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Professional Section:

PSYCHOSOCIAL REHABILITATION DURING NATURAL DISASTERS

In the light of the recent tragedy of natural disaster in Uttarakand, which many experts claim to be man-made disaster, has brought down the whole region into chaos. However, keeping away the politics and regionalism aside, the whole of India moved in integrity and The Rehabilitation Psychologist salutes this integrity.

Rehabilitation of the victims is an inevitable process, in this vein "The Rehabilitation Psychologist" has a done a review of literature on three topics:

1. The behaviours of people during evacuation process;
2. Studies done on psychological effects of natural disasters ;
3. The role of Rehabilitation Psychologist

There are no studies done in India regarding the behaviours of people during evacuation process, although, India does witness such emergencies frequently. Except for logistics, the evacuation process is different from emergencies like terrorist attack and natural disasters. In context to naturally occurring calamities Stanley and McCarty (2009) have studied the attitudes and factors influencing the evacuation process during hurricanes in 2004 identified that more than half of the non-evacuees believed that hurricane is not serious threat and their current location is safe. Others (8%) were concerned about leaving pets behind and houses unattended. "Families evacuate as a unit; typically, all members evacuate, or none do" (Stanley and McCarty, 2009). Studies report decline in evacuation rates as the household size increases. Households with children may be more likely to evacuate because of concerns about child safety and perhaps because women-- who are often found to have higher evacuation rates than men -- generally play the predominant role in making decisions affecting children. A number of studies have found older adults to have lower evacuation rates than younger adults. Homeowners may be less likely to evacuate because ownership make them more concerned about protecting their property against storm damage and looters. Another important demographic characteristic is previous experience.

Clearing the misconceptions about disasters and social attachment, Jacob (2008) delineates myths and facts about natural calamities, as to what is expected by the victims and other think about them. One of the interesting thing he mentions is that it is a myth that calamities bring worst of human behaviour (e.g., looting, rioting) although, isolated cases are reported but the fact is such stress brings out best of behaviours like altruism, endurance and resilience. Breaking down another such myth that things returns to normal within few weeks, Jacob et al., report that the fact is disasters stamp long duration repercussions and major economic consequences. Aids and resources wane away when the demands are more and shortage become more pressing.

Studies on Psychological effects are well documented with PTSD being the major culprit of aftermath of disaster. Jacob et al (2008) reports that experience of disaster leave a permanent mark on the lives of the victims. In the same vein, documenting the mental health problems in the victims of Tsunami Bryant (2006) report associated conditions like anxiety, depression and grief. These need to be addressed with psychological first aid containing the morbidity (Rao, 2006). Although certain studies claim healthy resilience (Bonanno, 2008), which is again limited to age, gender, levels of stress exposed to and social support. Disaster management is an inevitable economic burden both in developed and developing countries. Nevertheless, Government dutifully deploys resources like military, medical and meterological services, it is difficult to collaborate due to poor training in interdisciplinary emergency communication. Although, all the above said departments react professionally in their areas, it is difficult to convince the stakeholders and take them in confidence. It seems that the role of Rehabilitation Psychologist becomes pivotal in catalyzing and lubricating the process of evacuation, rehabilitation and main streaming the

effected population. Htay (2006) has studied disaster preparedness in Myanmar, which established Emergency healthcare Committee under ministry of Health (MoH) and has reported that psychosocial support to the affected community not only reduces its psychological distress but can also facilitate physical rehabilitation. Dorji (2006) reports the preparedness of Butan to natural disasters with a four-tier system of mental health intervention and counselling has been proposed in line with the existing healthcare system and resources available in the country to make it sustainable. The core of this programme is the mobilizing and training of volunteers from the community on psychosocial intervention, counselling and rehabilitation, backed up by three layers of trained health workers and mental health professionals. Choudary (2006) documents the preparedness in Bangladesh, who upholds the importance of NGOs during natural disasters because of their like with grass root workers and urges team work of government and non-governmental organizations.

Therefore, it is necessary to train the professionals by mock drills, in endurance training, negotiating, and techniques to mobilize the people living in high risk areas and protecting the vulnerable like women, children and senior citizens from exploitation. This makes the disaster management comprehensive and economical by preventing causalities and property damage and maintaining quality of life of geographically vulnerable population.

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Visitor's Section:

BRAIN AND BEHAVIOR: SEIZURES (Series-2)

The mechanisms of actions of the seizure drugs can be broadly classified according to action mechanisms :

1. Main effect on the Ion Channels

2. Main effect on the GABA mechanisms and

3. Mixed Actions

Now let us look at some of the commonly used drugs for the treatment of epilepsy in brief, specially with regards to children.

1. Phenytoin:

Phenytoin is one of the oldest drugs that are still being used for the treatment of epilepsy.

Uses

I. Treatment of Focal seizure, secondrily generalized tonic-clonic seizures and status epilepticus.

II. Phenytoin can be used in children for the treatment of childhood epilepsy.

Adverse Effects:

It can cause both dose-dependent (high doses) and dose-independent (allergic reactions). Because of its large number of adverse effects it is generally not the drug of first choice in children specially with the availability of the newer AEDs. On the other hand it is still one of the cheapest AED available in the market and therefore in a country like ours the use of Phenytoin is still very high. The first sign of an allergic reaction to phenytoin is a rash, so if you see any skin problems, call a doctor immediately. In rare cases, allergic reactions to phenytoin can result in damage to the liver or bone marrow.

It can have troublesome effects on appearance when used for a long time. The most common side effect related to phenytoin in children is jerky movements of the eyes called nystagmus. These movements often do not interfere with a child's vision.

Other side effects from high doses include unsteadiness in the feet and hands, sleepiness, and vomiting. These may be avoidable if the dosage is increased slowly. They should quickly disappear when the dosage is reduced.

In a few children, phenytoin causes problems with thinking or behavior, mood change, slow or clumsy movements, or a loss of energy. The adverse effects of phenytoin also include fetal hydantoin syndrome (intrauterine growth restriction with

microcephaly and develop minor dysmorphic craniofacial features and limb defects including hypoplastic nails and distal phalanges), ataxia and others.

One fairly common side effect in children is overgrowth of the gums

2. Valproic Acid:

Valproic acid can be effective against many types of seizures common in children

Uses

I. Absence seizures (this is one of the most effective medicines for these brief staring spells)

II. Myoclonic seizures, tonic-clonic seizures, such as those in Lennox-Gastaut syndrome, infantile spasms and seizures triggered by flashing lights

Adverse Effects

Children under 2 or 3 years of age who take valproic acid have a much higher risk of liver failure than adults or older children. (The risk is very low for children over 10, perhaps 1 in 50,000.) The risk is even higher for very young children who also take other seizure medicines, and it's highest of all for those with certain other serious disorders. Liver damage usually occurs within the first 6 months of treatment.

The first signs of it are vomiting, loss of appetite, sluggishness, and perhaps loss of seizure control, yellow skin and eyes, or swelling.

Higher-than-usual levels of the hormone testosterone have been found in many girls who take valproic acid when they're older than about age 10. No symptoms are apparent except may be weight gain

A few children who take valproic acid seem to become more irritable. To reduce side effects a low dose of valproic acid is slected for to starting and will be gradually increased. Children usually start with a dose of 5 to 10 milligrams (mg) for each kg of body weight per day. This is usually given in one to three equal doses per day.

Most children do best at about 15 to 60 mg/kg per day. Children taking a combination of valproic acid and another seizure medicine usually need the higher doses because of interactions between the medicines.

Valproic acid syrup is an easy way to give a valproate medicine to small children.

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Students Section:

ASSERTIVENESS TRAINING - (Part-2)

Assertiveness training begins with the proper assessment to find in which social situation person has problem. Assessment can be done by using questionnaire, behavioral interview, role play, self monitoring, and observation in real life. After finding out deficits in behavior following interventions are used. Combined use of these intervention strategies is common.

1. **Instructions:** Instructions concerning effective verbal and nonverbal behaviours may be given verbally or presented in written, audiotape, or filmed form. This is often combined with model presentation and coaching during role-plays. Specific behaviours are identified to increase, decrease, stabilize, or vary and their relationship to desired goals described. Preferably one behaviour is selected at a time but many behaviours can be targeted depending on client. Effectiveness of this technique alone is doubtful.
2. **Model presentation:** Model presentation is used for complex behaviours. An advantage of model presentation is that an entire chain of behaviour can be illustrated and the client then requested to imitate it. Nonverbal as well as verbal behaviours can be demonstrated and the client's attention drawn to those that are especially important. Effective behaviours may be modelled by the counsellor, or written scripts, audiotape, videotape, or film may be used. Essential elements of various responses can be highlighted and written models offered. Model presentation is used for complex behaviours.
3. **Behavioural rehearsal and feedback:** Following model presentation, the client is requested to practice (rehearse) the modelled behaviour. Corrective feedback is offered following each rehearsal. Specific positive aspects of the client's performance are first noted and praised. Praise is offered for effective behaviours or approximations to them, and coaching provided as needed. Models and instructions are repeated as needed, and rehearsals, prompts, and feedback continued until desired responses and comfort levels are demonstrated.
4. **Programming of change:** Specific goals are established for each session. Perhaps only one or two behaviours will be focused on in a session, or the initial repertoire might be such that all needed verbal and nonverbal behaviours can be practiced. Rehearsal starts with situations creating small degrees of anger or anxiety. Higher-level scenes are introduced as anxiety or anger decreases. Thus, introduction of scenes is programmed in accord with the unique skill and comfort levels of each client.

Improvements are noted and praised based on the current level of performance.

5. **Homework assignments:** After needed skill and comfort levels are attained, assignments, graded in accord with client comfort and skill levels, are agreed on to be carried out in the natural environment. Assignments are selected that offer a high probability of success at a low cost in terms of discomfort. Careful preparation may be required if negative reactions may occur in real life.

Along with these intervention strategies cognitive restructuring and some anxiety reducing techniques can be used based on clients needs. Generalization and maintenance of learned behavior can be achieved by use of natural reinforcer (involving significant others), self reinforcement, variety of social situations, homework assignments, covert modeling, and self monitoring.

Assertiveness training is required not only for psychiatric patients but all those people who has difficulty in expressing their feeling, ideas, opinion in appropriate way and hence has problem in their social lives.

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UDDYAM PRABHA

An Incentive Scheme to Promote Economic Activities for Self-Employment of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities

OBJECTIVE:

Promoting income generating economic activities for self-employment of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities through incentives.

JUSTIFICATION:

Persons with aforesaid disabilities, due to the uniqueness and severity of their disabilities are further marginalized in earning their livelihood even compared to persons with other disabilities. In fact persons with such disabilities, when given an opportunity, have surprisingly excelled in many fields and have even competed with the best in the world. It is in this context, the Scheme envisages providing some financial incentives to persons with such disabilities for undertaking economic activities for their self-employment by availing loans from financial institutions, banks etc.

Activities: Incentive will be provided for availing loan for any income generating economic activity.

ELIGIBILITY

1. Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities
2. Age 18 years or above
3. Loan for income generating activities from recognized financial institutions, banks etc.
4. No default in repaying the loan.

Incentive upto 5% for BPL and 3% for other categories will be given per annum upto 5 year on a loan amount upto Rs.1 lakh. For example, an eligible person below poverty line will get upto 5% of 1 lakh loan amount i.e. Rs. 5000/- pa for 5 years.

Target : The scheme aims to benefit 1000 persons every year.

IMPLEMENTATION

1. Applications, in plain paper, can be submitted throughout the year on first come first serve basis. Application Format is annexed for illustration only.
2. All applications will be received and scrutinized by SNACs on behalf of the National Trust. In States/ UTs not having SNAC, the National Trust may authorize any agency to receive and scrutinize applications on its behalf or may even receive applications directly. All applications shall be forwarded, with suitable recommendations, by the first week of the following months to the National Trust for approval.
3. On approval, the incentive will be disbursed directly to the loan account of the applicant on every successful completion of loan year.
4. Approved applicants may seek further guidance or assistance from SNAC/ National Trust or its authorized agency to successfully carry out the economic activities.

MONITORING

1. All approved cases will be closely monitored by SNAC/ authorized agency. At the end of every loan year, a report shall be furnished to the National Trust which will form the basis for continuance of disbursement of incentive.
2. Such monitoring shall continue even after the expiry of the loan period for at least another 5 years to ascertain the effectiveness of the Scheme.

LIST OF ENCLOSURES

1. Attested copy of Disability Certificate
2. Attested copy of Proof of loan received, loan account no., interest rate, repayment mode, period and EMI
3. Details of the Project for which loan is taken.
4. Any other relevant documents