

PSYCHOLOGICAL RESPONSE COVID-19

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LEARNING OBJECTIVES

- At the end of this session, participants will be able to:
 1. Identify psychological crises situations
 2. Threat Appraisal
 3. Describe the process of providing Psychological support
 4. Know How To Help Responsibly
 5. Know how to care for oneself and Colleagues
 6. Relaxation Techniques
 1. Describe Deep Muscle Relaxation
 2. Breathing Exercises etc
 7. Referral Resources

WHY PSYCHOLOGICAL INTERVENTION?

- **Psychological Intervention** is one of the key component of coordinated Crisis Response to disasters, extreme stressful event or psychological crisis.
- It helps a person to:
 - Feel safe, calm, hopeful and connected to others
 - Have access to social, physical and emotional support and
 - Feel able to help themselves as individuals and communities.

PSYCHOLOGICAL CRISIS

- Psychological Crisis is precipitated by unexpected external stresses over which an individual has little or no control and from which he or she feels emotionally overwhelmed and defeated.
- It results in disequilibrium from which many individuals may require assistance to recover.
- It can significantly disrupts normal community function and causes concern for the Safety, Health and Lives.

CRISIS SITUATIONS⁵

- Mass Casualty Incident is an example of crisis situation.
 - Mass Casualty Incident is any incident which produces multiple casualties such that emergency services, medical personnel and referral systems within the normal catchment area cannot provide adequate and timely response and care without unacceptable mortality and/or morbidity.
- Mass Casualty Incident may be due to a disaster (natural or manmade event) that suddenly or significantly disrupts normal community function and causes concern for the Safety, Property and Lives.

- Examples
 - Road Traffic Accident
 - Major fires
 - Building collapse
 - Civil disturbances
 - Hazardous materials incidents
 - Violent crimes (Terrorist attacks)
- These catastrophes create astronomical proportion of stress among those affected (victims, families and friends and witnesses)

GHANA EXAMPLES

- **FLOODS**: 3rd June 2015 Floods in Accra and other towns and villages across the country
- **MAJOR FIRES**: Houses and Offices e.g. Gas Explosion at La Gas station in Accra, Papa Kwesi Nduom's Office
- **Road Traffic Accidents** e.g. KN Circle Dubai Disaster
- **Collapse of Buildings**: Stadium Disaster), Melcom at Achimota, Houses - Dansoman etc
- **Civil Disturbances**: e.g. Strikes, clashes with the Police
- **Domestic Violence** e.g. violent crimes - tribal war & land disputes
- **Hazardous materials** incidents
- **Terrorist attacks**???

- Disasters may leave devastations of properties and or lives
- The event overwhelms local resources and threatens the function and safety of the community.
- Such tragedies leave victims with damaged sense of safety and wellbeing and varying degrees of emotions trauma.
- Children are particularly vulnerable.
- The high level of anxiety accompanying disequilibrium diminishes problem solving skills.
- The Psychological Crisis disturbs homeostasis and consequently coping mechanism such that one cannot resolve the problem effectively.

In Crisis situation:

- There is loss of life and property
- Many injured or killed:
 - Could produce as few as six patients or as many as several hundred
 - Patients are greater than resources of the initial responders
 - Effect on emergency response and community impact
- Local hospitals and clinics are affected
- Loss of control

- Disease outbreak is an example of crisis situation.
- The situation may overwhelms local resources and threatens the function and safety of the community.
- Leaves victims with impaired sense of safety and wellbeing and varying degrees of emotions trauma.
- The Psychological Crisis disturbs homeostasis and consequently coping mechanism such that one cannot resolve the problem effectively.
- The high level of anxiety accompanying disequilibrium diminishes problem solving skills.

In Crisis situation:

- Many are affected:
 - Could produce as few as six patients or as many as several hundred
 - Patients are greater than resources of the initial responders
 - Effect on emergency response and community impact
- Local hospitals and clinics are affected
- There is loss of life and control

REACTIONS

- Individuals can have wide range of reactions and feelings (from mild to severe reactions).
- Most may feel overwhelmed, confused or very uncertain about what is happening.
- The feeling could affect the individuals physically as well as psychologically.
- They may have high levels anxiety to the point of feeling of discomfort helplessness, confusion and disorganization
 - The anxiety levels could rise to the point that the individual becomes non-functional

- May not believe they have the resources to deal with the precipitating stressors of factors.
- May feel fearful or anxious, or numb and detached. Anger, aggression, depression, guilt, self blame etc
- Thought become obsessional and all behaviours are aimed at relief of anxiety being experience.

- Psychological intervention during this period could preserves self-esteem and promotes growth with resolution.
- It could also prevent Acute Stress Disorder, PTSD and even Panic Attack

ACUTE STRESS DISORDER

- A sense of numbing detachment or absence of emotional responsiveness.
- A reduction of awareness of his or her surrounding e.g. being dazed.
- Derailment, depersonalisation, inability to recall important aspects of the trauma.
- Recurrent images, thoughts, dreams, illusions, flashback episodes or a sense of reliving the experience, or distress on the exposure to the reminders of the traumatic events.
- Avoidance of stimuli that arouse recollections of the trauma.
- Difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response and restlessness.

PANIC ATTACK

- A host of jarring symptoms including laboured breathing,
- Rapid and pounding heartbeats,
- feeling of choking or smothering,
- dizziness, sweating, trembling,
- Intense fear and terror usually accompanies this feeling.
- There may be feeling of unreal or being outside ones body, going crazy.
- This may overwhelm the person and may rush to a health facility.

POST TRAUMATIC STRESS DISORDER

- If the symptoms be present for more than one month then it warrant the diagnosis of acute stress disorder may be made.
- PTSD often presents itself within the first three months after a traumatic event; however, it can also have a delay in presentation for months or even years (APA, 2005).
- Victims of violence experience wide range of mental health problems that would require the services of psychologists and psychiatrists, when necessary.
- To prevent the complications associated with violence the victim will need psychotherapy and supportive counselling.
- In about half of victims, complete recovery occurs within 3 months or longer with treatment (APA, 2005). The victims may need a combination of the therapies elucidated below to forestall future consequences mentioned above:

HOW CRISIS AFFECT PEOPLE

- In general, how the individual reacts depends on many factors such as:
 - the nature and severity of the event(s) they experienced
 - their experience with previous distressing events
 - the support they have in their life from others
 - their physical health
 - their personal and family history of mental health problems
 - their cultural background and traditions
 - their age (for example, children of different age groups react differently).

THREAT APPRAISAL: HEALTH BELIEF MODEL

- The Health Belief Model (Rosenstock et al., 1994) was developed in the 1950s by Godfrey Hochbaum (1958) as a psychological framework that attempted to discover the variables that accounted for the failure of the public to participate in the health screening programme for tuberculosis. It was further developed the model for health promotion.
- The model is based on the premise that people's attitudes and beliefs could be used to explain and predict their health behaviours.
- Developed based on operant and cognitive-behavioral theory

PREMISE OF THE HBM

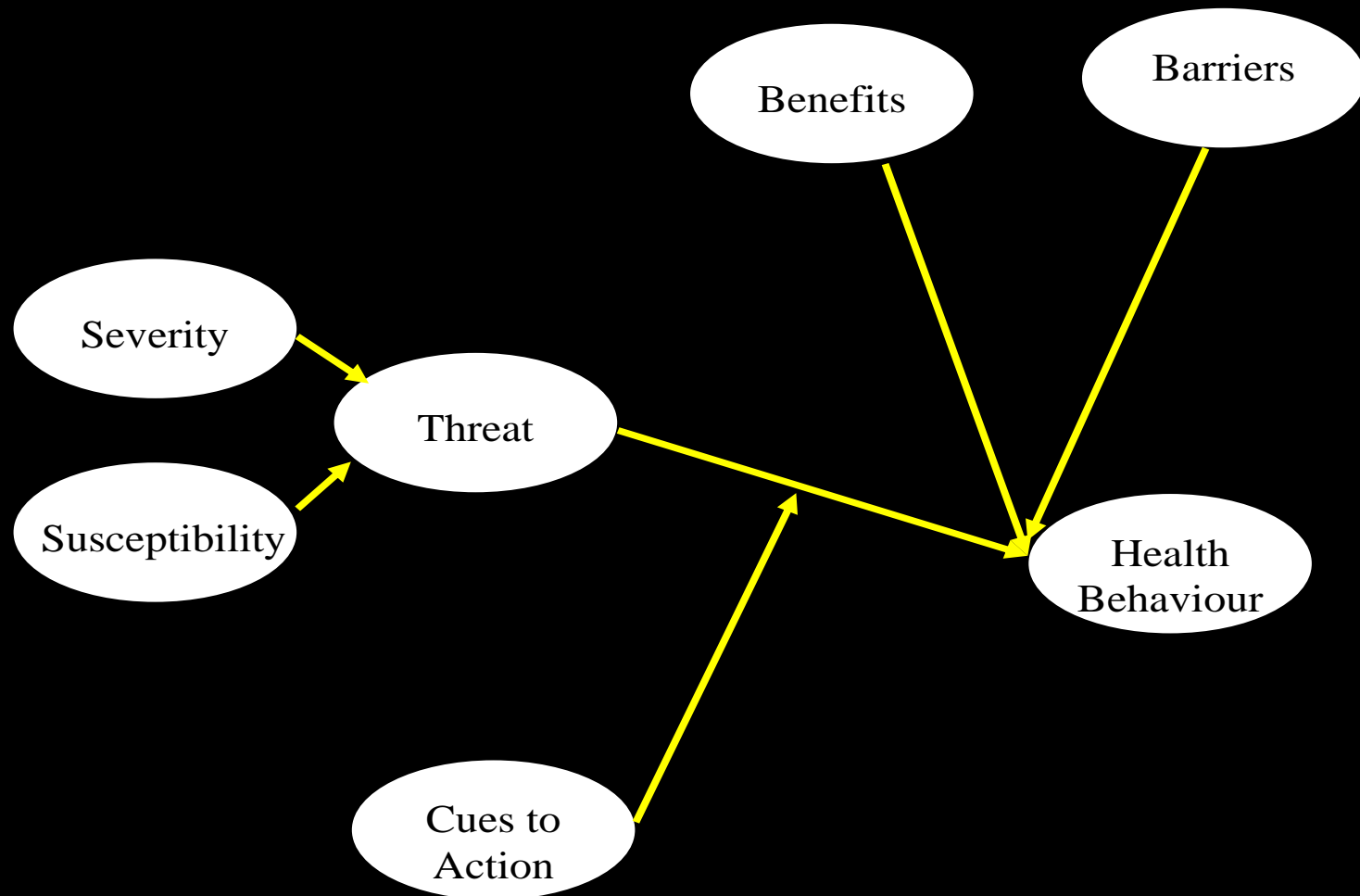
- Individuals will take action to ward off, to screen for, or to control an ill health condition if:
 - 1) they regard themselves as susceptible to the condition
 - 2) they believe it to have potentially serious consequences
 - 3) they believe a course of action can reduce the susceptibility and seriousness
 - 4) they believe the costs of the action are outweighed by its benefits

- The original model was conceived of four key determinants:
 1. **Perceived Susceptibility to a disease:** This is one's subjective perception of risk of contracting a disease.
 2. **Perceived Severity of the disease:** The beliefs about the seriousness of contracting the disease.
 3. **Perceived benefit of engaging in behaviours:** These are beliefs in the effectiveness of the preventive strategies designed to reduce the threat of the illness. Likelihood to reduce the threat of the health condition
 4. **Perceived Barriers to performing the action:** are the potential negative consequences of taking particular action. The barrier may be physical, social, psychological and financial.

- Note: the combination of these is the perceived threat of the health condition (emotive response is fear).
- Perceived benefits and perceived barriers provide a preferred path of action

HEALTH BELIEF MODEL

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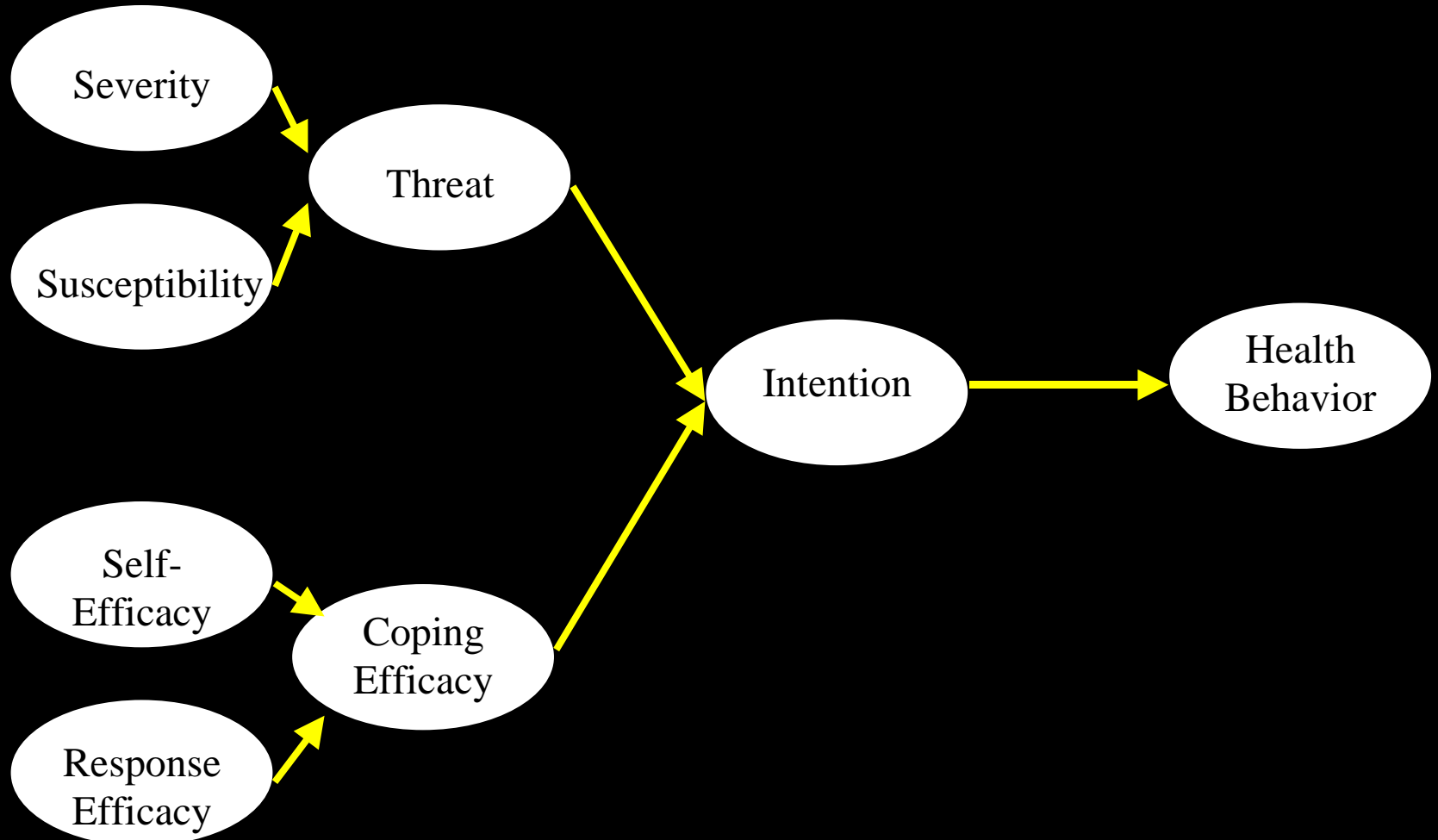
ADDITIONAL COMPONENTS?

- 1. Cues-to-action:** refer to events, personal, interpersonal and or environmental experiences that motivate a person to take action. The cues can be internal (such as symptom of a disease) or external cues (such as mass media communication, advice or reminders from health care provider(s) and interaction with family, friends etc.). Cues to action influence threat appraisals and may generate the initial preventive action taking
- 2. Self-efficacy (Perceived Behavioural Control):** to the belief in one's ability to successfully perform the behaviour required to produce the desired outcomes.

PROTECTION MOTIVATION THEORY²⁴ (ROGERS, 1984)

- Extension and re-working of HBM
- Intention to protect oneself is the proximal determinant of health behaviour.
- Intention is dependent on four components:
 - 1) perceived susceptibility
 - 2) perceived severity
 - 3) Self-efficacy
 - 4) Response efficacy (benefits versus barriers)
- Susceptibility and severity are considered “perceived threat”
- Response efficacy and self-efficacy are considered “coping efficacy”

PROTECTION MOTIVATION THEORY



WHERE DO WE INTERVENE?

- Educate about threat (vulnerability, susceptibility)
 - Fear appraisals
- Educate about coping (response efficacy, self-efficacy)
 - Health education
- Coping efficacy is the most important component
 - Self-efficacy (and perceived barriers) is the most influential component for health behavior
- Perceived severity is the weakest component
 - Health behaviours are long-term?
- Perceived vulnerability often influences intentions but not behavior

CHECKLIST

- Elicit patient's health beliefs.
- Reinforce positive attitudes to health.
 - i.e. praise for agreeing to be quarantined. Do not dwell on the fact they have not seen their family etc.
- Counter myths and negative attitudes.
- Inform patient about causes of COVID 19 and prognosis.
- Plan an *appropriate* course of action to suit client's needs and lifestyle.

WHO WILL NEED PSYCHOLOGICAL INTERVENTION?

- Many people but especially those who are particularly vulnerable in a crisis situation and need extra help.
- These are people who are so upset they cannot care for themselves or their children (if they are with him/her).
- Those at extremes of age (children, elderly)
- Those who have a mental or physical disability.
- Those who know someone infected or died from COVID-19.

ADDITIONAL SUPPORT?

- Members of the health staff and general community who are anxious about the disease and those who are experiencing distress even though they have not been affected.
- Distressed health care providers who are working with patients infected.
 - Know your limits and ask for help from others who can provide more advanced support, medical care or other assistance.

GOAL OF PSYCHOLOGICAL INTERVENTION

- The resolution of an immediate crisis
- Supportive with the aim of restoration of the individual to his/her pre-quarantine or higher level of functioning
- These individuals may be unable to solve problems and therefore require guidance and support to help mobilize the resources needed to resolve the crisis.
- Do what is necessary to help the individual to get relief
- Although you are to listen to people's stories, it is not about pressuring people to tell you their feelings and reactions to an event.

ASSESSMENT

- Assess the person's physical and mental status
- The person's previous experience
- The person's threat appraisal
- Health Staff Collaboration

INTERVENTION

- Use reality – orientation approach: focus on problems of here and now
- Remain with persons experiencing anxiety and panic
- Use the following techniques:
 - Abreaction: the release of feelings as the person talk
 - Clarification
 - Suggestion:
 - Manipulation
 - Reinforcement of Behaviour

- Shock: Attentive listening to the crisis details
- Denial: Permit intermittent denial, identify patients primary concern
- Remember Not everyone who is quarantined will need or want your support. **Do not force** help on people who do not want it, but make yourself easily available to those who may want support.
- **Know your limits** and get help from others, such as medical personnel (including, where relevant and available, mental health specialists, nurses and clinicians in district hospitals), your colleagues, local authorities, or community and religious leaders.

- Be Prepared to help
- Be gentle as you talk with the person
- Stress importance of the health and safety for themselves, family and their community, explain that early detection and supportive treatments people are more likely to survive. Inform them of the high risk of infection for anyone in the household who comes in contact with the infected person's body.

ACTION PRINCIPLES:

LOOK

- Check person for obvious urgent basic needs.
- Check person for serious distress reactions.
- Check for safety.

LISTEN

- Ask about people's needs and concerns.
- Listen to people, and help them to feel calm.
- Even if you must communicate from a distance because of safety precautions, you can still give the person your full attention and show that you are listening with care.

LINK

- Help people address basic needs and access services.
- Help people cope with problems.
- Give information.
- Connect people with loved ones and social support.

RESPECT

- It is essential to **respect confidentiality and the person's dignity**.
- This is important not only for confidentiality for the person, but also to avoid the spread of panic or rumours in the community.
- Respect person's safety, dignity and rights.
- Adapt what one does to take into account the person's culture.
- Be aware of other emergency response measures.
- Listen to people, but not pressuring them to talk
- Comfort people and help them to feel calm

CONFIDENTIALITY

- However, in the case of disease outbreaks, there are limits to confidentiality because of the importance of stopping the spread of the disease.
- Explain to the person that personal matters that she or he shares with you will be kept confidential and not shared with others, but you are required to report to health teams if the person may have been exposed to the disease and/or has symptoms of the disease

1. Help person connect to information, services and social support etc
2. Looking after oneself.

ETHICS:

- Ethical do's and don'ts are offered as guidance to avoid causing further harm to the person receiving support, to provide the best care possible, and to act only in their best interests.
- Offer help in ways that are most appropriate and comfortable to the people you are supporting.
- Consider what this ethical guidance means in terms of your cultural context.

DOS

- Be honest and trustworthy.
- Respect person's right to make their own well- informed decisions.
- Be aware of and set aside your own biases and prejudices.
- Make it clear to person that even if they refuse help now, they can still access help in the future.
- Respect privacy and keep personal details of the person's story confidential, if this is appropriate.

- Behave appropriately by considering the person's culture, age and sex
- Look after your own physical and mental wellbeing!
- As a psychologist, you may also be affected by the outbreak or may have family, friends and colleagues who are affected or at risk.
- Pay extra attention to your own wellbeing and be sure that you follow all safety precautions.

HOW SHOULD THE INITIAL INTERVIEW BE ORGANIZED?

There is no single ideal, but it is useful to think of the initial interview as having three components:

1. Rapport
2. Elicit specific information
3. Ask if the patient has any questions

RAPPORT

1. **Establish initial rapport** with the patient, and ask about the presenting complaint or problems i.e. the person's emergency.
 1. Some patients tell their stories without much guidance from the psychologist, whereas others require explicit instructions in the form of specific questions to help them organize their thoughts.
 2. During this phase of the first interview, the clients should be allowed to follow his or her own thought patterns as much as possible.

ELICIT SPECIFIC INFORMATION

- **Elicit specific information**, including a history of the presenting problems, pertinent medical information, family background, social history, and specific symptom and behavioral patterns.
- **Ask if the client has any questions** or unmentioned concerns and help address them.
- The initial assessment may require more than one session for complex situations—for example, when evaluating children or families, or when assessing a patient's suitability for a particular therapeutic approach, such as brief psychotherapy.

- Discover as much as possible about how the client thinks and feels. During the clinical interview, information is gathered from what the patient tells you. Critically clues can come from how the history unfolds.
- Thus, both the content of the interview (i.e., **what the patient says**) and the process of the interview (i.e., **how the patient says it**) offer important routes to understanding the patient's problems.

- Consider the order of information, the degree of comfort in talking about it, the emotions associated with the discussion, the patient's reactions to questions and initial comments, the coherence of the presentation, and the timing of the information.
- The full elaboration of such information may take one or several sessions over the course of days, weeks, or months, but in the first interview hints of deeper concerns may be suggested.

- Client must be given some opportunity to organize their information in the way that they feel most comfortable.
- Subjecting the client to a stream of specific questions limits information about the patient's own thinking process, does not learn how the patient handles silences or sadness, and closes off the opportunities to hint at or introduce new topics.
- Furthermore, the task of formulating one specific question after another may intrude on the clinician's ability to listen and to understand the client.
- This does not mean that specific questions should be avoided. Their responses may open new avenues to the inquiry. The key is to avoid a rapid-fire approach and to allow patients to elaborate their thoughts.

HOW SHOULD QUESTIONS BE ASKED?

- Questions should be phrased in a way that invites patients to talk.
- Open-ended questions that do not indicate an answer tend to allow people to elaborate more than specific or leading questions. In general, leading questions (e.g., “Did you feel sad you were violated?”) can be conversation stoppers, because they may give the impression that the psychologist expects the patient to have certain feelings.
- Non-leading questions (“How did you feel when you were violated?”) are as direct and more effective.

WHAT IS AN EFFECTIVE WAY TO DEAL WITH CLIENT HESITANCY?

- When client need help in elaborating, a simple statement and/or request may elicit more information: “Tell me more about that.” Repeating or reflecting what patients say also encourages them to open up (e.g., “You were talking about your girlfriend.”).
- Sometimes comments that specifically reflect the clinician’s understanding of the patient’s feelings about events may help the patient to elaborate.

- **How are questions best worded?**
 - The psychologist should use language that is not technical and not overly intellectual.
 - When possible, the patient's own words should be used.
 - This is particularly important in dealing with intimate matters such as sexual concerns.
 - People use some words and not others because of the specific connotations that different words carry for them; at first, such distinctions may not be apparent to the psychologist.

WHAT ABOUT CLIENT WHO IS UNABLE TO COMMUNICATE COHERENTLY?

- Remain aware at all times of what is going on during the interview. If the patient is hallucinating or intensely upset, failure to acknowledge the upset or the disconcerting experience may elevate the patient's anxiety.
- Discussing the patient's current upset helps to alleviate tension and tells the patient that the clinician is listening.
- If the patient's story rambles or is confusing, acknowledge the difficulty of understanding the patient and evaluate the possible reasons (e.g. psychosis with loosened associations vs. anxiety about coming to the visit).

- Identify the patient's strengths as well as problem areas.
- Avoid jargon and technical language.
- Avoid questions that begin with "why."
- Avoid premature reassurance.
- Do not allow patients to act inappropriately (e.g., break or throw an object).
- Also, be careful about assigning a diagnostic label to the patient's problems during the interview. The patient may be frightened and confused by the label.

SET LIMITS ON BEHAVIOUR

- Some patients may lose control in the session.
- Although the approach described here emphasizes letting the patient direct much of the verbal discussion, at times limits must be set on inappropriate behavior.
- The interview should be stopped until the patient's behaviour can be managed so that it is safe to proceed.

WHAT IS COMMONLY FORGOTTEN IN EVALUATING PATIENTS?

- It is helpful to gain an understanding of the patient's strengths, which are the foundation on which treatment will build.
- Strengths include ways in which the patient has coped successfully with past and current distress, accomplishments, sources of inner value, friendships, work accomplishments, and family support.
- Strengths also include hobbies and interests that patients use to battle their worries.

USE OF HUMOUR

- Be careful, because humor can backfire. It may be misunderstood as ridicule.
- It also can allow both client and you to avoid important topics. Sometimes humor is a wonderful way to show the human qualities of the psychologist and thus build a therapeutic alliance.
- Nonetheless, keep in mind the problematic aspects of humor, especially when you and your patient don't know each other well.

CHILD NEEDS

- Safety (freedom from maltreatment) and services to ensure safety;
- Intervention to stop maltreatment;
- Security and continuity in valued relationships, environments, and community;
- Treated with respect and dignity;
- Sensitivity to cultural needs;
- Speedy and clear decision-making;
- Confidentiality protections;
- Advocacy;
- Placement in most appropriate, least restrictive setting (relative, community, etc.) when needed;
- Participation in and clear understanding of the process to the extent possible; and Identify special needs.

FAMILY NEEDS:

- Timely intervention regarding harmful behaviours;
- Continuity in relationships;
- Treated with respect and dignity;
- Emergency services to help the family stay intact;
- Sensitivity to cultural needs;
- Advocacy
- Speedy and clear decision-making;
- Confidentiality;
- Participation in and clear understanding of the process to the extent possible;
- Opportunities to make positive changes regarding their situation.

OTHER NEEDS:

- Adequate information about your availability;
- Respect, Honest, open communication including mutual expectations.
- Clear time frames for service provision;
- Thorough risk assessment and safety plan;
- Acknowledgement and engagement as an active participant in case-planning.

LOOK AFTER YOURSELF

- Pay extra attention to your own wellbeing and be sure that you are physically and emotionally able to help others.
- Take care of yourself first, so that you can best care for others.
- If working in a team, be aware of the wellbeing of your fellow helpers as well, and find ways to support each other.
- As a helper, if you begin to exhibit any symptoms of the disease, do not go to work, as you will risk spreading the disease to co-workers and the people you are trying to help.
- Immediately inform your Department Head, seek medical care and take all necessary safety precautions to prevent infecting others.
- STOP when you recognise signs of burnout and get help

REFERENCE

- Aguilera DC (1994). Crisis intervention; theory and methods 7th Edition