THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Trauma-Focused Lay Counselor Training for Disaster Mental Health Care in Developing Countries

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Abstract:
Natural and human caused disasters affect tens of millions of people a year globally. Disasters happen with much greater frequency in developing countries, with the majority of deaths occurring from natural disasters and primarily among the poor. Developing countries are sorely lacking in Disaster Mental Health (DMH) care following a disaster, particularly the provision of longer term trauma and grief focused counseling for individuals and families. This is largely because of the extreme shortage of mental health professionals in resource limited countries and the absence of a longer term DMH care program in many areas of the world. Hence, there is the need for trained lay counselors within disaster impacted areas and communities who can provide counsel and practical help to survivors. This article discusses the importance and role of lay counselor training in DMH and outlines a two-day disaster care training program for indigenous lay leaders and helpers in developing countries. The contents of the DMH program, as well as the execution of this ongoing program in Nepal soon after and since the 2015 earthquakes, serves as an example of what can be done in other developing countries in both pre- and post-disaster training of lay personnel.

Keywords*: Disaster mental health, developing countries, lay counselor training, trauma-focused care*

1. Introduction

Natural and human caused disasters affect tens of millions of people a year globally. According to the International Federation of the Red Cross and Red Crescent Societies (IFRCRCS), a disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources (IFRCRCS, 2018). Disasters happen with much greater frequency in developing countries, with an estimated 90% of deaths occurring from natural disasters and primarily among the poor (Jamison et al., 2017). In 2017, almost 100 million people worldwide were affected by natural and human made disasters (SIGMA, 2018). There were 318 recorded natural disasters (e.g., earthquakes, volcanic eruptions, tornadoes, seasonal floods, droughts, wildfires, cyclones and tropical storms) that affected people in 122 countries, and over 11,000 people died or went missing (SIGMA, 2018; United Nations Office for Disaster Rick Reduction, 2018). Globally, there were more than 8000 victims of natural catastrophes in 2017, with human made disasters such as civil war, mass shootings, terrorist incidents, and chemical hazards responsible for roughly 3000 deaths. Economic damages were estimated at 314 billion US dollars (SIGMA, 2018). Even though the total economic losses due to disasters are greater in developed countries, the percentage of losses relative to the GNP in developing countries is far greater (Jamison et al., 2018).

Disaster mental health counseling in developed countries is a common practice of intervention into the lives of crisis and trauma survivors following natural disasters and human made catastrophes such as industrial and technological disasters, terrorist incidents, and, of course, war (Halpern & Vermeulen, 2017; Webber & Mascari, 2016). In the early stages after a disaster the goal of Psychological First Aid offered by community responders is to provide practical assistance to those affected, and to help people stay safe, calm, and connected to each other. In recent years, Disaster Mental Health (DMH) counseling has focused more on the application of mental health counseling principles and skills in the treatment of trauma and loss occurring over time and in diverse multicultural settings (see e.g. Miller, 2012; Stebnicki, 2016). However, despite these advances in culturally sensitive best practices of DMH counseling in various contexts, there is one major limitation in the practical application of DMH counseling in the developing world. This includes the extreme shortage of trained mental health professionals who can offer needed services to citizens in the wake of disaster (both in immediate crisis intervention and longer-term trauma), and who can teamwork with mental health professionals who come to help from outside the country. One theme that has received little attention in the literature on DMH is the need for training lay counselors in the practice of mental health counseling with disaster survivors who are struggling with a variety trauma-related symptoms and disorders, as well as complicated grief resulting from a plethora of losses.

The purpose of this article is to draw attention to the need for training lay counselors in developing countries who can provide assistance and care for individuals and families in the weeks, months, and sometimes years following a natural or human caused disaster. The author discusses the importance and role of lay counselor training in Disaster Mental Health (DMH) in resource limited countries where DMH programs are lacking and professional counselors and therapists are few and, in many cases, non-existent. Essential components of a two-day DMH and trauma counseling module of the ILCTP developed by Carson and colleagues (Carson, 2017; Carson et al., 2011) is outlined, along with suggested time blocks for small group interactions, role plays, and other experiential activities at various periods throughout the day. Finally, the implementation of the program in Nepal after the 2015 earthquakes, and again in Nepal in 2017, is highlighted. The contents of the DMH outlined in this article, as well as the execution of this ongoing program in Nepal, serves as an example for what can be done in other developing countries in both pre- and post-disaster training of lay personnel.

2. The Need and Rationale for Trained Lay Counselors Involved in Disaster Mental Health Care in Developing Countries

A disaster is an event (or series of events), according to DelCampo (2018), that involves the destruction of property, injury, and/or loss of life; has an identifiable beginning and end; adversely affects a relatively large group of people; is "public" and shared by members of more than one family; is out of the realm of ordinary experience; and is psychologically traumatic enough to induce distress in almost anyone, regardless of previous condition or experience. Disaster response often occurs in four stages: (1) Physical rescue and return to safety; (2) Crisis intervention (usually lasting at least a few weeks); (3) Post trauma counseling; and (4) The ongoing period of survival and growth. Stage 3 is where the emotional and relational needs of people affected tend to be glossed over and forgotten by members of their community or region (and even ignored or suppressed by survivors themselves) as the crisis is now over and, physically at least, people have begun to rebuild their lives and return to some sense of "normalcy". However, Stage 3 is also the longest and most difficult period of adjustment for many individuals and families after a disaster because it is the period when reactions from trauma and loss are deepening and becoming more pronounced. Hence, this is the stage when longer term (and a deepened level of) assistance from trained counselors, both professional and lay, is sorely needed in the developing world.

Disasters of any kind are immobilizing experiences that tend to overwhelm the ability of individuals and families to cope and move forward with their lives. Although many people exhibit uncanny resilience in the face of disaster, others do not. The management of both natural and human made disasters is a complex process that often involves the cooperation of local, national, and international organizations (UNISDR Prevention Web, 2017). A country's vulnerability to all types of disasters depends on a number of factors, including poverty, demographic growth, urbanization, unsafe residential areas, environmental pollution, limited or poor education, and unplanned development. Family problems, mental health issues, and substance abuse are common reactions of citizens to disaster, particularly in developing countries where mental health resources are lacking (de Goyet, Marti, & Osorio, 2006; Stebnicki, 2016**)**. Timely and culturally adaptive interventions such as counseling can help minimize negative outcomes in individuals and families (Substance Abuse and Mental Health Services Administration, 2017).

The reactions and coping abilities of individuals in the face of disaster are influenced by their cultural beliefs and traditions, social class or standing, prior health status (both physical and mental), and economic well-being. Primary mental health care workers need to have a high level of cultural competence and understanding in delivering effective services and counseling (Stebnicki, 2016). Adequate preparation in developing countries for the provision of psychosocial care in disaster situations must include training and education of people at various sectors, including lay leaders and workers, and a networking of community services. Although primary care workers are often responsible for identifying, managing, and referring citizens who need professional mental health treatment, they can also be available for counsel and support to many others. According to Lima (1986, pp. 203-204),

> The mental health training of primary care workers in developing countries has included the management conditions seen in routine clinical practice such as first-aid in neuropsychiatric emergencies; maintenance treatment of the chronically mentally ill; advice and support to high-risk families; referral of mentally ill people in a non-acute or unclear state to the nearest health facility; family education about psychosocial development and the needs of the elderly and handicapped; support and education of the mentally ill about self-care; and collaboration of community leaders in activities aimed at protecting and promoting mental health. Attention needs to be paid now to the special mental health needs of disaster victims and to the structural and procedural adjustments required from the primary case worker to meet them. Important areas in disaster education and training include: knowledge of disaster behavior (e.g. crisis/stress, loss and mourning, coping and adaptation); skills in the use of different treatment modalities (crisis counseling, group therapy, short-term focused therapy, psychopharmacology); understanding of the disaster aid system (e.g. shelter, medical care. home repairs; financial assistance); and the ability to utilize available family and community resources.

The provision of mental health services and interventions is particularly challenging in developing countries following a disaster where mental health resources are scarce. Historically, the most commonly employed strategy in developing countries has been the involvement of international mental health teams in disaster locations. However, this strategy has many limitations that include language and cultural barriers, visa and political restrictions, the absence of mechanisms to educate the community and promote its participation in the process of social recovery, and the temporal nature of this outside

help, to name a few (de Almeida, 2002). This strategy also does not help countries adequately prepare for future disasters using its own citizens. It is also important to remember that many different kinds of healing practices go into rebuilding individual, family, and community resilience following a disaster. These include cultural, ceremonial, communal, spiritual and religious practices. Over time people need to grieve their losses and strive to make some kind of meaning from the disaster, get back to the normal rhythms and routines of life, and hopefully experience renewed hope and a positive vision for the future. Trained lay counselors working in, and who are often from, disaster affected areas can be an integral part of this healing and rebuilding process in developing countries of the world.

3. The Importance and Role of Lay Counselor Training in Disaster Mental Health in Developing Countries

Counseling is a relatively new phenomenon in developing countries, and lay counselor training is even more recent (see e.g., Carson, 2017; Carson, Lawson, Casado-Kehoe, & Wilcox, 2011). Lay counselor training is particularly timely and important given the severe lack of mental health services in resource limited areas of the world. There is evidence that well trained lay counselors can have a positive and long-lasting impact on individuals, families, and communities in developing countries. For example, successful outcomes of lay counselor training for community members in India included assistance in the treatment of alcohol abuse (Nadkarni, 2018; Nadkarni, Vellerman, Dabholkar, Shinde, & Bhat, 2015), as well as depression and anxiety disorders (Nadkarni et al., 2015; Patel, Weiss, Chowdhary, Naik, & Pednekar, 2010). Results from studies in other developing countries supporting the efficacy of lay counseling training to helping citizens included counseling individuals with HIV with various psychosocial problems in South Africa (Kagee, 2012), post-traumatic stress disorder (PTSD) among Rwandan and Somalian refugees living in Uganda (Neuner, Onyut, Ertl, Odenwald, & Schauer, 2008), and traumatized children and families in Nepal (Keats & Sharma, 2014). Findings from these studies support the notion that trained lay counselors in developing countries can be a useful and cost-effective way for helping individuals with a variety of substance use and psychological disorders, as well as individual and family-based trauma.

Another complication to Disaster Mental Health care is that mental health treatment in general is one of the most neglected areas of overall health care in developing countries (Carson & Chowdhury, 2018; Patel, Chowdhary, Rahman, & Verdeli, 2011; Patel, Minas, Cohen, & Prince, 2014). Population density, limited resources, and the scarcity of trained counseling professionals do not make it possible for the mental health needs of people to be met through professionally trained counselors and therapists alone. In the wake of natural or human made disasters, the mental health and family-oriented needs of citizens are enhanced geometrically. In addition, in the weeks and months following a disaster, individuals and families in many countries of the world may not be open to "counseling" from individuals outside their culture, and even from outside their own community or region, including indigenous counseling professionals who might offer help. Hence, the need for trained lay counselors close to or from within disaster affected areas can be an essential component of post disaster relief and care for victims. Post disaster counseling and care thus becomes a critical part in the "normalization" of counseling for all citizens, both in the short and long run following a disaster. This process occurs through the enhancement of public awareness and education in both rural and urban areas in ways that are culturally sensitive, relevant, and appropriate.

3.1. Example of the International Laid Counselor Training Program

The International Lay Counselor Training Program (ILCTP; Carson, 2017; Carson et al., 2011) provides training for community members in the essential components of counseling in a two to five-day period, depending on the needs and requests of trainees. The ILCTP includes a Disaster Mental Health counseling and care component that has been used in response to a number of disasters in South Asia the last 10 years. These include, for example: (a) Training lay counselors in Mumbai, India soon after the 2008 terrorist massacre; (b) Training care providers in Odisha State, India soon after Cyclone Hudhud in 2014; and (c) Training lay counselors working with victims of the earthquakes in Nepal in 2015, and again in 2017. In each case international counselor trainers partnered with lay leaders from various communities in an effort to provide basic mental health counseling for individuals and families within a few weeks or months of these disaster experiences.

The ILCTP is a culturally sensitive and strongly applied program intended to help lay trainees become proficient in the essentials of counseling knowledge and skill. The trainings are often done through translation, with native translators being carefully chosen who can help contextualize the material and make it practical and relevant. Written materials are also often translated into the native language of trainees and distributed to them when the training is not done in English. The ILCTP typically employs a training the trainers approach even though other community citizens are also often invited to attend (Carson, 2017; Carson et al., 2011; Carson & Chowdhury, 2000). Select trainees who are community leaders are often targeted for training and then mentored in locations where the training has been requested by community members, or by those affiliated with secular and religious bodies (e.g., organizations, agencies, elementary and secondary schools, colleges and universities, temples and churches, etc.). These trained individuals can then expand their sphere of influence by training other lay individuals over time. This training-the-trainers approach has been successfully applied in several countries in South Asia, particularly in many parts of India, as well as in various parts of Nepal, Bangladesh, Sri Lanka, and Myanmar (see for example Carson, 2017; Carson & Chowdhury, 2000; Carson & Chowdhury, 2006; Carson, Chowdhury, & Ramirez, 2009).

The ILCTP operates on a modest level of funding that currently comes from three international NGO's. With regard to the Disaster Mental Health component of the ILCTP, the program can be conducted in either a pre- or post-disaster manner; for example, in designated "hot spot" areas of the developing world that are at high risk for and/or have had some history of

natural disaster occurrences. One ultimate goal of the ILCTP is to work with trained leaders and other volunteers in finding ways to offer free or very low cost ongoing counseling services in their local communities, either in people's homes or other facilities such as schools, community centers, or places of worship. The belief is that sustainable lay counseling activities are desperately needed that can help meet the personal and relational needs of individuals, couples, and families -- both generally speaking and in response to disaster, tragedy, and loss.

4. Overview of Essential Components of ILCTP Disaster Mental Health Training for Lay Counselors

4.1. Day One Training

4.1.1. Definition of Trauma and Trauma Focused Counseling

Trauma is a bodily, mental, or emotional injury (deep wounding) usually caused by another person or persons, or by an external event. Trauma overwhelms a person's ordinary known adaptations to life (coping) and threatens one's personal sense of safety, well-being, and integrity. Common immediate emotions in response to trauma and loss are fight, flight, or freeze. These reactions also often involve intense fear (terror) of injury or death, loss of control, and feelings of complete helplessness. Longer term reactions may be those associated with Post Traumatic Stress Disorder (PTSD), depression, various forms of anxiety, and a host of other symptoms. Trauma focused training involves a process which emphasizes helping trainees help people in disaster affected areas to (a) Have opportunities to tell and retell their trauma story with a caring person or close knit group; (b) Work through painful memories of the event or events and eventually separate the past from the present; (c) Feel and express emotional pain and grief over time and at deeper levels; and (d) Gradually change unhelpful beliefs about the trauma and themselves, and regain a sense of purpose in life and realistic hope for the future. Program material was adapted in part from a number of sources (Briere & Scott, 2014; Carson et al., 2011; Clark, Classen, Fourt, & Shetty, 2014; Courtois, Ford, van der Kolk, & Herman, 2013; Curren, 2013; Ford & Courtois, 2015; Greenwald, 2017; Herman, 2015; National Organization for Victim Assistance, 2015; Rothschild, 2010; van der Kolk, 2015; WHO/UNHCR, 2015).

4.2. Formal Definition of Trauma

- The person has been exposed to a traumatic event in which both of the following were present: The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. If witnessed a traumatic event but not directly experienced it, this is known as “vicarious traumatization”.
- The person’s response involved intense fear, helplessness, or horror. Children's responses may be expressed by disorganized or agitated behavior.

4.3. Types and Common Characteristics of Trauma

- Two types of trauma are situational and cumulative.
- Fight, flight, or freeze are common responses to traumatic life experiences for children and adults. Raging, running and dissociating, and shutting down emotionally are all survival mechanisms. Trauma sometimes blocks us from "feeling our feelings". Hence, we often "don't know what we don't know" after traumatic life experiences.
- Some common initial reactions to a traumatic event can include: shock, denial, anger, deep sadness and depression, grief/loss, guilt, confusion, powerlessness, disappointment, temporary rejection toward one's child or others, and a plethora of ambivalent emotions such as joy and thanksgiving, sorrow, shattered assumptions about life and faith, hope and despair that can continue indefinitely.
- Trauma memories are stored differently in the brain than other memories; i.e., in the "emotional brain"). As such we often do not have access to them. These memories can also be stored in our bodies (i.e., as "somatic memories" or "body emotions"). Painful memories and emotions can therefore be triggered through touch and our other five senses.
- All trauma work involves helping the person work through grief and loss (and regret), and to mourn at some deep level, while also recognizing their many survival mechanisms and characteristics.
- Trauma sometimes gets linked with addictions (e.g., substance abuse; other addictions such as prescription drugs, sex, gambling, food, spending, etc.) because of people's attempt to self-medicate in order to feel better and to cope.
- Giving words to trauma helps to heal it. Disaster survivors must be able to tell their trauma story, starting before the disaster took place, and then usually on more than one occasion after the trauma and loss.

4.4. The Ultimate Goal of Trauma Counseling

The ultimate goal of trauma counseling is to help individuals live in the present, with no intrusion from past distressing events, no fear of that intrusion or their own affect (emotions), and the ability to function and relate well to themselves and others. Although the past may seem or feel like the present to disaster survivors, it is very important to help them understand that the present is just a memory or impression and is not the event(s) itself, and therefore, that new

meanings can be created surrounding the event. Counseling can help the person make these wounds more conscious and allow repressed feelings to be expressed and put into words so that they can be worked through.

4.5. General Steps in Trauma Recovery (Sources: Briere & Scott, 2014; Clark Et Al., 2014; Rothschild, 2010)

- Choose whether or not to tell one's trauma story or stories and to communicate one's inner feelings to another person (e.g., parent, family member, pastor, counselor or therapist).
- Feel the fullness of the feelings and try to identify and label them, especially the primary (core) emotions.
- Explore the meaning and function of those feelings within the self with the help of another person.
- Connect the past with the present, then separate the past from the present and realize that the past is dead and gone.
- Understand one's trauma triggers (from other people and life situations) and learn how to respond to them in a proactive and productive way (i.e., have a plan for staying healthy).
- Create a new narrative (story) for one's life (and family/community) by building or restoring healthy relationships, learning new coping skills, and restoring self esteem.

4.6. Some Critical Survival-Based Principles of Trauma

- Trauma memories are often stored as bodily sensations and flashbacks; i.e., fragments of truth and reality that are disconnected from one another, and often in one's subconscious mind.
- When humans experience trauma they can lose track of their real and authentic emotions.
- Traumatized individuals often have difficulty accessing their true and deep inner emotions, identifying and labeling them, and putting these feelings into meaningful words -- to themselves or others.
- Close intimate relationships in the present can help bring healing, while at the same time trigger unresolved pain from the past. This pain can get projected on to others in one's current marriage and parent-child relationships (known as "reenactment").
- Trauma and addictions (e.g., substance abuse; other addictions such as prescription drugs, sex, gambling, food, and money-related) often go hand in hand, for example, as an attempt to self-medicate to feel better and to cope.
- Counseling can help make these early wounds conscious, and to allow repressed feelings to be expressed and be put into words so that they can be faced, understood, and gradually worked through so that more positive and healthy thoughts and emotions can emerge.
- People must feel to heal. We humans both feel what we think and think what we feel. Although feelings are not facts, they are crucial barometers of good mental health and powerful indicators of our inner experience in relation to others.

4.7. Morning: Break Out Time for Small Group Discussion

4.7.1. Common Reactions of Trauma Survivors, Including Disaster Victims

- Anxiety and Depression.
- Learned Helplessness.
- Emotional Constriction (unwillingness or inability to feel).
- Disorganized Inner World (confusion; bewilderment).
- Traumatic Bonding (forming unhealthy attachments with the "wrong" people).
- Cycles of Reenactment (doing the same destructive things over and in relationships).
- Loss of Ability to regulate one's Emotions (emotional roller-coasters; either-or emotions).
- Emotional Triggering (reacting to inner or outer triggers related to the trauma and loss).
- Distorted Thinking (e.g., regarding self, others, life).
- Loss of Trust and Faith (dread of the future; pessimism that the future will bring any loving and caring relationships).
- Hyper-vigilance ("waiting for the other shoe to drop").
- Loss of Ability to Seek or Make Use of Social Support.
- Fused Feelings (emotions that are all meshed together).
- Emotional Numbness (inability to feel one's feelings).
- Loss of Spontaneity (not feeling alive or allowing oneself to feel alive and in the moment).
- High Risk Behaviors (i.e., with people or in life).
- Self Medicating (use of alcohol or drugs to cope and to be able to relate to others).
- Untrue, unhealthy, or unrealistic views or beliefs about one's core sense of "Self" that may include thoughts of deep shame and self loathing, unworthiness of other people's love and affection, or self perceptions of being fundamentally unlikeable or unlovable. These core beliefs need to be explored and eventually changed, at least at some real level, in the process of trauma recovery.

4.7.2. Major Disorders and Behaviors That Can Be Associated with Trauma and Loss

- Acute Stress (short-term high-level stress).
- Generalized (free-floating) Anxiety.
- Post-Traumatic Stress Disorder.
- Complicated or Unresolved Grief.
- Moderate-Severe Depressive Disorder.
- Physical and Intellectual Disability (e.g., memory loss; difficulty concentrating and problem-solving).
- Harmful Use of Alcohol and Drugs.
- Suicide (thoughts, ideations, gestures, or actual attempts).
- Marital and Family Pain, Loss and Conflict.
- Other Significant Mental Health Complaints such as Phobias and Panic Disorder.

4.7.3. Other Symptoms and Difficulties Associated with Trauma And Loss

- Re-experiencing the event both psychologically and with physiological reactivity.
- Avoidance and isolation.
- Behavioral arousal.
- Sleep problems.
- Physical pain or complaints (e.g., headaches; tightness in chest; racing heart).
- Negative thoughts of self.
- Deeply experienced emotions and emotional pain.
- Images, smells, sounds, tastes, and touches that can be triggered by traumatic memories or associated stimuli.
- Bodily sensations associated with the trauma (trauma that is stored in the body).
- Non-reality-based perceptions about the self and the world (skewed worldview).
- Psychotic symptoms (e.g., strange beliefs and other features of delusional thinking; paranoia; seeing or hearing things that are not there; inappropriate affect; withdrawal from others).

4.7.4. The Potential Impact of Trauma on Children (Updated Source: Delcampo, 2018)

- Children process trauma differently and typically more slowly than adults.
- Trauma may also result in intellectual delays, deficits or disabilities, as well as impaired relationships with family members and peers.
- Increased dependency on parents.
- Nightmares.
- Regression in development.
- Specific fears about reminders of the disasters.
- Acting out or aggressive behavior at home or with peers.
- Emotional mood swings.
- Symptoms of anxiety and depression.
- Difficulty concentrating and focusing.
- Disruption of close attachments.
- Demonstration of the disaster through play.

4.7.5. Psychological Defenses Common in Trauma Survivors

- Denial ("Nothing bad really happened to me or my loved ones").
- Dissociation ("I'm somewhere safe in a corner of my mind").
- Intellectualization ("I'd rather talk about my feelings than feel them").
- Suppression ("I don't want to think about that so don't ask me; I would rather talk about something else").
- Repression ("What I don't know about can't hurt me").
- Projection ("If only you would change, I would be fine"; "I'm not the problem. He/she/they are the problem").
- Displacement ("I am really angry or upset about something or someone else but am taking it out on you").
- Survival Guilt ("Why me? Why was I spared? Why did I break free of this pain or these problems and other people did not?").

4.7.6. Traumatic Memory in Survivors of Trauma and Loss

- Sensations, feelings, and behaviors become deeply ingrained in the person and that are resistant to change
- Sensations, feelings and behaviors that can be triggered by external stimuli and events.
- Thoughts and memories that cannot always be remembered when wanted or called up at will.
- Flashbacks of traumatic event(s) that can occur.

4.7.7. Eventual Goals of Traumatic Memory Recovery

- The person can develop a whole, organized story about the event or events.
- Can talk about the whole story or parts of it without excessive anxiety.
- Can recall events and details when attempting to.
- Story can be shortened or made longer at will.
- Story can change and take on new meanings over time.

4.7.8. The Potential Impact of Disasters on Families

- Parental disorganization.
- Distance or conflict in marriage.
- Loss of normal routines that create stress and anxiety.
- Increased alcohol or drug use by a family member.
- Increased conflict or violent behavior between family members.
- Relocation to a new area, including school changes for children.
- Decreased physical and emotional availability of parents to children.
- Loss of children's friends and chance to participate in normal activities.
- Inability of family members to share and express feelings openly.
- Difficulty solving everyday problems.

4.8. Later Afternoon: Break Out Time for Role Play

5. Overview of Essential Components of ILCTP Disaster Mental Health Training for Lay Counselors

5.1. Day Two Training

5.1.1. Basic Principles of Communication and Assessment Following a Disaster (Adapted from WHO/UNHRC, 2015)

- Facilitate open communication, trust, and rapport with disaster survivors.
- Listen carefully; ask focused, concise, relevant questions.
- Use familiar language to the person, and if necessary work through a translator.
- Respond with sensitivity when someone discloses difficult and painful information and emotions.
- Do not judge people by their behaviors and emotions; but accept them for who and where they are.
- Explore the presenting problems and complaints with the person. What are they most needing at this time? What are they suffering from exactly? How are others in their lives (e.g., family members) influencing or being influenced by their struggles?
- Assess any residual crisis reactions the person is having (e.g., physical and emotional shock, disorientation, numbness, and exhaustion).
- Explore current stressors, coping strategies, and social and community support.
- Explore possible alcohol and drug use as efforts to cope.
- Explore possible suicidal thoughts and attempts, then assist and help the person agree to a "safety and no harm contract or plan". Help person find and cultivate relationships with people they can count on when needed.

5.2. Basic Counseling Principles

- Counseling is "helping people help themselves". It is not giving advice or trying to "fix" people.
- Human beings are made to need other people, including in response to crises, trauma, and loss. We are not built to handle everything on our own.
- Therefore, everyone needs counsel (or counseling) at times in life. This is because life involves pain and tribulation, and because we are all resilient and yet broken people.

5.3. What Counseling Involves for the Person Seeking Help

- To be listened to, heard, understood, and accepted unconditionally by the counselor or therapist.
- To be supported while you gather one's forces and gets one's bearings (i.e., re-group).
- To take a fresh look at alternatives and some new insights and learn some needed coping skills.
- To be able to express and work through painful emotions personally and relationally.
- To face one's fears and overcome them.
- To take risks, be able to make important decisions, and to have the courage to act on one's choices and accept the consequences.

5.4. Overview of Some Important Counseling Skills

- Active listening (including listening for what is not being said or expressed).
- Empathy and encouragement.
- Presence and mindfulness.
- Keen and careful observation (i.e., attending to person's verbal and non-verbal behavior).
- Paraphrasing and summarizing.
- Reflecting and drawing out painful emotions, then helping the person gradually work through them.
- Asking open-ended questions (e.g., What things are you most needing in your life right now"?) and focused questions (e.g., "What is most troubling for you right now"?).
- Providing feedback and helpful information, education, and resources.
- Building on the person's strengths and competencies and helping them galvanize their inner and outer resources.
- Using "immediacy" skills (e.g., "What's happening inside of you right now as you talk about that"? "Where do you most feel or experience those emotions in your body"?).
- Being able to sit with and listen carefully to families in trauma and pain, and help with family conflict or loss (i.e., presence and mindfulness).
- Exploring the person's Core Beliefs about themselves, family, community, the world, and God (e.g., regarding goodness, likeability, lovability, worthiness, justice, fairness, helplessness and hopelessness).
- Reflection and exploration of meaning with regard to major life experiences, including trauma and loss.

5.5. Other Methods of Helping Disaster Victims Tell Their Trauma Story and Communicate Their Pain

- Expressive therapies such as art (e.g., drawing, coloring, molding), music, dance, drama or choreography appropriate to the person's culture.
- Role playing (e.g., counselor with individual or family, or trainees with each other in groups).
- Various uses of the "empty chair" to help people deal with grief and loss (e.g., "Imagine your grandmother sitting in the chair in front of you. What would you like or need to say to her? What would she say back to you?").
- Letter writing, journaling, and the use of photographs (involving self and others).
- Imagery and visualization about what the person would like to change and how they might be successful on their journey.

5.6. Application of Small Group Trauma Intervention Strategies

- Small group case consultation is often a critical element in the application of trauma intervention practices that address the needs of individuals and families suffering from grief, loss, PTSD, and related difficulties. Small group meetings and sessions allow helpers to assist larger numbers of people. Counselors provide structure, organization, and leadership for people in small groups and a safe environment where everyone feels valued, heard, and understood.

5.7. Goals of Small Groups in Community Intervention

- Release of strong emotions after crisis and loss and feeling cared about.
- Peer group validation as a part of repairing the social fabric and educating community members.
- Group members affirming hope for the future in one another.

5.8. Morning: Break Out Time for Small Group Discussion

5.9. The Importance of Primary and Secondary Emotions in the Trauma Healing Process

Often trauma survivors initially get "stuck" at the secondary emotion level. However, people's deepest inner pain and struggle over time is typically at the primary or core level of their emotions. Lay helpers and counselors must help people have the freedom, opportunity, privacy, and safety to access, explore, and eventually express both levels of emotions in order to recover from trauma. Often people need to feel and express their secondary emotions before they can uncover, express, and work through their deeper core emotions. Secondary emotions are generally less threatening and are designed to cover up, dismiss, or minimize one's core emotions. Hence, core emotions tend to get denied, disowned, suppressed, or repressed. This is because these emotions are primal, powerful, and sometimes scary. People may believe that expressing these deep emotions in counseling will make them feel weak and vulnerable. Although there are many cultural variations in people's responses to the trauma and loss associated with natural or human made disasters, a short list of some of the more common primary and secondary emotions is listed as follows.

5.10. Common Primary (Core) Emotions

- Fear; hurt; loneliness; guilt; shame; regret; humiliation; rejection; betrayal; abandonment; loss; grief; depression; despair; emptiness; disgust or contempt (e.g., towards others or ourselves); self loathing (hate); joy; love; peace.

5.11. Common Secondary Emotions

- Anger; rage; hostility; sadness; frustration; apathy; indifference; disappointment; uncertainty; confusion; happiness.

5.12. Dealing with Grief and Loss

- Look for the grief components in the person's trauma story that need to be addressed.
- Help the sufferer cope with separation and loss, and work through the process of mourning.
- Teach disaster survivors ways to seek out helpful personal and community resources.
- Help victims understand that recovering from grief and loss will likely be a long-term process with many hills and valleys.

5.13. Issues Pertaining to Death and Dying

- Death of others raises deep questions and concerns about our own death.
- Trauma counselors need to explore their own concerns about death before working with others facing death issues.

5.14. Death-Related Anger

- Anger can be targeted at anyone, even family members, friends, and helpers.
- Anger can be a mechanism of coping.
- Anger can be a way to delay the pain of grieving.

5.15. Guilt and Shame as a Part of the Grieving Process

- Guilt about life-style changes following a disaster.
- Guilt concerning negative thoughts or feelings about the person or persons who died.
- Survivor guilt ("why me?").
- Survivor shame (e.g., "there must be something bad or flawed about me that I would experience this").
- Guilt over relief from suffering when others are still suffering.
- Circumstances after someone dies imposed by society (e.g., social stigma).
- No time to say good-bye to friends and loved ones.
- Grief may be minimized or denied.
- Everyone grieves differently.
- Sadness, anxiety, and despair are common responses to trauma and loss.
- Yearning and preoccupation with loss.
- Intrusive memories, images and thoughts of the deceased.
- Loss of appetite.
- Loss of energy.
- Sleep problems.
- Concentration problems.
- Social isolation and withdrawal.
- Medically unexplained physical complaints (e.g. palpitations, headaches, generalized aches and pains).
- Culturally specific grief reactions (e.g., public expressions of mourning; hearing the voice of the deceased person or being visited by the deceased person in dreams).

5.16. Spiritual Questions That May Arise Post-Disaster (Adopted from Smith, 2013; Yancey, 2015)

- Why me or us? Is this an act of God's will?
- Why would God hurt or take little children?
- Why doesn't God answer my prayers?
- Will God forgive me for what I feel (e.g., my anger)?
- Is there life after death?
- What did I/we do to deserve this?
- Why do bad things happen to good people?

5.17. Spiritual Ways of Coping with Disaster

- Prayer and seeking God's (or other's) help and presence.
- Seeking guidance from spiritual leaders.
- Helping others.
- Blaming God or spirits.
- Religious avoidance/distraction.

5.18. Spiritual Do's and Don'ts for Lay Counselors after Disaster

- Don't try to give answers to spiritual questions.
- Don't impose any spiritual answers on survivors.
- Do help them focus on thoughts of an afterlife and an eternal presence if that is part of that person's or community's belief system.
- Do affirm their right to ask questions about God's "judgment".
- Do allow them to modify spiritual beliefs.
- Do allow them to decide about the issue of forgiveness.
- Do affirm the wrongness or injustice of what has happened.
- Do give them materials that may help them in their search for meaning.
- Do emphasize that everyone must find their own way of understanding the disaster or catastrophe.

5.19. Stress Reactions of Caregivers, Helpers and Counselors

- Burnout: Burnout can occur because of social or professional isolation; emotional and physical drain of providing continuing empathy and care; erosion of idealism; lack of expected rewards; and vicarious victimization and traumatization.
- Compassion Fatigue: Counselors can experience the survivor's traumatic event through listening to the story of the event; experiencing reactions to the trauma through empathic contact with victims; cumulative exposure and re-exposure to traumatic stories of victims; inability of helpers to distance themselves from the stories they hear; and emotional exhaustion.
- Counselor s need to engage in high level "self care" during and after the process of helping traumatized individuals and families.

5.20. Other Specific Steps toward Trauma Recovery (Sources: Briere & Scott, 2014; Rothschild, 2010)

- Moving from "victim thinking" to a survivor mentality. This involves gradually shifting one's self-concept from that of a victim to a survivor.
- Being aware of "secondary wounding". This involves dealing with others who disbelieve, deny, discount, minimize, or stigmatize the victim of the trauma, and sometimes even blame the victim and refuse to provide help or support (e.g., family members, friends, others in the community, etc.).
- Regaining a sense of control again in one's life – both internally and externally. This may involve acquiring new boundaries (physical, relational, and emotional) with others and learning to make healthy choices.
- Restoring self-esteem (thinking and feeling good about oneself again).
- Rebuilding intimacy (closeness) with oneself and others.

5.21. Later Afternoon: Break Out Time for Role Play

6. Lay Counselor Training as a Part of Disaster Mental Health Care in a Developing Country: The Example of Nepal

Nepal is ranked high among developing countries that are vulnerable to natural disasters (United Nations Development Programme/Nepal, 2008). Nepal has eight of the ten highest mountains in the world and includes a terrain that is rugged and fragile, and climatic conditions that are often extreme. It is susceptible to earthquakes because of continental tectonic plates that are pressing against each other. Avalanches occur in the high Himalayas, often putting entire villages at risk. Nepal also has some of the most severe flood hazard zones in the world. Monsoon rains, along with runoff from the melting snows in the high Himalayan mountains and from glacier lake outbursts, contribute to rivers flooding and landslides on the steep slopes where people live. During the dry season fires are common, and also during monsoon season due to an unequally distributed or irregular monsoon rainfall. Floods, fires in the mountains and the terai (flat) region, and drought occur annually in various parts of the country, as do windstorms, hailstorms, and thunderbolts. These disasters frequently result in loss of life, damage to crops, and destruction to property (Disaster Preparedness Network Nepal, 2018).

Nepal is in the top 20 of the world's poorest countries (International Monetary Fund World Economic Outlook, 2015) as indicated by the GDP (gross domestic product) of U.S. $2,480.80 along with a low literacy rate and low employment. A dense and increasing population, coupled with a certain degree of urbanization, an ever present unstable political situation, unplanned settlements, and sub-standard housing, make the Nepali people particularly at risk for host of natural and human caused calamities. Diseases that include cholera, gastro-enteritis, encephalitis, meningitis, typhoid, jaundice, and malaria occur especially during the summer rainy season. Until recently, Nepal has lacked favorable government policies that would assist disaster victims and enact a coordinated effort of disaster management among various government agencies and non-government organization (NGO's). The remote, rural nature of the country and lack of education in some areas present major challenges to disaster management in Nepal. As a developing country Nepal lacks the resources needed to provide adequate assistance to the natural disaster victims. Reconstruction and rehabilitation programs following a natural disaster tend to

suffer because of such resource constraints. However, despite these limitations, in recent years Nepal has been making great progress in the area of disaster management and assistance, including to some limited extent post disaster mental health. However, since Nepal is a poor country, it often needs assistance and support from international NGO's in the aftermath of disaster.

6.1. United Mission to Nepal's Disaster Response Program

In late April of 2015 a 7.8 magnitude earthquake hit Central Nepal. Within 42 seconds countless homes and buildings were demolished and thousands of people died. Over 9,000 people were killed and another 25,000 injured, with over one half million people becoming homeless (USAID, 2015). Following the first major earthquake there was no electricity, gasoline, or cooking and heating fuel in much of the affected areas throughout the country, nor were there needed supplies available, including in the capital of Kathmandu. A second devastating earthquake struck in May 2015. Political tensions and disagreements between Nepal and India complicated the situation, with both Indians and some angry Nepalese blocking all major roads and entry points into Nepal for a number of months. Food, medicines, and supplies were not able to enter the country, resulting in more deaths and suffering among the Nepali people. In response to these immense problems a number of existing organizations working in Nepal and some from the outside became involved with various aspects of disaster relief. The United Mission to Nepal (UMN) was one such organization.

The Disaster Response Programme (DRP) of UMN provides an excellent example of what can be done and is currently being done in response to natural disasters in Nepal. In recent years the UMN has been preparing the Nepali people throughout the country for the possibility of impending disasters, as well as responding in an effective way after a disaster strikes. As the oldest international community development organization in Nepal, UMN strives to serve the people of Nepal by addressing root causes of poverty so that people can thrive in all areas of life. In cooperation with the Government of Nepal, UMN has been working in many areas of development (e.g., health, education, housing, economic development, agriculture, hydro-electric power, technology, etc.) since the 1950's. In regards to disaster management, UMN provides funds as well as in-kind and technical assistance for the rescue and relief operation of the disaster victims. As part of pre-disaster training and education, UMN engages multicultural teams of Nepali and volunteer expatriate staff who work in partnership alongside local people and organizations in some of the most remote districts of the country. In recent years, partly in response to the 2015 earthquakes, UMN has initiated disaster relief projects that involve helping people rebuild their lives and communities (physically and socially), for example, in hard hit districts such as Dhading and Gorka, the epicenter of the first 2015 earthquake. Other DRP related activities can be seen, for example, in districts such as Rupandehi and Rukum. The ultimate goal of these projects is to benefit communities by increasing knowledge about and resilience in response to disasters and changing climatic conditions. Various risk reduction measures include education and prevention through the mobilization of local people's skills.

Within the first year following the 2015 earthquakes in Nepal and since then the UMN has had disaster relief staff and volunteers working in a number of different parts of the country (Mission Box, 2016; United Mission to Nepal, 2018). The ultimate goal of these projects is to help people in various districts to recover from the results of the earthquakes so that their way of life is restored and their preparation for future disasters is increased. Workers also help traumatized adults process their trauma in constructive ways that will benefit both them and their local communities. Moreover, the psychological and emotional needs of children and adolescents are addressed within a family and community context (United Mission to Nepal, 2018).

6.2. Lay Counselor Training as a Part of Disaster Mental Health Care Enacted In 2015 and 2017by the ILCTP Team

Another example of international organization involvement in disaster relief and community development in Nepal after the 2015 earthquakes has been the training of lay counselors in three districts (Dhading, Kaski, and Kathmandu) through the International Lay Counselor Training Program (ILCTP; Carson 2017; Carson et al., 2011). This work is supported in part by Partners International (PI) headquartered in Spokane, Washington, USA. PI has been supporting and cooperating with various indigenous organizations in Nepal for a number of years, including the National Churches Fellowship of Nepal (NCFN). Since the 2015 earthquakes PI has provided NCFN and other affiliated groups with both financial and human capital to help citizens to physically rebuild their communities, as well as their individual, family, and social lives (Partners International, 2015). Part of this involvement has been an attempt to address the family and mental health needs of post-disaster earthquake victims. Team members associated with the ILCTP were deployed within months of the 2015 April and May earthquakes in an effort to train lay community leaders and citizens in post-disaster trauma counseling in three different districts. The ILCTP Team trained local pastors and lay leaders both in and outside the church in hard hit areas to provide disaster mental health care and counseling to community citizens. Especially targeted for grief counseling, mental health counseling, and family counseling by lay counselors after the training were community members who had lost family members and friends in the earthquakes, as well as people who were showing signs of Post Traumatic Stress Disorder (PTSD) and other trauma-related symptoms. Meetings where post-disaster trauma and grief issues and interventions were discussed were also held between ILCTP team members and medical college students and faculty in Kathmandu and Pokhara with regard to their role in post-disaster care in various areas of Nepal. Lay counselor training was conducted once again in 2017 in Kaski District in west central Nepal and Sankhuwasabha District in far eastern Nepal. Lay counselors have consistently reported that the

knowledge and skills they obtained from the training have been useful to them and highly effective in helping others experiencing great pain and loss -- both in general as well as in response to the 2015 earthquakes. These kinds of activities provide evidence that lay counselor training not only works, but that trainees are able to maintain trauma-focused counseling knowledge and skills in helping others over time.

7. Conclusion

Lay counselor training in developing countries is but one way to help meet the needs of disaster survivors. This article provided an example of a two-day program in Disaster Mental Health (DMH) training program in lay counseling that can be implemented in highly disaster-prone areas of the world (i.e., pre-disaster), as well as within weeks or months following a natural or human caused disaster in resource limited areas of the world. Host country governments and government agencies must work together with both domestic and international NGO's to create opportunities for Disaster Mental Health training and care in the aftermath of disasters. Trained lay counselors from within or near the disaster affected area(s), as well as others within the country, not only know the culture and often the language of those impacted but are also likely to have already known relationships with people inside those communities; hence, a normal rite of passage into the community. Carefully planned lay counselor training in DMH often requires shared expertise among professionals (domestic and foreign) and lay leaders in disaster areas. Effectively trained lay counselors can make potentially long-term differences in the lives of children, adults, families, and communities through improving people's mental and family health. In addition, lay persons in or near disaster impacted areas can help create greater public awareness of mental health symptoms and issues, as well as the components of positive mental health and trauma healing, both before and after a disaster strikes. Addressing these issues can, in turn, have a long-lasting impact on the social, economic, and infrastructure development in disaster affected communities. Lay counselors are most helpful to survivors if they are acutely culturally aware and sensitive, and if they understand what the mental, emotional, and relational needs of disaster victims are in the shorter and longer phases of disaster recovery. Counselors do this best by asking relevant questions, mastering the art of listening to people's trauma stories, showing empathy in response to their emotional pain, and learning from disaster survivors themselves throughout the helping process.

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