European Network for Psychosocial Crisis Management – Assisting Disabled in Case of Disaster

Prof. Dr. Robert Bering & Lena Richter

Koordination

Germany, Federal office of civil protection and disaster assistance, Bonn (EUNAD-IP)
Germany, Center for Psychotraumatology, Alexianer, Krefeld (EUNAD)

Partners:

Czech Republic, Charles University, Prague
Denmark, University of Southern Denmark
Norway, Norwegian Center of Violence and Traumatic Stress Studies, Oslo
University of Innsbruck, Innsbruck

In cooperation

Sociedad Espanola des Psicotraumattologia y Estres Traumatico (SEPET-D), Madrid, Spain
University of Cologne, Education of hearing impaired individuals, Cologne Germany
Israelian Trauma Coalition (ITC), Jerusalem, Israel

Co-Financed by the European Commission

What is the objective of EUNAD?

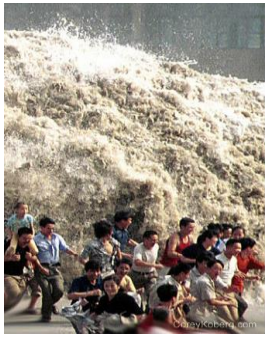
How did we get on this way?

Disaster and Disabilities?

How to integrate psychosocial support in disaster management?

Main objectives of EUNAD

- EUNAD aims toward the implementation and preparation of EU human rights-related assistance programmes for disabled survivors of disasters.
- EUNAD aims to be a step forward in the implementation of the UN Convention on the Rights of persons with disabilities.



Tsunami Japan, 2011

EUNAD
HELPING THE DISABLED IN DISASTERS

CBRN Incidents

Break down of the historical archive in Cologne, 2009

What about disabled?

Love parade disaster, 2010

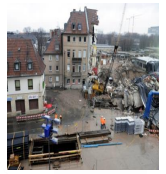
What is the objective of EUNAD?

How did we get on this way?

Disaster and Disabilities?

Psychosocial care after disaster: Projects co-financed by ECHO

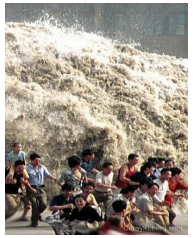
- EUTOPA (2007-2009) - TGIP Manuals
- EUTOPA-IP (2009-2011) - Intervention
- CBRN & PSS (2011-2013) - Trainings
- EUNAD (2014-2015) – Disabilities
- EUNAD-IP (2015-2017) - Disabilities



23 Countries were represented in EUTOPA

Dean Ajdukovic, David Alexander, Rosemarie Barwinski, Roman Birvon, Jonathan Bisson, Barbara Blanckmeister, David Bolton, Gernot Brauchle, Claudia Bredenbeck, Chris Brewin, Bruno Carlos Almeida de Brito, Ranieri Brook Barbieri, Alarcos Cieza, Paul Cutajar, Francine Dal, Anita Deak, Katherine Deeley, Albert Deistler, Fruzsina Deme, Aida Maria dos Santos Dias, Michel Dückers, Jose Felix Duque, Ask Elklit, Lucy Faulkner, Maja Furlan, Eva Garossa, George Gawlinski, Eric Geerligs, Oliver Gengenbach, Stelios Georgiades, Berthold Gersons, Annika Gillispie, Irina Gudaviciene, Miroslav Harvan, Trond Heir, Leonie Hoijtink, Simona Hoskovcová, Barbara Juen, Maria Kee, Zafiria Kollia, Uwe Korch, Dietmar Kratzer, Nora Lang, Talia Levanon, Vivienne Lukey, Jana Malikova, Robert Masten, Giulia Marino, José M.O. Mendes, Tiiu Meres, José Carlos Mingote Adán, Maureen Mooney, Maria Eugenia Morante Benadero, Carlos Mur de Viu, Josée Netten, Àgatha Niemyjska, Ilina Nikolova, Brigit Nooij, Dag Nordanger, Lasse Nurmi, Miranda Olff, Francisco Orengo, Gerry O'Sullivan, Anthony Pemberton, Danila Pennacchi, Delphine Pennewaert, Pascal Perez Guertault, Cristiana Pizzi, Gerd Puhl, Raija-Leena Punamäki, Ralf Radix, Gavin Rees, Maire Riis, Magda Rooze, Claudia Roth, Arielle de Ruijter, Salli Saari, Rob Sardemann, Christina Schloßmacher, Claudia Schorr, Frederico Galvao da Silva, Jana Seblova, Aysen Ufuk Sezgin, Erik de Soir, Marc Stein, Gisela Steiner, Sofia Stoimenova, Axel Strang, Jan Swinkels, Lajos Szabó, Dominique Szepielak, Petra Tabelling, Hans te Brake, Miguel André Telo de Arriaga, Graham Turpin, Willy van Halem, Koen van Praet, Joszef Vegh, Ronald Voorthuis, Edgar Vor, Stepan Vymetal, Dieter Wagner, Lars Weisaeth, Martin Willems, Richard Williams, Moya Wood - Heath, William Yule, Bogdan Zawadzki.

Target Group Intervention program (TGIP)



Psychological First Aid

Trauma

Psychological First Aid

Psychoinformation

Prognostical Screening: CRI-D

Group of Recovery

Guidance in Self-Help

Information about professional help

Switcher

Guidance in Self-Help

⇩

Monitoring

⇩

Clinical Diagnostic

⇩

In need of Trauma Therapy

High-Risk-Group

Guidance in self-Help

⇩

Clinical Diagnostic

⇩

Trauma Therapy

⇩

Rehabilitation

Target Group Intervention Program (TGIP)

Manual I:Implementing the Cologne Risk Index-Disaster

Manual II: Measures for TGIP

Manual III: Trauma-based psychoinformation

Manual IV: Rehabilitation of stress response syndroms

- TGIP offers a framework to plan psychosocial interventions from the acute phase up to the mid- and longterm course.
- TGIP is based on psychosocial and clinical experiences as well as empirical evidence, TGIP offers a tool of measures, depending on the riskprofile of the affected.
- TGIP contains the concrete description of actions for a gradual intervention planing that focusses first of all on the mid- and longterm traumatic process.

http://eutopa-info.eu/index.php?id=23&L=2

Flexible Prognostical Screening in TGIP

- In TGIP we recommend a prognostical screening of risk factors (CRI), dissociation and PTSD related symptoms.
- Cologne Risk Index-Disaster enables the classification to Group of Recovery, Switchers and High-Risk Group and thereby establishes the basis of TGIP.
- Prognostical screening should be conducted flexible according to the situation – (Standardized)Interview or questionnaires

Intervalidation of the Cologne Risk Index in Field Studies

	Fischer et al. (1999)	Walter (2003)	Bering (2005)	Bering & Kamp (2007)
	CRI-Civilian Trauma	Bank Hold Ups	Military zone	Inpatients with PTSD
Pre-Traumatic Factors				
Female gender		*	*	
Low education	*			
Former traumatic experiences	**	**	**	*
Unemployement	*			
Situational factors				
Fear of Death	*	*	*	
Duration of the traumatic exposure	*			
Dissociation	***	**	***	**
Physical Injury	*		*	*
Subjective Evaluation of Stress	*	*	*	
Personal relation to the perpetrator	*	*		
Factors in the time of latency				
Limited social support	*	**	**	**
Limited home contact			*	
Bad experiences with Institutions	*	**	*	
Speechlessness			*	*

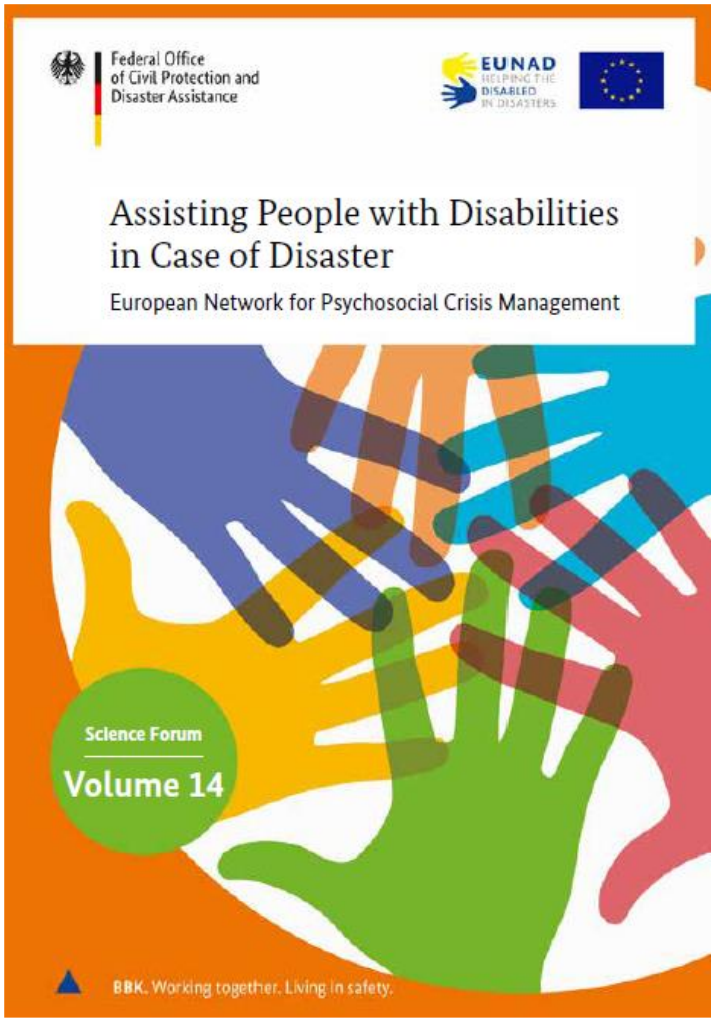
Bering et al., 2007, ZPPM

What is the objective of EUNAD?

How did we get on this way?

Disaster and Disabilities?

Results of EUNAD and EUNAD-IP



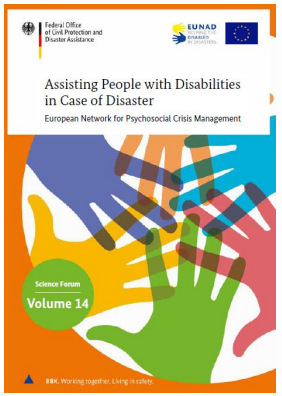
- Visual impairment
- Hearing impairment
- Interllectual impairment, dementia and autistic spectrum disorder
- Physical impairment

General recommendation – Prepardness – Psychological first aid- psychosocial aftercare

6.2.3.1 Psychological first aid

The same established principles for emergency response and psychosocial first aid must be applied for all population groups. For visually impaired and blind individuals, the following should be taken into consideration:

- Ensure predictability: communicate clearly what has happened and the order of what is going to happen next.
- Identify your role when approaching a person with visual impairment, and touch their shoulder. Place the person next to the wall, and describe the setting. Inform them when you leave.
- When accompanying a person who is visually impaired or blind, the most common companion techniques should be applied: offer to assist the person by letting the person hold your elbow.
- Offer your assistance, listen, and then assist.
- If possible, address people who are blind or have low vision by their names so they know you are speaking to them.
- Ask people who are blind or have low vision what they want or need. Do not direct questions through their companion.



6.2 Recommendations for the blind and visually impaired people

BMJ Open

Sexual assaults in individuals with visual impairment: a cross-sectional study of a Norwegian sample

Audun Brunes,[1] Trond Heir[1,2]

Table 2 Prevalence of sexual assaults in the visual impairment population (VI) and in the general population (GP), according to age and gender

	Female VI (n=403)*		Female GP (n=941)*			Male VI (n=333)*		Male GP (n=828)†		
	Cases/tot	% (95% CI)	Cases/tot	% (95% CI)	P values†	Cases/tot	% (95% CI)	Cases/tot	% (95% CI)	P values†
Age groups (years)										
18–35	15/88	17.1 (10.5 to 26.5)	22/189	11.6 (7.8 to 17.1)	0.26	1/69	1.5 (0.2 to 9.7)	1/105	1.0 (0.1 to 6.5)	1.00
36–50	26/101	25.7 (18.1 to 35.2)	31/273	11.4 (8.1 to 15.7)	0.001	4/85	4.7 (1.8 to 12.0)	3/184	1.6 (0.5 to 5.0)	0.21
51–65	17/106	16.0 (10.2 to 24.4)	28/267	10.5 (7.3 to 14.8)	0.16	2/94	2.1 (0.5 to 8.2)	6/286	2.1 (0.9 to 4.6)	1.00
≥66	12/108	11.1 (6.4 to 18.6)	13/212	6.1 (3.6 to 10.3)	0.13	1/85	1.2 (0.2 to 8.0)	4/253	1.6 (0.6 to 4.1)	1.00
Total	70/403	17.4 (14.0 to 21.4)	94/941	10.0 (8.3 to 12.1)	<0.001	8/333	2.4 (1.2 to 4.7)	14/828	1.7 (1.0 to 2.8)	0.48

*No missing data due to non-response for the VI population, while there were 23 participants from the general population who did not respond to questions related to age and/or gender.
†P value calculated using Fisher's exact test.
tot, total number of participants in that particular subgroup.

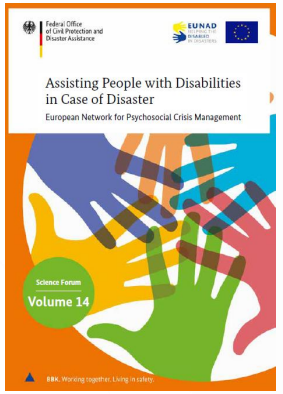
Risk of experiencing sexual assault appears to be higher in individuals with visual impairment than in the general population.

General recommendation – Prepardness – Psychological first aid

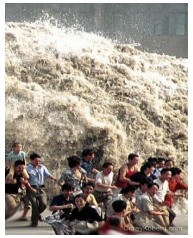
5.2.3 Emergency response

5.2.3.1 Psychological first aid

- **Try not to separate D/HH individuals** from each other or their relatives/ friends as these people promote their feeling of security and their chance to communicate and receive information.
- **When evacuating D/HH individuals let them take their compensatory equipment with them if possible.** (e.g. notebook, hearing aid, mobile phone).
- **Specific communication advice:**
  - Ask for preferred means of communication (e.g. spoken language, written language, sign language).
  - Call sign language interpreters if D/HH individuals prefer sign language. If you cannot arrange direct interpretation use remote sign language interpretation.
  - Maintain eye-contact and observe their facial expressions and reactions.
  - Make sure there is enough light so they can see your face and what is going on around them.
- Use signal symbols (e.g. logos, orange vest, and blanket) in chaotic situations so that they can orientate visually.
- Do not wear helmets etc. outside the danger zone to give deaf and hard-of-hearing individuals the chance to lip-read or see facial expressions.
- Be aware that deaf and hard-of-hearing individuals are most vulnerable in the dark or while asleep when they cannot compensate their hearing loss with the visual sense.



Target Group Intervention program (TGIP)



Psychological First Aid

Trauma

Psychological First Aid

Psychoinformation

Prognostical Screening: CRI-D

Group of Recovery

Guidance in Self-Help

Information about professional help

Switcher

Guidance in Self-Help

Monitoring

Clinical Diagnostic

In need of Trauma Therapy

High-Risk-Group

Guidance in self-Help

Clinical Diagnostic

Trauma Therapy

Rehabilitation

Medical Rehabilitation of deafs (n=9)

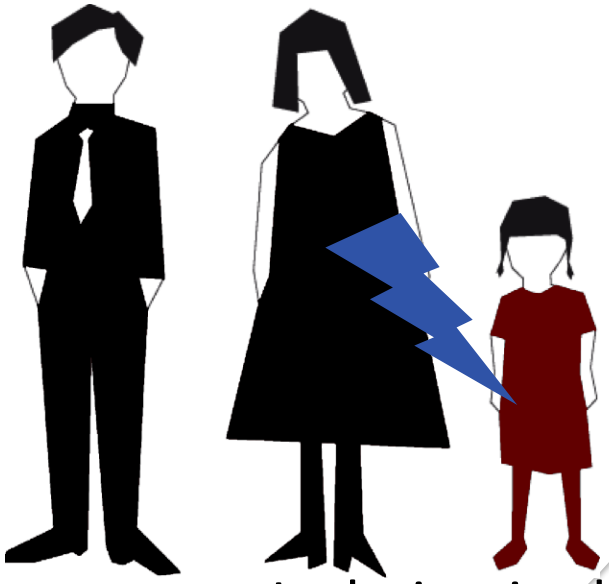
Alexianer KRANKENHAUS MARIA-HILF GMBH KREFELD

Co-Financed by the European Commission

SOZIALISATION – CULTURAL GAP

Hearing parents with hearing impaired children

shok/
guild



Short communication
sign language

Isolation in the family

Misunderstanding

Traumatisation

90% of parents with deaf children do not learn sign language

The following **research questions** can be derived:

- Which symptoms are shown by traumatised deaf/ hearing impaired patients?
- What kind of special needs do traumatised deaf/ hearing impaired patients have?
- Which stabilization techniques take effect in traumatised deaf/ hearing impaired patients?

Which symptoms are shown by traumatised deaf/ hearing impaired patients?

- symptoms often reported by traumatised deaf/ hearing impaired patients: disturbed affective regulation, self-destructive behaviour, attention deficit, overexcitement and avoidance → **complex** PTSD

- symptoms less reported by traumatised deaf/ hearing impaired patients: intrusion, **dissociation**

Discussion: Terms like intrusion are difficult to explain in sign language, it may be that these phenomena occur, but can not be verbalized or expressed.

PDEQ/ Frage 2

Ich fühlte mich so als ob ich automatisch handelte. Ich habe **Dinge** gemacht zu denen ich mich gar nicht bewusst entschloss hatte, wie ich später bemerkte.

What kind of special needs do traumatised deaf/ hearing impaired patients have?

- Difficulties in the understanding of metaphorical utterances and partial limited abstraction ability (e.g. item psychometric questionnaire: “Ich kann Menschen für mich einnehmen, wenn ich es will.”) **Needs:** detailed descriptions in sign language, adaptation of psychometric questionnaires
- Difficulties in connecting and sympathizing to problems of others, **Needs**: psychoeducation, role-plays and exercises to promote empathy
- Frequently incriminating communicative experiences in the family of origin up to deprivation **Needs**: reparative reparenting

Which stabilization techniques take effect in traumatised deaf/ hearing impaired patients?

In case of increased arousal:

- Discreet body contact (e.g. arm on leg or shoulder).
- Overall, haptic stimulation by ice cubes, hedgehog ball etc.
- Awareness exercises such as breathing.
- Use of different aromas.
- No imagination methods: they are hardly imaginable and feasible for deaf/ hearing impaired people (transfer performance, abstraction ability).
- Movements such as running and ‘Galileo’ (vibration plate).

General recommendation – Prepardness – Psychological first aid- psychosocial aftercare

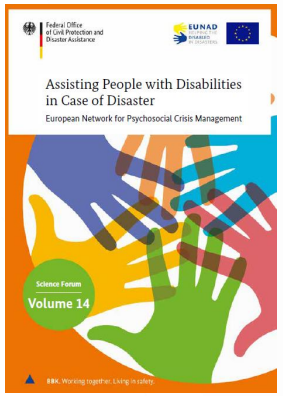
7.3.2 Emergency response

In the response phase psychological first aid must be adapted to the skills and needs of persons with mental disabilities.

First contact to persons with mental disabilities

- Respect the dignity and independence of people with intellectual disabilities during an emergency: For example: Don't treat persons with intellectual disabilities like children, talk to in a manner that is appropriate to their age.
- Take into account that despite all effort some people with mental disabilities will not be able to understand.

- According to the degree of impairment, communicate with the assistants or staff to get needed information.
- Ensure orientation according to the degree of impairment.
- Pay attention to nonverbal signals and try to respond to these adequately.
- Explain each action you perform verbally even though there might be a lack of speech comprehension.
- Use simple, slow, but not infantilizing language.
- Be careful in the case of physical proximity (caution: Individuals with intellectual disabilities might fear medical interventions).
- Some people with intellectual disability or autistic spectrum disorder use assistive technologies to communicate.



7.3 **Recommendations for people with intellectual disabilities, dementia and autistic spectrum disorder**

Thank you for your attention!

Centre of Psychotraumatology, Alexianer Krefeld GmbH, Germany

Prof. Dr. Robert Bering

r. bering@alexianer.de

Co-Financed by the
European Commission