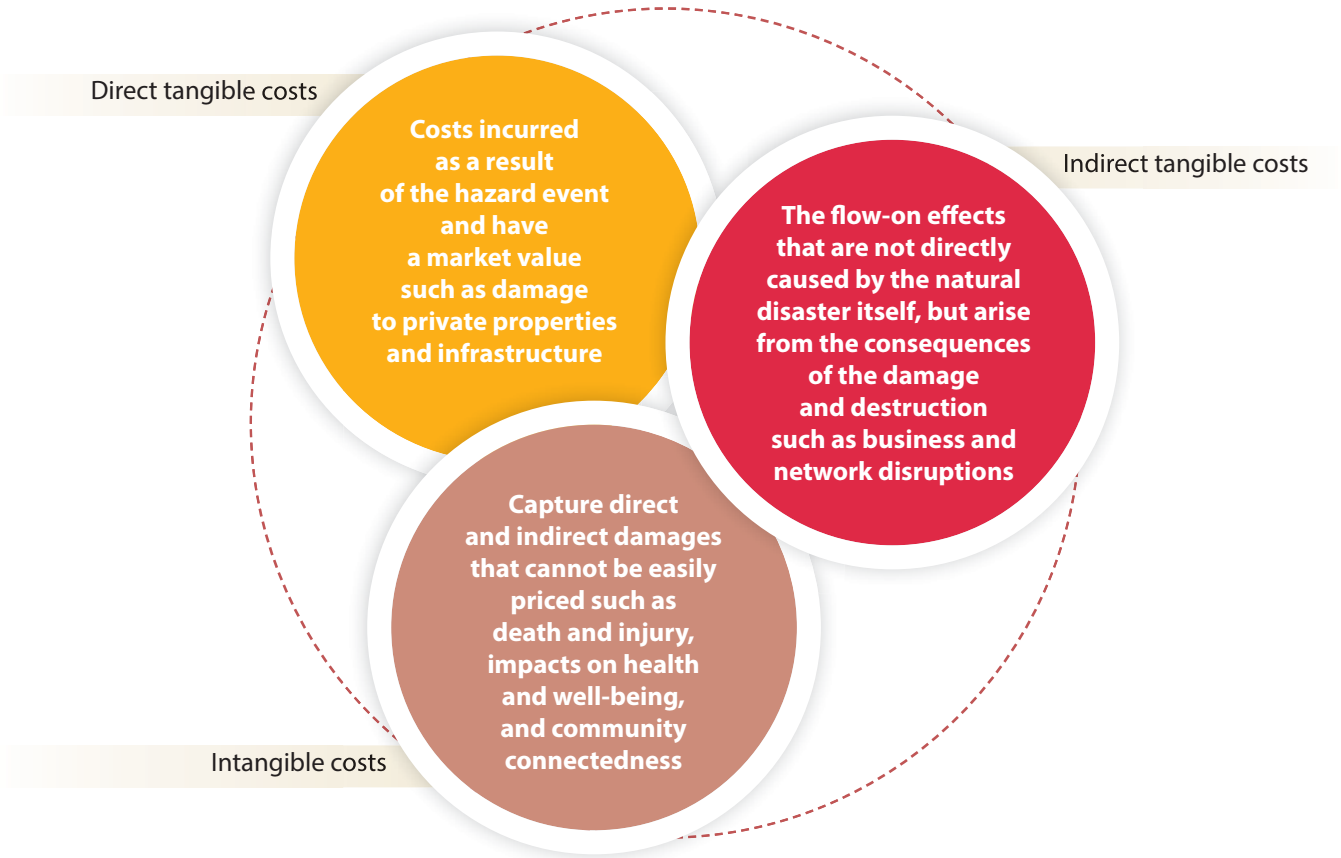


Source: Disaster prevention white paper by Cabinet Office, Government of Japan – 2010

Natural disasters and their outcomes – meaning the overall destruction, the loss of sources of profit, the hydrogeological instability and the presence of human fatalities – have always been at the centre of attention. Over the last few decades, this concern has also been spreading in geographic areas in which calamities used to be seen as divine punishments, as nature's furious activity or as mere components of a person's existence. In Asia, Africa and Latin America changes in this direction have in fact been taking place for more than 30 years: more and more importance is being given to the development of intervention skills aimed at providing a quick emergency response, while the attention from the media, the presence of state, parastatal and non-governmental aid agencies, the political strategies and the resources allocated for this purpose are increasing and consolidating.

Because these disasters cause wounds, disabilities, physical dysfunctions and states of invalidity, the "health factor" is central and it's no wonder that the first rescuers to arrive, right after the army, are usually doctors and paramedics. The costs of healthcare are part of the so-called intangible costs, and they play a major part in the overall impact of natural calamities on the economy of the country, both in the short and in the long run.

TOTAL ECONOMIC COST OF NATURAL DISASTERS



Source: The economic costs of the social impact of natural disasters, Australian Business Roundtable for Disaster Resilience & Safer Communities, March 2016

Leaving economic expenses aside, the effects of natural disasters on the healthcare system belong to four main typologies:

- **Direct impact on individuals' health:** wounds, infectious diseases, acute pathologies – such as respiratory dysfunctions following volcanic eruptions or due to gas and spore contamination of the atmosphere after earthquakes – and in some cases aggravation of preexisting conditions.
- **Direct impact on the country's health facilities:** destruction of hospitals and medical centres and death of hospital staff.
- **Indirect impact on individuals' health:** lifestyle changes, including difficulties in accessing one's earnings, medicines and quality food, with a consequent damage to people's health both in the short and in the long run.
- **Indirect impact on the country's health facilities:** interruption of water and energy supplies, on which medical facilities depend on [1].

COST OF NATURAL DISASTERS IN ASIA *(In Billion of United States dollars)*

359 Billion FLOODS | **314 Billion EARTHQUAKE** | **223 Billion TSUNAMI** | **167 Billion CYCLONE** | **34 Billion DROUGHT**

Source: Centro per la ricerca sull'epidemiologia dei disastri (Cerd), School of Public Health, Brussels

In the recent history of the professional response to – and prevention of – natural disasters, the progressive worsening of the victims' mental health following major adverse events is mostly forgotten or at least widely neglected. It is true that numerous essays and articles on natural disaster emergencies, as well as documents of humanitarian agencies, widely address this issue, illustrating how the individual and social psychological effects can ultimately be highly severe in terms of quality of life and social costs for the government. On the other hand, however, there is a widespread perception that psychological and psychosocial interventions can be easily postponed or overlooked.

Natural disasters and their impact on the victims' psychological balance

Specialised post-disaster and emergency psychiatric and psychological studies are relatively new branches of human ethology; they emerged in response to the need for professionals who would take care of the inner wounds caused by – or aggravated by – natural catastrophes, working alongside those in charge of the material and infrastructural reconstruction.

The resolution put forth by the the WHO in May 2005, which was approved by the World Health Assembly, stated the importance of post-disaster and post-war psychological trauma management; it urged humanitarian agencies to plan their emergency interventions accordingly, and the organisations at issue soon adjusted to these requirements[2]. As a result, the universally recognised standards in the humanitarian field include a specific attention to the stress generated by calamities and affecting both the population and the rescuers and aid workers involved[3]. Several studies have in fact shown how severe and heterogeneous the damage to people's mental health can be after natural disasters, wars and terrorist attacks, particularly as far as individuals and groups' welfare and social stability are concerned.

- **Emotional effects:** shock, terror, irritability, anger, feelings of guilt, sadness, emotional numbing, perception of being useless, loss of interest towards familiar and enjoyable activities, difficulties in feeling happy and loved.
- **Cognitive effects:** lack of concentration, inability to make decisions, confusion, distrust, nightmares, loss of self-esteem, sense of guilt, self-reproach, intrusive thoughts, intrusive memories, dissociation.
- **Physical effects:** weariness, exhaustion, insomnia, hyper-vigilance, hyperactivity, weakened immune response, reduced pain tolerance, migraine, gastrointestinal problems, lower appetite, lower libido, vulnerability to diseases.
- **Relational effects:** increment of interpersonal conflicts, social isolation, reduced relational intimacy, alienation, lower job performance, less gratification from relations, distrust, perception of being abandoned.

The post-traumatic stress disorder

The post-traumatic stress disorder (PTSD) is a mental condition that an individual may develop after being exposed to a calamitous event such as a hurricane, earthquake, tsunami or accident, and it involves a number of psychological and behavioural symptoms that eventually affect the body, too. Not merely those directly involved in the disaster may suffer from it, as this disorder can also strike far-away witnesses or people who listen to reports of the traumatic episode.

The symptoms of psychological pain that come along the post-traumatic stress disorder are numerous and many-sided. According to diagnostic manuals, however, for the illness to be diagnosed with certainty some elements must be present:

- the exposition to a traumatic event, which may be factual or reported and may have occurred or just be threatened;
- intrusive symptoms: recurring dreams, repetitive thoughts and the perception of experiencing the trauma over and over again;

- a tendency to avoid any stimulation linked to the traumatic experience, such as places, people or emotions that may take him or her back to the event;
- major changes in the emotional sphere: negative emotions towards oneself (sense of guilt, self-doubt, depression) and emotional excesses (anger, sadness) that contribute to generate distorted thoughts about reality.

The PTSD is a relatively new dysfunction that was firstly classified after the Vietnam War, as a medical response – also due to insurance reasons – to the extremely large number of veterans that had returned home impaired by traumas and psychological wounds.

Not only PTSD

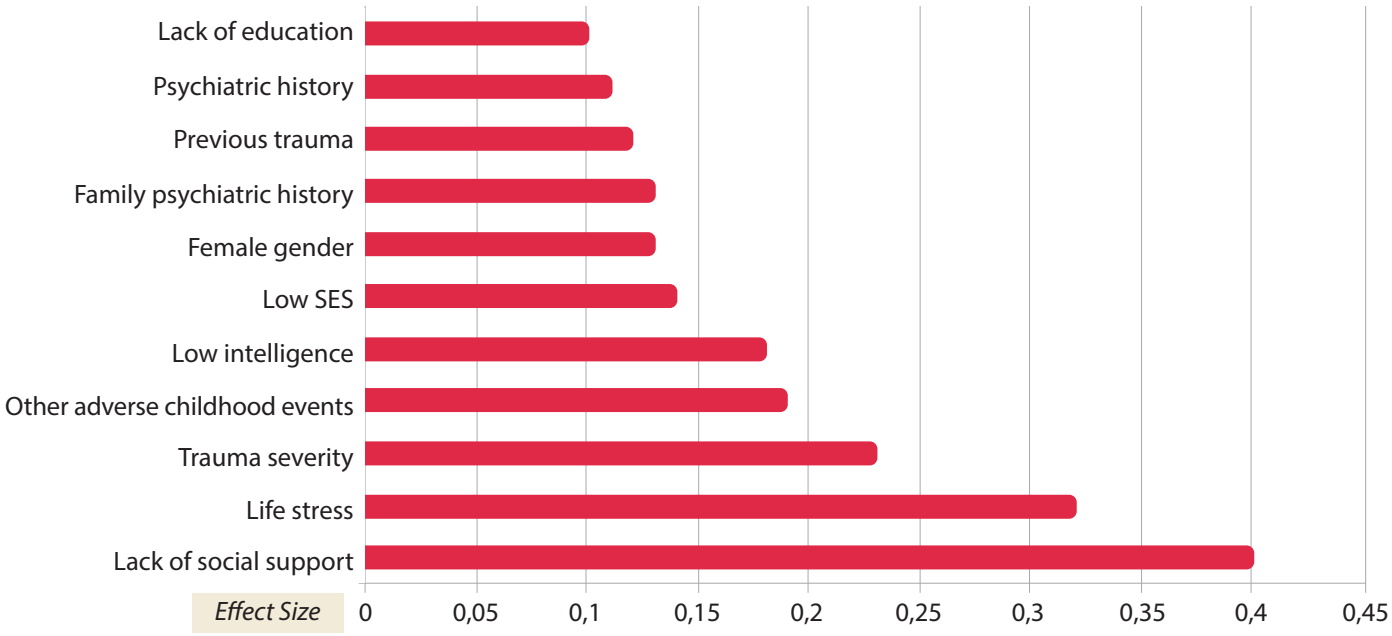
The post-traumatic stress disorder is one of the most common diseases connected to natural disasters, but a number of other issues are just as frequent[5]. In fact, most victims do not actually develop PTSD, as their symptoms do not reflect its diagnostic criteria on the whole; the majority of people show clear signs and symptoms related to major stress and associated with behavioural manifestations, such as: anxiety, generalised fear, insecurity, anger and aggressivity, apathy, acute stress disorder[6].

Data on the incidence of PTSD in case of natural catastrophes

Studies on PTSD incidence rates following earthquakes provide mixed data, which cannot totally account for the real impact of calamities on the victims' mental health. According to the figures, nine months after the seismic event almost one fourth of the population is affected by post-traumatic stress disorder. Other surveys, focused on natural disasters more in general[7] and not only on earthquakes, record an incidence rate that goes between 5 and 60%, with a frequency placed in the lower half of the scale, between 20 and 35%. After a catastrophe, some factors have a major influence on the number of future PTSD cases:

- the person's role in the emergency: direct or indirect victim, rescuer or victim's relative;
- physical closeness to the traumatic event;
- age (children being statistically less likely to develop the disorder);
- gender (women being more at risk[8]);
- intensity of the event itself;
- level of education;
- damage to his or her house;
- history of psychiatric diseases;
- injuries suffered during the calamitous event;
- methodology employed to carry out the investigation[9].

RISK FACTOR FOR POST-TRAUMATIC STRESS DISORDER



Source: adaptation of Brewin et al. 2000, quoted in "Post Traumatic Stress Disorder: Diagnosis and Assessment", The National Academies Press, Washington

Suicide rates are another element that allows us to gain a deeper understanding of the psychological impact of catastrophes. As far as suicide rates in Asia are concerned, Nepal is second only to Sri Lanka. What is surprising in the data provided by the Nepalese police force, however, is not so much the number of suicides as a general phenomenon, but its dramatic increase after the 2015 earthquake. It inevitably indicates a higher weakness and the inability to face the difficulties brought about by the catastrophe.

3. Some data on psychological pain in post-disaster Nepal

The analysis tools

After the earthquakes in 2015 there was a lack of precise data concerning the well-being of the people struck by the calamity, although several signs indicated that they were undergoing increasing distress. This is why a new and independent inquiry was promoted in the area, using the accredited tool PCL-5[1]. This instrument was translated on a semantic and lexical level for the Nepalese people and thereafter administered to a chosen sample between the damaged communities. The PCL-5 does not have an immediate effect nor has it been used to obtain clinical diagnoses of post-traumatic stress disorder, but was rather employed to capture the present state of health and well-being of the Nepalese citizens, almost two years after the disaster.

Considering the size of the earthquakes and that they hit through and through all the districts involved, it was decided to administer the questionnaire to a heterogeneous sample of people. The local aid workers acted as intermediaries and contacted 270 people living in the districts of Gorkha, Kathmandu, Kaski, Kavrepalanchowk and Sindhupalchowk, both males and females, coming from diverse social backgrounds, aged 12 to 75 years old, married and unmarried and coming from families who may or may not have lost any members due to the earthquakes.

What the data can tell us

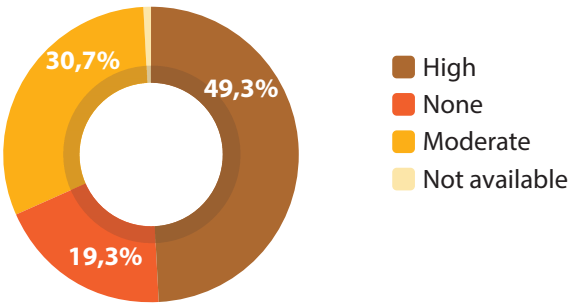
As previously mentioned, the tool in use does not allow to obtain clinical diagnoses of PTSD or of its incidence on the human sample, nor was this the purpose of the inquiry. It however made it clear that, despite the amount of time between the earthquakes and the interviews, several symptoms revealing emotional and behavioural instability still persisted.

The population that formed the sample for the inquiry was selected as follows. 270 people completed the questionnaire overall, 100 were men and 158 women, while 12 people did not provide data regarding their gender. 32 were aged 12-20 years old; 83 aged 21-30; 51 aged 31-40; 42 aged 41-50; 33 aged 51-70; 9 people were more than 70 years old; 20 people did not give any answer. They came form the following districts: Kathmandu Valley (23 people); Sindhupalchowk (44 people); Kavrepalanchowk (110 people); Kaski (51 people); Gorkha (31 people); no reply (11 people).

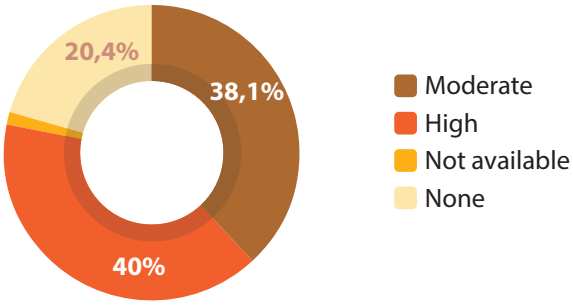
Concerning both behavioural alterations and changes in the emotional sphere and in its activation, the test replies bear witness to a reality that, on more than 50% of the cases, is highly ("extremely") o mildly ("moderately") altered compared to the situation before the earthquake. In particular, there are high peaks concerning the memories linked to the traumatic experience (charts 1 and 2), irritability and intrusive emotions (items 4 and 11), behavioural changes such as difficulty concentrating, insomnia and hyper-vigilance (items 17, 19 and 20), and the inability to recall part of the events (item 8).

More than 68% of the people stated to be having intrusive thoughts and about 60% to be experiencing behavioural disorders on a daily basis. Thus, despite the time passed and the existing statistics, the Nepalese people – no matter their age, gender or district – have affirmed to be still suffering on a psychological level because of the traumatic earthquakes that took place on 25th April and 12th May 2015.

PRESENCE OF INTRUSIVE THOUGHTS



PRESENCE OF TRAUMA-RELATED NIGHTMARES

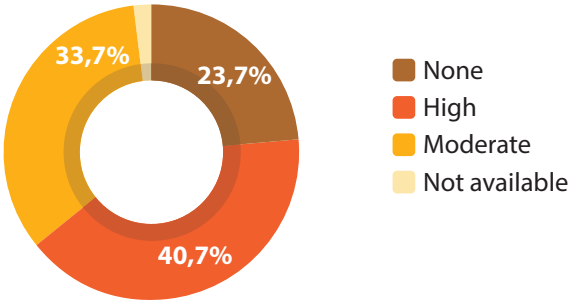


The charts above show the impact that the memories related to the earthquake still has on the population in the forms of intrusive thoughts or nightmares.

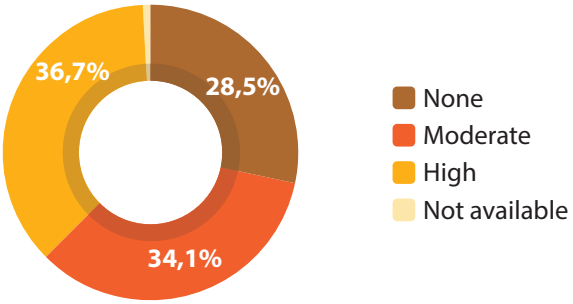
The charts in the following page, on the other hand, underline the effects of those memories on eve-

ryday behaviour. The first graph concerns the feelings of hyper-vigilance, while the second one testifies the arising of strong physical reactions (such as rapid and irregular heartbeat, sweating and gasping respiration) while recalling the traumatic events.

SUBJECTIVE HYPER-VIGILANCE

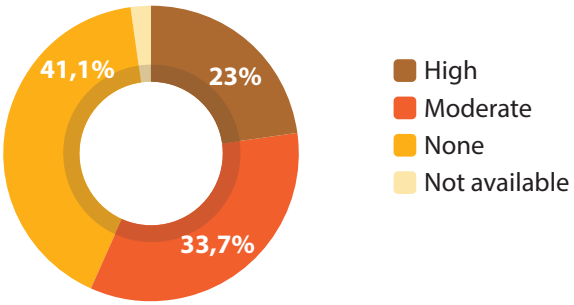


UNPLEASANT PHYSICAL REACTIONS WHEN REMEMBERING THE EXPERIENCE



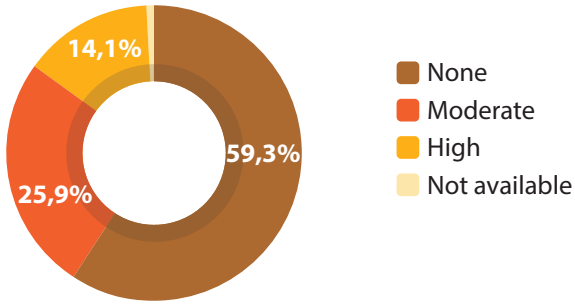
Also the subjective indicators – those related to a sense of guilt and to negative thoughts about oneself –provide interesting data, showing that these occurrences are, as a whole, not very frequent. The test answers on this topic are, in reality, perfectly coherent with the characteristics of the Nepalese society. In fact, in Nepal a person's individuality is always secondary to the collectivity (meaning one's family, village, ethnic or religious group and caste), which helps explaining why all those symptoms connected to a devaluation of oneself are low and not highly influential.

NEGATIVE PERCEPTION OF ONESELF, OTHERS AND THE WORLD



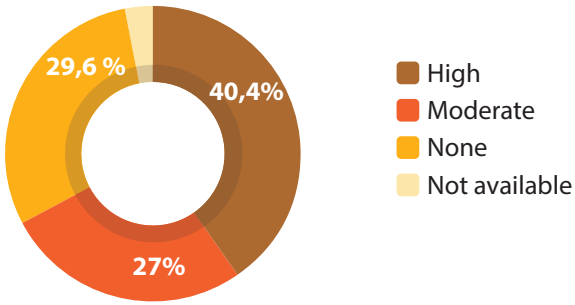
The tendency not to put blame on the individual or on subjective behaviours is just as coherent with the strong religious foundation of the Nepalese society, which makes people inclined to shifts the responsibility on a divine and superhuman level.

TENDENCY TO BLAME ONESELF AND OTHERS FOR WHAT HAS HAPPENED

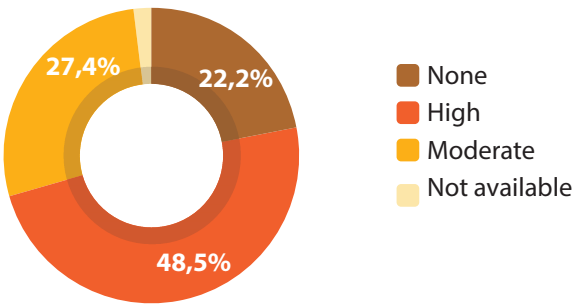


Other symptoms, however, are still frequent despite the passing of time and they have an impact on the victims' recovery skills, on their ability to take care of their relations, to go back to work and to their normal lives.

DIFFICULTY CONCENTRATING



DIFFICULTY FALLING ASLEEP AND INSOMNIA



The interventions so far, rather than dealing with the population's mental well-being, have mostly focused on rebuilding the houses and public facilities and on creating jobs for the communities. As discussed later on, all of these activities provide a fundamental contribution towards the victims' full rehabilitation, and thus towards the recovery of their mental balance, too. But they are not sufficient: in the vague silence that surrounds the sphere of human emotions, the high incidence of post-traumatic stress disorder related symptoms clearly requires more targeted, competent and therapeutic interventions that deal with the individual as a whole, with his or her need for security, meaning and hope.

4. Understanding post-disaster suffering

A diagnosis by itself does not heal

Writing diagnoses is a prerogative of healthcare professionals, that is to say of doctors specialised in all branches of medicine; especially regarding psychiatric diseases, the "issue" thus tends to shift from a social to a clinical level. Witnessing people in pain or even being able to name the symptoms or classify a disorder, however, is not by itself sufficient nor therapeutic.

While this approach eradicates a number of inappropriate and potentially damaging practices, it risks to smother the support system that is peculiar of the communities involved and that could be extremely helpful in reducing the symptoms, solving the issue and avoiding the collateral effects of a psychiatric diagnosis in terms of stigma, isolation and segregation.

As a result, merely receiving a diagnosis and consulting a specialist not only is it not therapeutic, but even potentially harmful. In the following paragraphs we are then going to analyse more inclusive approaches, focused on integrating the cultural environment of disaster victims with psychotherapeutic and pharmacologic treatments, in order to obtain long-term results, with fewer relapses and social handicaps.

The relevance of linguistic codes

While in the Western world the concept of "trauma" has by now become a synonym of stress [1] and suffering, in other cultures existence is conceived using different reference frames. Studying the languages and the terms used to define traumas, stress and mental response thus becomes essential in order to deeply understand the effect of traumatic experiences on the individuals' mental health and to distinguish between the psychological difficulties that the victims are able to manage independently and those that require specialised support instead.

Some studies on languages have actually focused on Nepal and underlined how tricky it can be to transfer some fundamental meanings from Western into local languages. For instance, they dealt with the term "trauma" or "shock", which is normally rendered with the Nepali word *agatha* (आघात). Although on a theoretical level the translation is correct, the words that are more readily comprehensible to the natives are *paagal* (पागल) and *ris* (रीस) – which mean "crazy" and "rage" respectively – while the word *agatha*, if employed by counsellors or mental healthcare professionals, has a potentially negative effect on the patients because it is usually associated with a highly stigmatised condition [2].

In the process of translating some specific terms, it is essential to keep in consideration which words may carry a mark of shame. Although the situation is gradually improving in the Western world, in fact, in several cultures psychiatric diseases are still viewed as blameworthy, and mentally ill people considered shameful individuals to segregate and marginalise. The stigma aggravates the way people experience their disease, leading to limited access to specialised care, social isolation, feelings of guilt, shame and inferiority [3], and thus aggravating the issue and concurring to make it chronic.

When people have lost their loved ones and their home and have been deprived of their livelihood and social stability following a natural catastrophe, acute suffering and pain are perfectly natural responses and need to be expressed and processed just as naturally

Suffering and pain are not pathologies

The work of international organisations, the coping strategies of mental health departments in different countries and the varied diagnostic approaches (even if the latter are highly subjected to the aforementioned symbolic and semantic cultural barriers) are indeed significant and helpful insofar as they provide professional responses to psychological distress and preventative measures that confine future harm, thus contributing to the overall mental balance of the society. However, despite the limited duration of the projects that institutions and humanitarian agencies carry out, the consequences of their actions may have long-lasting implications. The main risk is that of pathologising what is natural, that is to say transforming human and balanced reactions into behavioural, mood and personality disorders.

When people have lost their loved ones and their home and have been deprived of their livelihood and

social stability following a natural catastrophe, acute suffering and pain are perfectly natural responses and need to be expressed and processed just as naturally. To understand what should be considered consistent with the so-called "normality"– assuming that normality in its absolute sense does not exist – we need to focus on the specific concept of individual that is inextricably linked to the culture at issue in that specific moment in history, and that represents a direct response to the implied requirements of the society in which the person grows up and lives. In fact, when facing traumas, shocks and emotional turmoil, each individual tends to respond coherently with their inherited genetic traits, with their ability to form emotional bonds, with their cultural baggage and with their interiorised constructs of meaning.

Diagnosing diseases, searching for manifest and silent symptoms and conducting screenings in the population are all fundamental actions to undertake after a disaster. Nonetheless, they should only be performed on the basis of a deep understanding of the personal, social and relational dynamics of the people who are supposed to benefit from that service. Otherwise, those actions stand a chance of worsening the stigma, of increasing social exclusion and of providing an incorrect interpretation of the symptoms, thus labelling a "disease" what may be the sum of sane human emotional responses.

Resilience

The term "resilience" originally refers to the ability of a metal to absorb impacts without breaking, and it was later adopted in psychology to describe people's skills to adapt to adverse events, traumas, tragedies, threats and to other significant stress factors[4]. As a matter of fact, resilience is actually a much more complex phenomenon and is highly influenced by social, cultural, biologic and psychological factors. It is not a fixed personality trait, but it changes over time and according to the context, so that a person may be extremely resilient when facing a natural disaster but not at all concerning relationship issues, and vice versa[5].

The actual impact of a trauma on people is highly subjective, because each individual is different and their perception of events depends on a large number of factors – some of which are impossible to detect – and in the end it is all about making sense of what has happened. According to several studies conducted in diverse cultural contexts, in fact, traumas are related to a "meaning crisis" or a "shuttering of the self"[6]. The impact of traumas on individuals and how likely they are to develop post-traumatic stress disorder or mood and personality disorders caused by a catastrophe, together with the victims' ability to overcome these issues, are all linked to the very concepts of person and community; in other words, they depend both on individual and social resilience.

Personal psychological characteristics and spirituality are the main factors that influence individual resilience. The former are related to a person's natural attitude at solving problems rather than overthinking about them, to their positive and optimistic vision of existence, to their flexibility, elasticity, and to the ability to express their emotions. On the other hand, having a spiritual (non necessarily religious) point of reference helps the survivors to develop a coherent perception of their identity as men or women, and believing in a superior entity alleviates the anxiety of everyday life and helps their search for meaning[7].

The social network is just as relevant, as it plays a major role concerning the individuals' mental balance and their psychological response to calamitous events. The primary group of relations is composed by all those people that a person meets every day, such as family members, people from the same village, acquaintances, colleagues, members of the same community and so on. Alongside, the secondary group includes all social institutions – like schools, hospitals and administrative offices – that bear the responsibility for defining and dealing with people's needs[8]. Lastly there is a subjective group, which is a social entity that depends completely on the perception and point of view of the subject who describes it and who also belongs to it[9]. Essentially, it is made up of all the friends whom the subject is attached to and who have a bond with him or her. All considered, these researches and arguments can constitute the foundation for a psychosocial or, more precisely, psycho-&-social approach.

Traumas are related to a "meaning crisis" or a "shuttering of the self". The impact of traumas on individuals and how likely they are to develop post-traumatic stress disorder or mood and personality disorders caused by a catastrophe, together with the victims' ability to overcome these issues, are all linked to the very concepts of person and community; in other words, they depend both on individual and social resilience

5. Natural emergencies and psychological traumas in Italy

Text by Fabio Sbattella, Unità di ricerca in Psicologia dell'emergenza e assistenza umanitaria, Università Cattolica del Sacro Cuore, Milan

Natural emergencies in Italy and social responses to disasters

Just like most world countries, over the course of centuries Italy has been struck by numerous natural calamities, which have shaped the collective memory of the local communities and affected their culture. Landslides, avalanches, floods, earthquakes, volcanic eruptions, tornados and even tsunamis have challenged and called into question the intellectual, emotional and relational skills of generation after generation of Italians, while the institutions supporting the survivors have gradually adjusted their approach to these issues[1].

The most significant earthquakes that have occurred in Italy over the last 50 years are those in Sicily (1968), Friuli Venezia Giulia (1976), Irpinia (Campania, 1980), Umbria and Marche (1997), Molise (2002), Abruzzo (2009) Emilia Romagna (2012) and again Central Italy (2016-2017). These events caused a total of 4.900 victims, which are few if compared with the overall 352.500 casualties attributed to the ten most deadly earthquakes that occurred in the country from 1110 to 1915[2]. However, the most recent events have confirmed that the beautiful Italian peninsula is not a safe haven, but rather a land of shifting mountains whose surface shudders and breaks because of the deep tension underneath.

For centuries, direct interventions of the Church and theological considerations have supported and encouraged solidarity actions and resilient responses from the inhabitants. On the other hand, in recent years psychologists and mental health professionals have started to hold a major role as well. They work for the national healthcare system, which has a widespread coverage and coordinates public and private intervention procedures, in cooperation with the body in charge of the management of catastrophic emergencies: the Protezione Civile (Civil Protection)

For centuries, direct interventions of the Church and theological considerations have supported and encouraged solidarity actions and resilient responses from the inhabitants. On the other hand, in recent years psychologists and mental health professionals have started to hold a major role as well[3]. They work for the national healthcare system, which has a widespread coverage and coordinates public and private intervention procedures, in cooperation with the body in charge of the management of catastrophic emergencies: the Protezione Civile (Civil Protection). The peculiarity of this Italian Department, which was designed and established after the 1980 disaster in Irpinia[4], derives from the organisation of its system, which is no more based on the centralised control of emergency relief efforts, with the State providing all support to the victims, but on the actions of the regional governments and authorities, coordinated by the central Department. Local institutions, organisations and teams of trained volunteers thus work together in mutual aid, all suppling specific assistance according to the Metodo Augustus[5], which has been gradually improved.

Because this system is grounded on the work of local entities, it makes it easier to deal with post-emergency issues with continuity. Moreover, it highly values prevention – meaning perceiving and foreseeing risks and providing training accordingly – as a key practice to limit the damage and come out of crises in the best possible way.

The idea to offer specialised mental health services to the victims and to provide psychological support to aid workers started to take shape inside this system. It is indeed a priority to take care of material resources and technologic supplies and to meet the everyday needs of the organisations involved and of the people struck by the disasters; besides, it is also necessary to rescue, protect and nurse human minds and relational networks (groups, families and local associations) in order to restore the population's active and cultural ca-

pacity to react to environmental challenges. As a result, in 2006 the Protezione Civile drew up a plan containing general directions related to psychosocial assistance during severe national natural emergencies[6].

According to international considerations and guidelines, specific funds should be allocated to mental healthcare before, during and after natural disasters. The national healthcare system is supposed to provide these resources, with the support of aid organisations. The first systematic and organic psychosocial actions in Italy occurred after the 2009 earthquake, although significant efforts in this field were made in 1997, 1980 and even 1908 (after the dreadful earthquake in Messina)[7].

Emerging needs and viable responses

These recent organised efforts have made it possible to monitor the impact of earthquakes in terms of healthcare and social and psychological disruption; moreover, they became an instrument to verify the limits and efficacy of the different strategies of intervention and support.

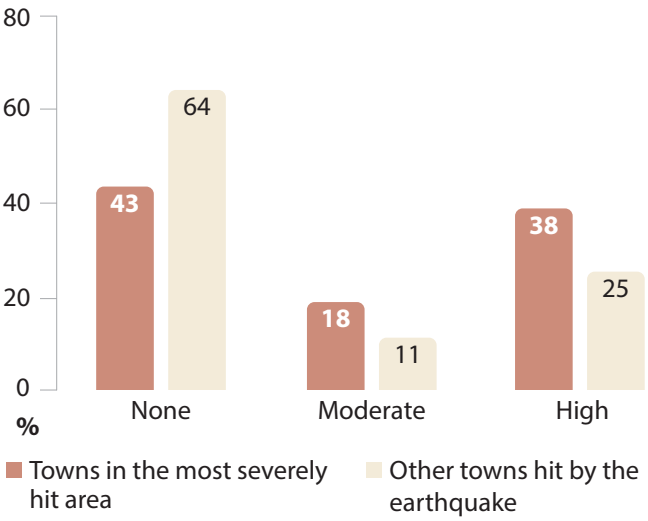
In 2010 the first systematic study on the impact of earthquakes on people's mental health was conducted in Abruzzo. In order to properly evaluate the consequences of the disaster, which had occurred the previous year in 2009, the first step was to define some key indicators. These fixed markers were then employed to compare the data related to the time right after the earthquake and all the information that had been collected in the same area (around the town of L'Aquila) in 2007 and 2008[8].

Because these pre-disaster data were available, the research gained major significance. All the previous studies, in fact, had only analysed the situation of post-disaster distress, thus being unable to evaluate the actual changes in people's psychological conditions before and after the tragic events.

The research showed that, after the earthquake:

- the symptoms of depression had become more frequent compared to the numbers assessed at L'Aquila before the disaster, while the percentages of cases of post-traumatic stress disorder now outnumbered those recorded in the studies about the whole country;
- the incidence of harmful behaviours in people had increased: more people were living sedentary lifestyles, the number of former smokers had diminished, smoking and alcohol abuse in young people aged 18 to 34 was more frequent compared to the national average (although excessive alcohol consumption in the general population was not higher in comparison with the situation before the disaster);
- the perception of one's state of health and his or her health-related quality of life had not notably gotten worse, so it was not possible to assess significant changes in relation to the economic and human losses or caused by the stress due to the dislocation. Similarly, the data did not show a statistically meaningful correlation between the victims perceiving that their quality of life had become worse and the manifestation of symptoms of depression or post-traumatic stress disorder – despite their incidence was very high. As a matter of fact, compared to the general sample, the people that had been experiencing symptoms of depression were actually less likely to perceive that their health and quality of life had gotten worse.

INTRUSIVE THOUGHTS OF PEOPLE AGED 18-69 AND LIVING EITHER IN THE MOST CRITICALLY DAMAGED ZONE OR IN SURROUNDING AREAS



Source: Istmo

Following the 2012 earthquake in Emilia-Romagna, an accurate research study further assessed the impact of disasters on the physical health, lifestyle and emotional state of the population involved, making use of data that was collected up to three years after the events[9]. We will focus on the results related to intrusive symptoms of PTSD and to states of anxiety and depression.

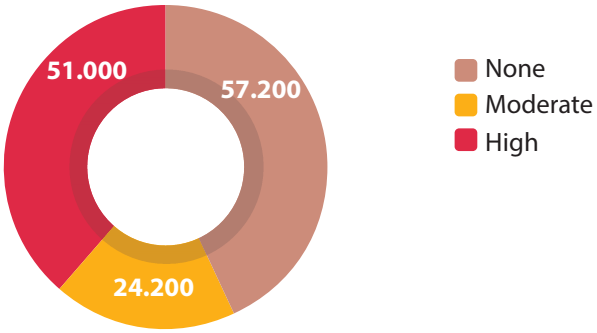
According to the collected data, the people from Emilia-Romagna were still considerably suffering from intrusive symptoms connected to post-traumatic stress disorder two or three years after the earthquake. 52% of adult residents aged 18 to 69 reported having intrusive thoughts; of them, 35% were experiencing them in a severe form and 17% in a moderate form. Severe intrusive thoughts were notably more frequent in the area that was most critically damaged by the tremors, especially in the town of Mirandola.

These statistics accounted for thousands of people in distress: in the municipalities involved, an estimated number of 61.000 adults kept thinking about the tra-

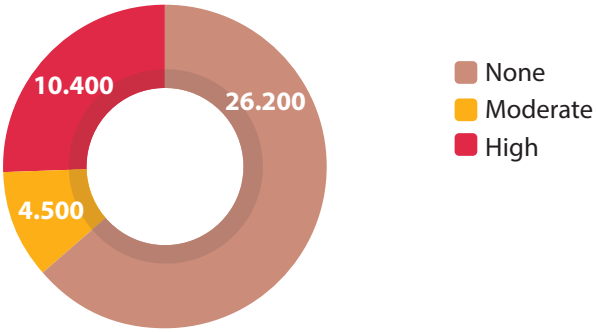
gic events against their will and 51.000 of them were residents of the most severely hit area *(see diagrams)*.

ESTIMATED NUMBER OF PEOPLE AGED 18-69 AND LIVING EITHER IN THE MOST CRITICALLY DAMAGED ZONE OR IN SURROUNDING AREAS

Towns in the most severely hit area



Other towns hit by the earthquake



Source: Istmo

As far as anxiety-related issues are concerned, in the survey 14% of the inhabitants aged 18 to 69 reported that a healthcare professional had attested to them some form of anxiety disorder at least once in their lifetime: 5% had experienced it before the earthquake, 7% after the calamity and 2% both before and after the events. The percentage of victims that were diagnosed with anxiety disorder only after the earthquake – an estimated number of almost 12.000 adults – did not vary significantly whether their place of residence was more peripheral or more central in relation to the epicentre, with 8.000 people from the most damaged area reporting these issues.

Combining these data with all the sociodemographic variables considered (gender, age group, level of education, financial means and citizenship) there seemed to be no real correlation between clinically relevant states of anxiety and personal suffering due to injuries and losses in terms of human lives and emotional bonds. However, levels of anxiety were considerably higher among the victims who had suffered severe material losses (11,5%) and especially among those who had lost their job (16,7%).

Regarding depression, the percentage of people showing clinically relevant symptoms was higher among the victims who had suffered physical injuries or who had lost family members or human bonds due to the earthquake, thus showing a direct statistical correlation between symptoms of depression and personal and human losses.

However, it is worth mentioning that the overall percentage of people manifesting symptoms of depression decreased from 10,3% to 7,2% after the earthquake, while this phenomenon did not involve the residents living in the same Province but in municipalities that were not affected by the disaster. A similar trend was reported at L'Aquila, where the symptoms of depression had increased in the year right after the earthquake, but decreased over the following three years[10].

Analogous investigations have been conducted following the more recent earthquakes that have hit Central Italy, which struck groups of people who were still upset by the previous calamitous events and were in the process of rebuilding their homes and coming to terms with the trauma. Moreover, the protracted duration of the new tremors forced the communities and the individuals into a state of incessant alarm and did not give them a chance to finally feel safe and reorganise their lives.

Conclusive considerations

The data that have been mentioned above reasonably leads to a few final remarks:

- the systematic application of appreciable indicators that have been agreed on by the scientific community is effective in order to evaluate the impact of earthquakes on the population's mental health. Amongst the indicators to take in consideration are the new diagnoses of anxiety and depression, the presence of intrusive thoughts, the amount of self-harming behaviours, the subjective perception of discomfort and the personal evaluation of one's quality of life.
- It is essential to dispose of preliminary data concerning the victims' previous mental state to appraise the actual changes that have occurred after the disastrous events. Therefore, it becomes crucial to collect data and keep the selected indicators monitored as a preventive measure.
- Analysing the relation between an individual's demographic attributes, the vicissitudes encountered and his or her psychological responses is of the outmost relevance, because the human mind responds differently according to the individual's expectations from life and to age-related past experiences. As a matter of fact, losing a job could cause deeper psychological scars than actual physical injuries. Moreover, dealing with critical environmental conditions could even bring about positive changes for

people who had been experiencing symptoms of depression before the disaster.

- So far, the major limit of these quantitative investigations is that they fail to establish a correlation between the data and the social, economic, cultural and psychological interventions that take place on the territory. In fact, organisations and volunteers regularly rush to the victims' aid after each earthquake in Italy, which may have led to many positive phenomena, such as the general unchanged perception of one's quality of life and the relative improvement of people suffering from depression. On the other hand, some critical states of anxiety and the persistence of intrusive thoughts could be due to a lack of interventions aimed at preserving social bonds and providing specific trauma-related treatment.

All of these considerations should encourage the scientific, professional, civil and ecclesiastical communities to stand by the victims' side and to renew their efforts towards a deeper understanding of those struck by unexpected and destructive natural events such as earthquakes.

THE EXPERIENCES OF THE CARITAS ITALIANA IN CENTRAL ITALY

Text by father Andrea La Regina, Major Projects Office, Caritas Italiana

The increasing number of emergencies related to natural catastrophes and man-made disasters impels the society to find a way to rebuild what has been damaged not merely in terms of housing, but also concerning community life and the population's psychological response.

In the "Global North", Italy included, decision-making processes can take several different forms, which could be questionable on a daily basis but show their deeper weaknesses in times of emergency. In those occasions, central government representatives often tend to appropriate all decision-making power, at once demeaning the role of the local authorities and making choices that radically affect the future development of the territory at issue. This is what happened, for instance, after the 2009 earthquake in Abruzzo, when the residents felt uninvolved and deprived of their personal responsibility. In other occasions, central government politicians avoid making decisions as an electoral strategy, or even choose to join the protests against the management of the emergency in order to gain popular consent.

When the earthquake struck Emilia-Romagna in 2012, the state of emergency was declared for a limited amount of time, which allowed the regional authorities to take charge of the situation. They opted in favour of a direct management of the European Union emergency funds, while the national government merely fulfilled its legal duties and even the involvement of the Protezione Civile was limited.

The citizens responded with an active participation, as the cooperative interaction between families, workers, businessmen, trade unions and social groups kept the community together and promoted the economic recovery, for instance, of the agricultural and healthcare sectors, in which the region went back to excel on a global level.

The most recent major emergency is the 2016 earthquake in Central Italy, which has involved a wide geographic area across four Regions. The calamity is persisting to this day with minor shakes that are denying the population the chance to recover. In many cases, the victims were forced to leave their houses and seek refuge on the shore, deserting an agricultural territory on the Apennine Mountains which was already suffering from a growing phenomenon of depopulation. Although the core of the social structure seems to have overcome the difficulties, the socioeconomic reconstruction of these areas will be particularly challenging.

New forms of active participation should be put to the test in order to enhance safety in regions of high seismic hazard as well as to reconstruct the population's social and cultural identities. These activities could, for instance, promote agricultural development, the tourist industry or more in general any enterprise that values the cooperation of the community and looks ahead to the future.

In the light of these considerations, all emergency interventions should keep the following elements in consideration:

- the cultural and historical identity of the territory;
- the socioeconomic situation and the human and social capital;
- the involvement and participation of people and local institutions;
- the importance of keeping the social groups at the centre of the process;
- the relevance of projects aimed at the development of "the whole man".

6. Stories and testimonies

RESTLESS SLEEP

It was an ordinary Saturday morning in Nepal, a day of rest to spend with one's family and loved ones. Sweta had done the laundry and marinated the chicken for dinner and was now in the kitchen preparing some good *chyia* (tea) for the whole family. That night relatives and friends were going to arrive from all parts of Kathmandu to celebrate the *gupha basnu*, a ceremony for the upcoming first menstruation of her 12 year-old firstborn Samu. It was almost midday and her husband Krishna was watching television, while their two daughters Samu and Laxshmi were light-heartedly playing in the garden.

Planes would often take off close to the neighbourhood of Jawalakhel, rumbling over the roofs and lightly shaking the windowpanes. It was a familiar noise to which all residents were accustomed to, and that blended with the sounds of traffic and with the screams of the peddlers, who would sweep all the alleys of the city on their bicycles heavy with fruit.

A rumble interrupted that moment of peace. Sweta imagined how large that plane must be to cause such an uproar and make the panes convulse so dreadfully. But something unexpected was about to happen: the house started to shudder horribly, while a gloomy and terrifying noise emanated from the bowels of the earth.

Sweta left the kitchen quickly and went for the front door, followed by Krishna and the two girls. The earth under her feet was quaking uncontrollably and the beautiful house where she had been living since her marriage seemed to be about to collapse at any moment. She ran frantically towards the field beside her home, where all the neighbours were gathering too. She thought that it must certainly be the end of the world, because she had never experienced something like that, nor ever heard of similar events in the stories of the elders.

All the residents remained in that safe open space for hours, terrified at the idea of new devastating shakes. They were unable to think about what to do next and could only wonder whether they'd see the sun rise again. The earth kept trembling, while everybody was starting to feel a profound fear of new possible catastrophes, a dread which would not let go in the months to come and which many people would try to smother with too many glasses of the local liquor. That day, the incessant tremors under their body and the cries of the exhausted children made it impossible for everybody to find some rest.

«Shiva is angry with the conditions of our country and this is his punishment for the corruption, the bad politicians and the criminality. We should expect something even more terrible» shouted Prakash, Sweta's old father-in-law.

No-one had the courage to enter their own homes, not even to cook. Only Sweta, brave and unheeding of the warnings, decided that they needed to eat something after all or at least to drink some hot *chyia*, which would lift the spirits of the evacuees and bring some normality to that tragic Saturday. Wrapped in her red *salwar kameez*, she entered her house.

But a new powerful earthquake shook the building. Sweta could not reach the front door, she was trapped! She could hear her daughters scream in the distance, the people panicking and the roar of the rubble slamming into the ground...

Sweta woke up suddenly and sat on her bed, covered with sweat. Krishna was sleeping untroubled by her side and only some stray dogs fighting were breaking the silence of the night. **She tried to go back to sleep and to chase away the monster that was haunting her dreams.**

THE VIEW ON THE KOSHI RIVER

Watching the great Koshi River, Shyam was savouring the rice with lentils that his wife had prepared. The watercourse was flowing peacefully through the terraced hills of Koshidekha, with the corrugated metal roofs of the temporary houses shining on top. **Two years had passed since the terrible earthquake that had brought Nepal to its knees and many of Shyam's fellow citizens were still living in precarious conditions, without a safe and comfortable place to call home. Just like him.** The snow-capped peaks of the Himalayas were framing the scenery, moving Shyam deeply as if he was admiring that glimpse of Nepal for the first time.

The lunch break was about to end, so it was time for Shyam and his family to resume making bricks for their new house. That week it was their turn to use the machinery, so they had to put to use all minutes available and just hope that there would be no blackouts, because they needed electricity to run the generator that powered the brick-making machine.

What kind of life was that? What had he done wrong to deserve such a fate? Shyam was the youngest of seven siblings and at his father's death, when he was just a teenager, he had left home to go find a job in Kathmandu. Working as a waiter and as a salesperson he had finally managed to save enough money to return to his village and build a house. However, he had enjoyed the new home with his family for merely a year... Two years before, on the morning of the 25th of April, the house had collapsed in an instant like a sandcastle, leaving only ruins behind.

Nothing could ease Shyam's sorrow: the memory of the rumble, of the small buildings crumpling and of the women screaming in despair were haunting him. His young bride Priska seemed sometimes filled with joy and in other moments completely uninterested towards life. Some days she would barely look after baby Ramesh and spend all waking hours on her bed, drinking too much of that *raksi* that the neighbours made. Some other days she would display her most beautiful smile, take care of the household chores and spend time with her girlfriends. Also Shyam's mind was playing tricks on him. In his dreams, he would constantly see Koshidekha shrouded in a ghastly atmosphere and hear the deafening sound of the earth shaking violently, threatening to swallow everything and everyone.

But it was now time to get back to work and dream about his new house overlooking the placid Koshi River.

COLIN, FROM IRELAND TO NEPAL

His eyes widen imperceptibly, his jaws tighten a bit and his internal vigilance is triggered. It is just another truck full of rocks to repair the road, which is travelling through the clouds of dust in the centre of Kathmandu. The weight of the vehicle is putting the road under stress, and even the vibrations of the pavement are enough to alarm Colin.

Almost two years have passed since 12th May 2015. He was under the shower, after two full days of field work and the morning in the office, when the earth started shaking again. The screams of the people on the street, terrified and exhausted by the incessant tremors, merged with the roar of the earthquake and generated a steady terror in his mind. That day he put on his clothes without drying himself and ran down those narrow swaying stairs, blinded with fear. Sharing his experience with his colleagues, providing aid to the population and setting up the tents for the night, however, soon helped to dilute his feelings of dread. They had dinner all together at the camp and spent hours counting the shakes, so his knees gradually stopped trembling and the swirling thoughts in his mind started slowing down.

Every time Colin has returned to Nepal since that day, his vigilance has automatically sharpened and his mind become alert as if after an intensive training, making him check all escape routes of buildings, cities and mountain paths.

Some of Colin's colleagues have been having recurring nightmares for months, some have been using alcohol to help them sleep and some others have slowly cut down on their missions in Nepal and ended up not going anymore, but most of them just kept smoothly doing their job. Colin, instead, feels the vibrations almost before they reach him and avoids closed spaces even in Ireland, his country of origin. In Nepal, he sleeps with his door unlocked, keeps clothes always ready in case of an emergency and mentally maps the escape routes several times a day.

He relies deeply on the company of friends and colleagues. In that way, the earth seems to vibrate a little less, even when trucks pass by.

DOCTOR PRAVEEN K., PSYCHIATRIST AT KATHMANDU PUBLIC HOSPITAL

Are cases of PTSD still widespread at the moment?

«No, they have been gradually decreasing since the earthquake. During the first six months after the disaster, a high number of victims presented trauma-related symptoms and some of them were suffering from actual PTSD, but the people coming in with these issues have become much fewer over time. Today, almost two years after the earthquake, maybe one or two percent of the patients may be suffering from PTSD».

Did you receive any useful data from the Ministry of Health or the Department in charge of mental health?

«No first-hand reliable data are available at the moment, and one of the reasons why is that there are several concurrent diseases whose symptoms tend to overlap. In other words, concerning psychiatric disorders and psychological distress, many issues often coexist and some of the symptoms of different diseases are the same, which makes it hard to draw a precise distinction. As a result, most of the cases that we are treating could also be linked with PTSD, but we cannot be one-hundred percent sure».

What are the most common psychological issues in the capital?

«Here in Kathmandu we mostly deal with cases of generalised anxiety disorder and psychosis, but we also have several patients with schizophrenia and depression».

A large number of the victims came from the hill country or from remote and mountainous regions. What effect did the earthquake have on them?

«I believe that the disaster had a similar impact on them and on city residents, but we have no data to

support that. In case of psychiatric disorders, the people from the valleys and villages can turn to regional hospitals».

Are psychological and psychiatric services not available at the health posts and health centres of the villages?

«No, they aren't. Only regional hospitals have a psychiatrist and it is very uncommon to find a psychologist at all».

Could you explain that in other words?

«Just like in all parts of Asia, psychological and psychiatric services are not widespread nor developed here. People often turn to psychiatrists for non-psychiatric health problems, because alternative therapies are seldom available in Kathmandu and even more infrequent in the villages. After the earthquakes, several humanitarian organisations have sent more or less specialised aid workers in the outermost areas, which helped in some cases. However, it would be necessary to monitor and evaluate those interventions».

What is the main psychotherapeutic practice in Nepal?

«It is cognitive behavioural therapy. Other approaches are limited and nearly non-existent».

You work in the most important public health facility in the country. Is it true that health professionals from your hospital travelled to the most remote regions to examine the victims?

«Since the earthquake we have helped in suburban areas of the city or inside Kathmandu District, but never in a systematic and regular way».

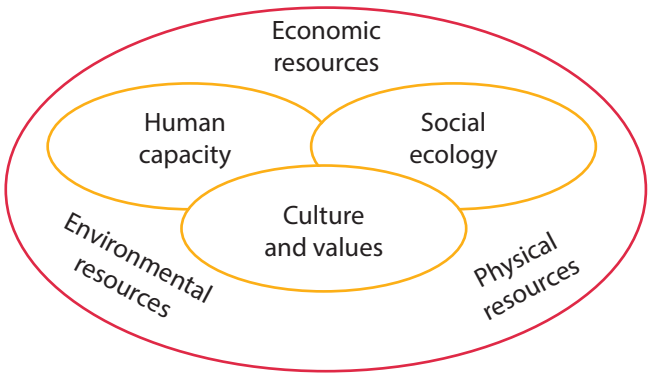
7. Possible responses to the issue of psychological pain

A psycho-&-social approach

Several scientific studies have underlined and confirmed that natural disasters deeply affect the lives of individuals and communities and alter the society as a whole, giving rise to new issues as well as exacerbating pre-existing psycho-&-social weaknesses and distress.

The psycho-&-social spheres, which are affected by catastrophes, are intimately related and interdependent, with a mutual influence on each other. That is why, in the field of humanitarian aid, the interventions in support of the victims are usually designed on a psychosocial basis, as the directions and guidelines of several organisations clearly show.

DOMAINS MAP OF PSYCHOSOCIAL WELL-BEING
(from the Psychosocial Working Group 2003)



The diagram above illustrates how all the core domains of psychosocial well-being are part of a whole, with «… the recognition that there is always a close, ongoing circular interaction between an individual's psychological state and his or her environment»[1]. Given the complexity of these relations, the best approach to tackle psychosocial issues would be to coordinate several different professionals, all of them focused on their specific field of expertise and working jointly towards a common goal. However, experience on the field shows that this approach risks to generate confusion in the management of the emergency, which would not be of any help to those in need.

As a matter of fact, especially in developing countries and in the whole of Asia, specialised psychological and psychiatric services tend to have a one-sided medical approach; in fact, most interventions rely on medication, even in those cases in which associating drugs with psychotherapy or simply relying on psychotherapy is proven to give better results and provide higher recovery rates. Moreover, the social services in these areas often lack training and competence, have a mild influence on the society and are more focused on charity actions that in building and promoting resilience amongst the population.

As a result, even in post-emergency contexts, healthcare professionals may have to deal with social issues, while social workers happen to take charge of psychological or even psychiatric interventions. In these situations, the aforementioned interdependence and connection between the social and psychological spheres does not help, nor does the habit to consider different professional roles and qualifications as nonspecific. This approach is very common in humanitarian organisations, which are the main bodies that come in contact with the population during an emergency.

According to our experience in terms of project monitoring and evaluation, we believe that considering – as well as defining – the psychosocial spheres as more independent from each other would lead to a functional division of professional roles and to more specialised and efficient services. That is why the terms "psychosocial" or "psycho-social" should be replaced with "psycho-&-social", because the latter definition at once expresses the relation between the two and their specific fields of intervention, including the peculiar expertise of the professionals belonging to each group.

The two terms were combined for historical reasons, because at the time it was necessary to learn how to synchronise and coordinate everybody's work. This approach led to good results but also to an inaccurate organisation, which is why a slight separation of the two spheres would lead to prompter and more meticulous services.

The terms "psychosocial" or "psycho-social" should be replaced with "psycho-&-social", because the latter definition at once expresses the relation between the two and their specific fields of intervention, including the peculiar expertise of the professionals belonging to each group

MODES OF INTERVENTION

Psychological support for people suffering from PTSD

In order to treat people affected with PTSD there are several different modes of approach, which may belong to the medical (treatment with specific drugs), psychological or social areas. When approaching this disorder from a psychological perspective, there is a large variety of different procedures and therapies, some of which are enlisted below as examples.

Cognitive behavioural techniques

Cognitive behavioural interventions focus on the relation between an individual's thoughts, emotions and behaviour. Among them, the most widely used to treat PTSD are:

- exposure therapy, which helps the patient to face the memories of the trauma and deal with the people and objects associated with it;
- cognitive therapy, which is based on the work on the patient's frame of reference and on their thoughts and emotions, with a consequent change in behaviour and a reduction of the symptoms;
- stress management: the therapist teaches the patient how to deal with stress and with his or her perception of stress through different relaxation techniques.

Other techniques

EMDR (Eyes Movement Desensitization and Reprocessing): this therapeutic technique, devised by Francine Shapiro, includes a tested, approved and verified protocol and consists in reprogramming the memories of traumatic events through eye movement exercises and rhythmic hand movements.

Person-centered counselling: helping the patient express their feelings, ideas and emotions, the therapist can use this non-directive support therapy to help them sort their issues out and reach their life goals effectively and with peace of mind.

Psychodynamic therapies: these approaches are focused on revealing and resolving the unconscious conflicts caused by the trauma.

Preventing PTSD and other stress-related disorders

Prevention plays a fundamental role concerning stress-related issues, and its main purpose, as mentioned in the previous chapters, is to make the resilience of individuals and communities stronger. Social networks are extremely important in these regards, because they can strengthen people and provide them with the necessary skills to face the general problems of existence and to deal with accidents or natural catastrophes. Moreover, social cohesion – meaning the integration of individual, family and community networks for a common purpose – has a major role too.

Working towards a more solid social cohesion and stronger social networks leads to healthier citizens, living in a society that is able to provide each individual with the necessary support in case of stressful events, with a consequent decrease of psychological suffering cases and mental diseases following natural disasters. The development of these social elements contribute to the improvement of people's resilience and psychological flexibility when unforeseen events occur. Other factors related to psychological wellness and the management and development of social relations, for instance the parenting style during infancy, have a fundamental role too.

Caritas, other humanitarian organisations and the governments should therefore put in practise some preventative measures aimed at shielding the victims of natural catastrophes from psychological issues and protecting the communities:

- parenting education for young couples before and after marriage;
- parenting education for married couples with young children;
- motherhood guidance for pregnant women and women who have just given birth (prevention of post-partum depression);
- community social skills education [2], with groups divided according to age and/or basic social skills;
- promoting activities aimed at enhancing social belonging and self-trust [3] such as volunteering, community work, cultural and sports activities and so on;
- promoting social groups that are not based on income [4] but on common interests, on spending time together, on making new experiences and on developing their social resources;
- specific social skills training;
- specific individual and community emotional skills training;
- creation of areas dedicated to creative expression.

Engaging with these activities and similar others is helpful in terms of prevention and to alleviate some of the victims' symptoms after traumatic events, but it does not solve the situation of distress that the emergency itself has brought about. In fact, when

such activities are planned shortly before the calamitous event, it is already late for them to give a significant contribution. However, working on the social sphere is nonetheless fundamental to make the society more and more resilient and cohesive.

Alongside the activities in the social field are psychological interventions, which Caritas and other organisations could organise as follows:

- advocating the establishments of efficient health systems that are able to meet the citizens' mental health needs;
- hiring people specialised in the treatment of psychological fragility;
- official coordination with representatives of the government and of public health and mental health departments;
- creation of protocols containing guidelines to reach the people in need, to identify early signs of psychological distress, to provide specialised support and to ensure regular follow ups over time;
- coordination with government social workers and between the organisation's employees in order to maintain the right balance between the social and psychological spheres;
- inserting specific guidelines regarding emotional training and post shock coping strategies in all DRR (Disaster Risk Reduction) programs;
- emotional practise.

8. The response of the ecclesiastical world after the earthquake in Nepal

Nepal's extremely complex political and social history had a deep impact on the relief operations and the reconstruction efforts after the earthquake. The constitutional law reforms, the social tension, the geopolitical manoeuvres (with the involvement of the neighbouring countries China and India) and the incessant succession of elections and new governments did not contribute to create a stable and functional institutional framework, ready to face any unexpected event. As a result, the general context in which the aid operations and the reconstruction took place was not easy to deal with and caused delays and obstructions.

Despite its minor presence in Nepal, church has been giving dynamic and considerate contributions to the society. After the earthquake, Caritas Nepal and other faith-based organisations in the country took an active part in the aid operations, and Caritas Italiana also gave support to non-church organisations that had been working in those areas for a long time.

Immediately after the earthquake, the relief support mainly consisted in providing food and water, makeshift shelters and hygiene kits. In the second phase of the intervention, it became a priority to build temporary medium-term shelters, guaranteeing a supply of food and other essential goods and providing basic health services to the most isolated communities. In that stage, the coordination between all aid organisations was essential.

During the reconstruction phase – which is undergoing to this day and is going to absorb most of the resources and care in the medium-term – aid workers are busy with the construction of thousands of permanent houses, schools and health facilities, while giving their support to small local enterprises.

In Nepal's hour of need, all the different bodies of the Nepalese Catholic Church – Caritas Nepal, the deanery and the female and male religious congregations – rushed to the victim's aid to help them regain and preserve their mental and social well-being. The Jesuits are building a day-time reception centre for boys and girls with mental handicaps or psychiatric disorders, while the Sisters of the Good Shepherd and the Sisters of Charity of Nazareth have been supporting villagers with individual and group counselling sessions.

Caritas Nepal's post-disaster intervention, on the other hand, has been focused on many sectors, including the psycho-&-social spheres. Thanks to the support of the Cadis Foundation – the humanitarian and development arm of the Order of the Camillians – Caritas Nepal managed to set up and initiate an extensive support program integrating the psycho-&-social spheres and including an operation of mainstreaming, that is to say aimed at reaching all segments of the population, even the weakest and disregarded ones. Caritas Nepal social workers were specifically trained to be able to spot early signs of distress in people, to master animation and community rebuilding techniques as well as methods to improve the communication with the specialised services.

The program includes the following activities:

- recreational and group-building projects for children;
- cultural initiatives;
- individual and group counselling;
- specific training on socially relevant themes, such as gender-based violence, alcohol addiction and social exclusion;
- providing help to people requiring appropriate psychological and psychiatric services.

Caritas Nepal is carrying out these projects also with the help of local organisations such as TPO, an experienced and technically competent organisation that is specialised in blending psycho-&-social interventions as well as providing specifically psychological treatments, all of this thanks to its team of psychiatrists, clinical psychologists and counsellors.

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OVERVIEW OF THE INTERVENTIONS FINANCED BY CARITAS ITALIANA IN SUPPORT OF THE NEPALI COMMUNITIES HIT BY THE EARTHQUAKE TWO YEARS AFTER THE DISASTER *(march 2017)*		
Area of intervention	**Project description**	**Grant** *(€)*
Kathmandu	Joined intervention with Caritas Nepal in support and immediate assistance to the victims of the earthquake	100.000
Rasuwa	Provision of temporary shelters resistant to the monsoon and of other pieces of equipment	93.404
Lalitpur	Humanitarian aid in schools hit by the earthquake in the Lalitpur District	29.616
Sindhupalchowk	Community-based psychosocial support	9.140
Kathmandu	Support to 100 poor families	88.800
Kavrepalanchowk	Assistance to the victims of the earthquake through the provision of temporary shelters and seed	199.109
Pokhara, Kaski District	Relaunch of school activities	20.000
Kathmandu	Overhaul and reconstruction of health centres	46.200
Ramechap District	Reconstruction of four schools torn down by the earthquake	367.000
National level	Joined program of reconstruction and socio-economic rehabilitation of the communities hit by the earthquake	2.600.000
Pokhara, Kaski District	Support to children who are abused and at risk for human trafficking	55.000
Makwanpur	Support and basic health assistance through medicines and specialised staff	30.000
Simpani, vdc Khaniyapani 4, Ramechhap District	Construction of Shree Balkayan School	100.000
Makwanpur, Gorkha	Reconstruction of 288 houses for poor families	314.000
Kavrepalanchowk, District	Post-disaster aid, overhaul and reconstruction of school facilities	358.808
Rasuwa	Building a better future in the most damaged areas	450.000
Rasuwa	Reconstructing and strengthening the resilience of the communities	200.000
Different areas	Social advancement of the young generations, against human trafficking and sexual exploitation	195.500
Bhimtar, Sindhupalchowk	Health centre in Bodgaun	160.000
Kavrepalanchowk	Humanitarian aid to school students and staff hit by the earthquake	21.174
Bajura District	Aid during landslide emergency	26.920
Banke District	Building community resilience during calamities	50.000
Kathmandu Valley	Assistance and social care for people with drug addictions	102.300
Banke District	Support to the reconstruction, psychosocial assistance and relaunch of local enterprises	77.000
Banke District	Better access to water, to sanitation services and to basic medical services	121.500
Lalitpur District	Promotion of production lines	167.145
National level	Technical support to health projects	5.000
National level	Support to the development of drug abuse programmes	10.000
Banke	Community-based risk management	50.000
Dhading District	Strengthening livelihood capacities and transforming the way of life of the Chepang community	42.927
Sindhupalchok	Reconstruction of a school	17.000
Nuwakot District	Better living conditions for poor families in rural areas	38.712
	Totale	**6.146.255**

NOTES

Introduction

1 Caritas Italiana (2015), *Serbia e Montenegro: Liberi tutti! Salute mentale: non gabbie ma dignità per i malati*, Dossier con Dati e Testimonianze (Report with Data and Testimonies), n. 9.

1. The issue: psychological balance and the importance of mental well-being

1 Preface to the constitution of the World Health Organization, which was signed in occasion of the World Health Assembly (New York, 19-22 June 1946) by 61 countries and became effective on 7th April 1948.

2 World Health Organization (WHO), http://www.who.int/features/factfiles/mental_health/en/

3 Extract from the *Mental Health Action Plan 2013-2020*, WHO, 2013, http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1

4 Research on patients living and receiving treatment in the United States, conducted by Alex J. Mitchell and David Lawrence and published in the *British Journal of Psychology*, May 2011.

5 Extract from the *Mental Health Action Plan 2013-2020*, WHO, 2013.

6 *Ibidem*.

7 Studies on the correlation between natural disasters and suicide rates show that the number of attempted suicides and actual suicides drop drastically during the phase immediately after a calamitous event, but have a peak right after the emergency phase, that is to say after the so-called "honeymoon" has passed (Kõlves K, Kõlves KE, De Leo D, *Natural disasters and suicidal behaviours: a systematic literature review*, *Journal of Affective Disorders*, 2013).

2. Natural disasters and their impact on human health

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3. Some data on psychological pain in post-disaster Nepal

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Although after natural catastrophes physical destruction draws a lot of attention, the victims' psychological suffering is often less visible but just as harmful, because its effects can persist for a very long time.

Weaker people are also the most vulnerable in these circumstances, because their deeper psychological suffering may turn into actual mental disorders. Social, cultural and religious aspects play a major role in the way that such pain is processed and faced.

A study conducted in Nepal two years after the earthquake clearly shows how this suffering still lingers amongst the population and how hard it is to give an answer to the issue.

It is vital to intervene with the right instruments and on various levels: on a social basis, teaching the communities how to support the individuals in need, and providing actual psychological aid.

This dossier illustrates the complexity of multi-faceted interventions aimed at helping people endure the adversities of life.

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