

**ORIENTATION SEMINAR – Education Staff**  
**TO DISSEMINATE AND IMPLEMENT THE**  
**IASC GUIDELINES ON MENTAL HEALTH AND**  
**PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS**



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on Mental Health and Psychosocial Support in Emergency Settings  
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This guide includes samples of Orientation Seminars developed to inform specific target audiences about the Inter Agency Standing Committee (IASC) Mental Health and Psychosocial Support (MHPSS) Guidelines for Emergency Settings. This samples includes:

- **Orientation Seminar – Education staff**

These seminars were first designed during a TOT of the IASC Reference Group on Mental Health and Psychosocial Support (October 2008) and then enhanced for this guide. They are samples and will need modification according to the culture and context where they will be used. They can be presented with or without power point. They follow a 6 part seminar design which is one model that can be used for the development of other Orientation Seminars. The 6 part design used for these Orientation Seminars includes:

## **I. ASSESSMENT**

The process of assessment varies but always includes a review of the participants' context, capacities, learning needs to determine if and how they can utilize the IASC MHPSS Guidelines in their work. First, the Trainer decides what specifically s/he needs to know about the participants. Then, Trainers collect this information directly from the future participants and/or from their employers, donors, other organizations and seminar sponsor, through written questionnaires, and (direct and/or online) discussion, field visits to observe activities and discussion with recipients of activities where appropriate etc.

## **II. GOALS**

The assessment findings lead to the design of an Orientation Seminar with specific goals that will enhance the participants' utilization of the IASC MHPSS Guidelines. The goals can lead to participants acquiring knowledge, enhancing skills and modifying attitudes.

## **III. SEMINAR STEP-BY-STEP**

Orientation Seminars are outlined step-by-step and include:

- Content (outlined in parts)
- Training methodologies (ranging from participatory presentations, lectures, discussions, experiential learning)
- Timing
- Practical application of what is taught
- Way forward (ideas about how to practically apply what is learned)
- Trainer's summary of key points
- Plan for follow-up (including ongoing supervision, training etc.)

## **IV. MONITORING**

The learning process is monitored throughout the Orientation Seminar to ensure that participants understand what is being taught. Monitoring can be done by asking participants specific questions about what they have learned, or asking them to summarize what they have learned as well as from listening to their responses from small groups to see if they have utilized what has been taught etc.

## **V. EVALUATION**

It is essential that each Orientation Seminar includes a specially designed method for evaluation to:

- Determine whether what the participants' learn during the seminar actually leads them to enhance their utilization of IASC MHPSS Guidelines in their work.
- Improve future seminars.

Methods of evaluation can include:

- Participants' evaluations of the seminar via written structured or semi-structured questionnaires immediately after the seminar to evaluate their immediate response to the value and clarity of the content, training methodology and initial reactions about what they learned and its relevance and applicability to their work.
- Pre and post tests (immediate and months later) via written structured questionnaire to evaluate and compare what the participants knew before the training to what is learned and known after the training to gauge what is actually learned.
- Pre and post tests (immediate and months later) via visits to participants' work sites to compare their ability to effectively integrate the IASC MHPSS Guidelines into their actual work compared to what they did prior to the seminar.
- Pre and post tests (immediate and months later) via discussions and/or written questionnaires with participants' employers, donors, collaborating organizations, seminar sponsors, recipients of services and others to compare participants' knowledge and ability to effectively integrate IASC MHPSS into their actual work.

## **VI. READING AND HANDOUTS**

Participants are provided with related reading materials distributed in the appropriate language which include the full IASC MHPSS Guidelines and/or its Checklist for Field Use as well as the resources recommended at the end of the relevant Action Sheets.

To ensure the accuracy of the learning, Trainers also send participants the seminar notes, power point presentations and summaries of all small group presentations.

The following is an example of an Orientation Seminar for members of the Education Cluster as recommended in the IASC MHPSS Guidelines. The design follows six parts: 1/ Assessment 2/ Goals 3/ Seminar Step-by-step 4/ Monitoring of learning during the seminar 5/ Evaluation and 6/ Reading and Handouts. Since every group participating in an orientation has different needs and expectations, the following Orientation Seminar is only one example and must be modified to fit the context and capacities of every training group.

## I. ASSESSMENT

To design an Orientation Seminar that specifically meet the needs of their trainees, Trainers facilitate an assessment prior to designing the seminar, that includes a review of the existing knowledge, needs and expectations of the future trainees and the needs, problems and context of the situation in which they work.

What does the Trainer want to know?	How does the Trainer collect the information?
Outcome of assessments that include education.	Request copies of assessment reports or other supporting information from relevant agencies.
Level of understanding of future participants about the concepts included in the IASC MHPSS Guidelines and how they can be integrated into education programmes.	Interview future participants and discuss their understanding of the IASC MHPSS Guidelines key concepts and the existing integration into education programmes. Where possible, this should be done in an open, learner-friendly, informal way so as not to discourage potential participants.
Actual operations within the Educational Cluster, its current challenges, coordination and integration with other partners.	Where and when possible, visit education programmes to observe the existing programmes and services; to what extent has the participant been trained, by who, experience etc  While observing different aspects, aim to assess aspects of the Education Cluster that may enhance or hinder the promotion of psychosocial wellbeing and support. Be careful not to conduct a broad assessment of the cluster that will not be helpful to you in designing your seminar!  Discuss the education programme with a small cross section of potential participants or recipient population.
How existing education programmes support and/or are contrary to the IASC MHPSS Guidelines and why.	Investigate the rationale behind existing education programmes. Why have they been developed and how are they supporting and promoting mental health and psychosocial well-being?

## II. GOALS

Based on an initial understanding of how the participants use or apply MHPSS elements in their education work, the Trainer determines the goals for this Orientation Seminar. It is necessary to include the global goals within the IASC MHPSS Guidelines and Action Sheet 7.1: Strengthen access to safe and supportive education. It is also essential, however, that each Orientation also includes how this specific Education Programme can utilize the IASC MHPSS Guidelines in its context.

Some possible goals could include:

- Increase the understanding of the participants about the importance of education as a psychosocial intervention and how it is critical to the mental health and psychosocial well-being of children.
- Increase the capacity of the participants by learning about ways that their education programmes can actually support the mental health and psychosocial well-being of children of all ages and their families.
- Increase the understanding of the participants that improved collaboration among all actors will lead to better and more appropriate MHPSS services.

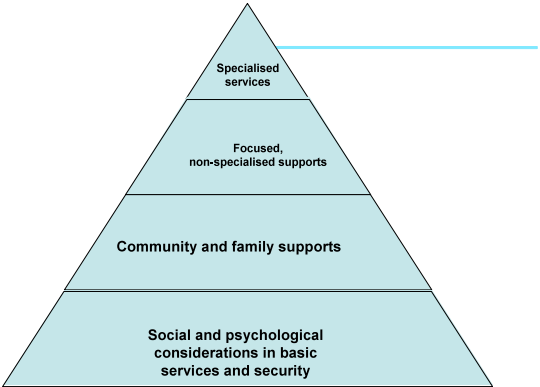
## III. SEMINAR STEP-BY-STEP

The following is an example of an Orientation Seminar for Education Cluster members and is based on the goals above. This seminar is 240 minutes or 4 hours. It can be taught in one day with 2 / two hour sessions each with a break and with lunch in the middle of the sessions. Or, it can be taught 2 hours on two different days. It is best if this Orientation Seminar is co-facilitated with someone from the Education Sub-Cluster.

Content	Training Methodology	Minut
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<b>Introduction: Trainers and Participants / Goals of the Orientation Seminar</b>	<b>Brief presentations by Trainer and Participants including:</b> <ul style="list-style-type: none"> <li>Trainers: Name / Relevant background</li> <li>Participants: Names / Work sites / Job titles / Previous MHPSS training</li> <li>Trainer: Presentation of seminar goals.</li> </ul>	10
<b>Part 1: How Education operations can affect people's MHPSS.</b>	<p><b>4 small groups: (10 minutes)</b> Trainer asks each group to create a brief example of a child of varying ages and gender who experienced an emergency and having difficulty doing his/her school work. (If the participants have no emergency experiences, then the trainer can provide them with appropriate case examples.) A case example can include the child's age, family make-up and the problems experienced during the emergency. Each group chooses one person to role play that child.</p> <p>Participants sit with their groups. The Trainer has 2 chairs in the center of the room.</p> <p><b>Trainer role plays</b> a teacher and calls each child to talk to him/her about the child's poor school performance. (5 minutes x 4 children = 20 minutes.) The conversation is only about the child's school performance. The Teacher does not ask nor listen to anything about the child's life situation. The Trainer shows very poor skills and does not listen or empathize.</p> <p><b>Trainer asks groups to answer these questions (10 minutes)</b></p> <ul style="list-style-type: none"> <li>How does the child feel due to the Teacher's behavior?</li> <li>How might the child's life situation influence his/her behaviour and experience at school?</li> <li>What might be ways to address these issues in the classroom?</li> </ul> <p><b>Trainer with full group: (10 minutes x 4 groups = 40 minutes)</b> Each small group explains their answers to the question. The rest of the class comments.</p> <p>Expected answers could include:</p> <ul style="list-style-type: none"> <li>How does the child feel due to the teacher's behaviour? Sad / Disappointed / Frightened / Hopeless / Wants to run away and not go to school / Lonely / Angry / Frustrated / Determined to succeed / Survivor guilt etc.</li> <li>How does the child's life situation influence the child's behaviour and experience at school? Loss of family makes it difficult to concentrate due to worry and sadness / No school fees due to no income or no caregiver leads to anxiety / Many chores due to poverty and living situation leaves little time for school / Lack of light at night makes it impossible to do homework / Lack of security at night leads to inability to do homework/ Parent pressuring child to do well as only hope for the family etc.</li> <li>What might be activities to address these issues in the classroom? Activities can include the child, teachers, parents, community members, and/or changes in school policies etc..</li> </ul>	80
<b>Part 2: Understanding the link between humanitarian operations and MHPSS.</b>	<p><b>Trainer presentation (power point, when possible) with discussion with full group:</b></p> <p>"Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being." (IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007)</p> <p>"Exposure to the disruption, loss, and violence associated with emergencies places significant psychological and social strain on children, adolescents, their families and communities. The way in which children and families experience and respond to conflicts and disasters varies greatly, yet with the right support the majority will be able to overcome these difficult experiences. It is essential that social and psychological issues are not ignored while homes are rebuilt, social services re-established and livelihoods recommenced. It is now widely accepted that early psychosocial interventions must be an integral part of humanitarian assistance." (UNICEF, 2007)</p> <p>Trainer defines with examples relevant to this context:</p> <p>Definition: The term 'psychosocial' emphasizes the close connection between psychological</p>	30

	<p>aspects of our experience (that is, our thoughts, emotions, attitudes and behavior) and our social experiences (that is, our relationships, traditions, spirituality and culture) The association of these two elements in the term 'psycho-social' demonstrates the close and dynamic relationship and interaction between the two, each continually influencing the other. (UNICEF, 2002)</p> <p>Definition: Psychosocial well-being refers to the psychological adjustment of an individual in relation to his or her social environment. (UNICEF, 2002)</p> <p>Definition: "Mental and behavioural disorders are clinically significant conditions characterized by alteration in thinking, mood (emotions), or behaviour associated with personal distress and/or impaired functioning. Mental and behavioural disorders are not just variations within the range of "normal", but are clearly abnormal or pathological phenomena." (World Health Organization, 2001)</p> <p>Trainer clarifies prevalence of problems (% of persons affected), using WHO Table below.</p> <p>Trainer explains: Most people, including children, are resilient and cope with the consequences of an emergency utilizing their protective factors. Most people do not develop mental disorders.</p> <p>The trainer can define the following using case examples related to this context:</p> <ul style="list-style-type: none"> <li>▪ Definition "Resilience": the ability to recover quickly from setbacks</li> <li>▪ Definition "Coping": to deal successfully with a difficult problem or situation</li> <li>▪ Definition "Protective factors": factors that prevent somebody or something from harm or damage.</li> </ul> <p><b>Trainer asks and with discusses with full group based on their experiences:</b> What are the actual consequences of emergencies for children, families, communities and societies?</p> <p><b>Trainer presents:</b> The IASC MHPSS guidelines offer ideas for what schools can do to better assist children affected by emergencies.</p> <p>Trainer provides a brief overview of the IASC MHPSS Guidelines i (Could use power point).</p> <p>"These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support MHPSS. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems."</p> <p>"In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity."</p> <p>"These guidelines were designed for use by all humanitarian actors, including community-based organisations, government authorities, United Nations organisations, non-government organisations (NGOs) and donors operating in emergency settings at local, national and international levels. The orientation of these guidelines is not towards individual agencies or projects."</p> <p>"Implementation of the guidelines requires extensive collaboration among various humanitarian actors: no single community or agency is expected to have the capacity to implement all necessary minimum responses in the midst of an emergency."</p> <p>"These guidelines are not intended solely for mental health and psychosocial workers. Numerous action sheets in the guidelines outline social supports relevant to the core humanitarian domains, such as disaster management, human rights, protection, general health, education, water and sanitation, food security and nutrition, shelter, camp management, community development and mass communication."</p> <p>IASC MHPSS Core Principles:</p> <ol style="list-style-type: none"> <li>1. Human rights and equity; Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination.</li> </ol>	
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	<ol style="list-style-type: none"> <li>2. Participation; Humanitarian action should maximise the participation of local affected populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts.</li> <li>3. Do no harm; Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Humanitarian actors may reduce the risk of harm in various ways, such as: Participating in coordination groups to learn from others and to minimise duplication and gaps in response; Designing interventions on the basis of sufficient information; Committing to evaluation, openness to scrutiny and external review; Developing cultural sensitivity and competence in the areas in which they intervene/work; and developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.</li> <li>4. Building on available resources and capacities; All affected groups have assets or resources that support mental health and psychosocial well-being. A key principle, even in the early stages of an emergency, is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programmes often lead to inappropriate mental health and psychosocial support and frequently have limited sustainability. Where possible, it is important to build both government and civil society capacities.</li> <li>5. Integrated support systems; Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, can create a highly fragmented care system.</li> <li>6. Multi-layered supports; In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.</li> </ol>  <p style="text-align: center;">26</p>	
<b>Part 3:</b> <b>Actions that Education operations can take to facilitate MHPSS and how to deal with the challenges.</b>	<p><b>Trainer presentation:</b> Trainer hands out Action Sheet 7.1 and discusses each key point.</p> <p>Action Sheet 7.1 provides guidelines about how to: “Strengthen access to safe and supportive education.</p> <p>“In emergencies, education is a key psychosocial intervention: it provides a safe and stable environment for learners and restores a sense of normalcy, dignity and hope by offering structured, appropriate and supportive activities.”</p> <p>“Many children and parents regard participation in education as a foundation of a successful childhood.”</p> <p>“Well-designed education also helps the affected population to cope with their situation by disseminating key survival messages, enabling learning about self-protection and supporting local people’s strategies to address emergency conditions.”</p>	40

	<p>"It is important to (re)start non-formal and formal educational activities immediately, prioritising the safety and well-being of all children and youth, including those who are at increased risk (see Chapter 1) or who have special education needs."</p> <p>"Loss of education is often among the greatest stressors for learners and their families, who see education as a path toward a better future."</p> <p>"Education can be an essential tool in helping communities to rebuild their lives."</p> <p>"Access to formal and non-formal education in a supportive environment builds learners' intellectual and emotional competencies, provides social support through interaction with peers and educators and strengthens learners' sense of control and self-worth."</p> <p>"It also builds life skills that strengthen coping strategies, facilitate future employment and reduce economic stress."</p> <p>Educators – formal classroom teachers, instructors of non-formal learning and Trainers of educational activities – have a crucial role to play in supporting the mental health and psychosocial well-being of learners.</p> <p>Far too often, educators struggle to overcome the challenges that they and their learners face, including their own emergency-related mental health and psychosocial problems. Training, supervision and support for these educators enable a clear understanding of their roles in promoting learners' well-being and help them to protect and foster the development of children, youth and adult learners throughout the emergency."</p> <p><b>Key actions:</b></p> <ol style="list-style-type: none"> <li>1. Promote safe learning environments.</li> <li>2. Make formal and non-formal education more supportive and relevant.</li> <li>3. Strengthen access to education for all.</li> <li>4. Prepare and encourage educators to support learners' psychosocial well-being.</li> <li>5. Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.</li> </ol> <p>The IASC MHPSS guidelines complement another set of guidelines: Inter-Agency Network for Education in Emergencies Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction (INEE Minimum Standards). They state:</p> <p>"Wars and natural disasters deny generations the knowledge and opportunities that an education can provide.</p> <p>"Education is not only a right, but in situations of emergencies, chronic crises and early reconstruction, it is a necessity that can be both <i>life-sustaining</i> and <i>life-saving</i>, providing physical, psychosocial and cognitive protection. It sustains life by offering physical safe space for learning, as well as the ability for providing support to and screening those affected, particularly children and adolescents."</p> <p>"Education mitigates the psychosocial impact of conflict and disasters by giving a sense of normalcy, stability, structure and hope for the future during a time of crisis."</p> <p>"It can save lives by protecting against exploitation and harm, including abduction, child soldiering and sexual and gender-based violence."</p> <p>"Lastly, education provides the knowledge and skills to survive in a crisis through the dissemination of lifesaving information about landmine safety, HIV/AIDS prevention, conflict resolution and peace-building."</p> <p>"INEE promotes access to and completion of education of high quality for all persons affected by emergencies, crises or chronic instability."</p> <p>"INEE recognizes the key role that teachers play in restoring access to quality education in emergency, chronic crisis and early reconstruction."</p> <p>"With the protection and psychosocial needs of children in mind, trained teachers communicate critical messages to children and youth, serve as models of caring adult behavior, help reestablish children's trust, and have the potential to create a climate in the</p>	
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	<p>classroom that helps children and youth heal.”</p> <p>“Teachers help build academic and social skills and prepare future generations for the challenges in their communities.”</p> <p>“Yet far too often these teachers struggle to overcome the challenges that they and their students face in emergency or early reconstruction contexts. Teachers - some formerly trained, others not - may find themselves in multi-age, overcrowded classrooms with little to no teaching and learning resources and support. Teachers are often unable to respond the physical and emotional needs of their students or themselves. Quality training programs in these contexts are indispensable in preparing teachers to help protect and foster the development of children and youth from the outset of an emergency through early reconstruction.”</p>	
<b>Part 4: Practical application of action sheet on Education</b>	<p><b>Trainer with full group asks:</b> As an Education Cluster member in this location: What can your organization do to promote the psychosocial health and wellbeing of children through schools or other child friendly spaces? How can you:</p> <ul style="list-style-type: none"> <li>▪ Support good teaching and learning practices?</li> <li>▪ Put a referral system into place?</li> <li>▪ Support the physical and psychosocial needs of teachers and Trainers?</li> </ul> <p>Flip charts with each point listed above are presented with blank space. One participant is next to each flip chart and lists ideas about HOW this can be done in this location as they are presented by the class.</p> <p><b>Trainer asks:</b> IASC MHPSS Guidelines uses a pyramid to outline a multilayered structure of intervention. What can the Education Cluster in this location do to facilitate intervention at each layer of the pyramid?</p> <p>The pyramid is on a flip chart and the participants write in their responses at the appropriate place on the pyramid. Trainer can add to their answers using the following examples:</p> <p>Layer 1: Social and psychological considerations in basic services and security</p> <ul style="list-style-type: none"> <li>▪ Advocate for schools to be protected during conflict</li> <li>▪ Reschedule exams or gradually returning to formal curriculum</li> </ul> <p>Layer 2: Community and family supports</p> <ul style="list-style-type: none"> <li>▪ Train teachers to provide classrooms that offer PS support through education.</li> <li>▪ Facilitate environment of peer support</li> <li>▪ Establish child friendly spaces</li> <li>▪ Establish parent discussion groups</li> <li>▪ Involve parents in school</li> </ul> <p>Layer 3: Focused non-specialised supports</p> <ul style="list-style-type: none"> <li>▪ Strengthen school counseling via proper training</li> <li>▪ Structured group sessions for children by qualified people (usually external)</li> <li>▪ Referral of children or families to social services outside of the school</li> <li>▪ Support groups for teachers</li> </ul> <p>Layer 4: Specialised services</p> <ul style="list-style-type: none"> <li>▪ Referral to clinical mental health services</li> </ul>	30
<b>Part 5: Summarize seminar learning</b>	<p><b>Trainer presentation to full group:</b> Using a flip chart that was prepared prior to the seminar, the Trainer summarizes key components of what was discussed in the seminar.</p>	10
<b>Part 6: Ways forward</b>	<p><b>3 small groups (10 minutes)</b> : (Change group members from last group.) Each small group prepares a flip chart in answer to this question: What can <i>this</i> Education operation practically do to promote MHPSS including: Action / Who does it? / How they do it? / When? With whom and how must they coordinate their actions?</p> <p><b>Trainer with full group: (5 minutes x 3 groups = 15 minutes).</b> Each small group shares its Flip Chart.</p>	40

	<p><b>Trainer asks:</b> (10 minutes) What might prevent the Education Cluster from ensuring that the points on the lists happen?</p> <p><b>Trainer summarizes:</b> (5 minutes) Trainer combines key points from workshop with participant's ideas for way forward.</p>	
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## VI. MONITORING

After part 3. Ask the participants to form groups of four. Within their group, ask each participant to share with others the most interesting and most relevant thing they have learned during the seminar. Participants (and if time allows each group) are invited to share key points of learning.

## V. EVALUATION

### Evaluation of the training:

Participants' evaluations via written structured or semi-structured questionnaires immediately after the seminar to evaluate their immediate response to the value and clarity of the content, training methodology and initial reactions about what they learned and its relevance and applicability to their work.

### Evaluation of the impact of the training on schools, classroom and children:

Pre and post questionnaires (immediate and months later) via visits to participants' work sites to compare their ability to effectively integrate the IASC MHPSS Guidelines into their actual work compared to what they did prior to the seminar. Indicators to gauge this can include:

- Percentage of girls and boys of different ages with access to formal and non-formal education.
- Percentage of educational administrators and teachers trained in how to integrate psychosocial support into the schools.
- Percent of children referred with severe difficulties to specialised services.
- Percent of involvement of parents and communities within the schools.
- Percent of schools and classrooms that include activities that are designed to facilitate psychosocial well-being.
- Percent of schools and classrooms that have policies that maximize psychosocial well-being.
- Percent of schools and classrooms that have and apply ethical standards that protect children.

## VI. READING AND HANDOUTS

The Trainer provides participants with copies, in their language, of the IASC Guidelines Checklist for Field Use and the full Action Sheet 7.1 of the IASC MHPSS Guidelines, plus the attached Handout and other relevant resources recommended at the end of Action Sheet 7.1. The Trainer also sends participants the seminar notes, power point presentations, summary of all small group presentations to facilitate their way forward.

**HANDOUT FOR EDUCATION STAFF ORIENTATION SEMINAR**  
**Size of the problem: Summary Table of Generic WHO (2009) Projections<sup>a</sup>**

	<b>BEFORE DISASTER: 12-month prevalence<sup>b</sup> (median across countries)</b>	<b>AFTER DISASTER: 12-month prevalence (median across countries)</b>
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder)	2-3%	3-4% <sup>c</sup>
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15-20% <sup>d</sup>
"normal" distress / other psychological reactions (no disorder)	No estimate	Large percentage

Notes: PTSD indicates posttraumatic stress disorder.

- <sup>a</sup> Observed rates vary with setting (e.g. time since the emergency, socio-cultural factors in coping and community social support, previous and current disaster exposure) and assessment method but give a very rough indication what WHO expects the extent of morbidity and distress to be.
- <sup>b</sup> The assumed baseline rates are the median rates across countries as observed in the World Mental Health Survey 2000.
- <sup>c</sup> This is a best guess based on the assumption that trauma and loss (a) may exacerbate previous mental illness (e.g., it may turn moderate depression into severe depression), and (b) may cause a severe form of trauma-induced common mental disorder.
- <sup>d</sup> It is established that trauma and loss increase the risk of common mental disorders (depression and anxiety disorders, including posttraumatic stress disorder). Higher quality studies (random, large samples; diagnostic interviews) report lower rates.