

Coping with Crisis

Reference Centre for Psychosocial Support

Window of opportunity for promoting psychosocial preparedness

By Janet Rodenburg, head of the IFRC Reference Centre for Psychosocial Support

The massively destructive tsunami that struck across the Indian Rim caused extensive loss of life and injury, as well as devastation to property and community resources. The combination of life-threatening personal experiences, loss of loved ones and property, pervasive post-disaster adversities, and enormous economic impact on families and entire nations pose an extreme psychological challenge to the recovery of people in the affected areas.

While we will never be able to prevent calamities like these, the tsunami clearly underlined the need of including psychosocial aspects of health in national disaster plans and in the *disaster preparedness* of Red Cross and Red Crescent Societies. In other words, there should be a 'culture of preparedness' where National Societies have established a basic capacity to prepare and mitigate against locally prevailing hazards. The rehabilitation process after the immediate relief operations is the ideal entry point for preparing and planning how to reduce impacts of the next disaster, as there are painful but valuable lessons learned. Preparing a sufficient capacity to respond includes (proactive) training of personnel in dealing with the psychosocial aspects of health, as well as adequate and timely staff support. An example of such training is

given in the article on Community-based First Aid Training, held in Myanmar in November 2004.

An example of providing direct support to beneficiaries comes from the British Red Cross, which quickly gathered a team to be sent to Thailand to attend to the psychological needs of British tourists who had survived the tsunami. The article on Grenada demonstrates the importance of volunteer involvement and support in the early hours. It clearly shows that the relief work of the Red Cross stands or falls with the perseverance of local volunteers.

For the first time in IFRC history, psychosocial delegates were added to the FACT (Field Assessment and Coordination Team) mission, last autumn in Grenada following hurricane Ivan and recently as part of the tsunami response in Sri Lanka and Indonesia. As the article on Sri Lanka describes, it is a challenge to include psychosocial assessment in emergencies that require a rapid overview of the situation, close coordination with dozens of actors, quick decision-making and timely deployment. It is hoped that the article will trigger some discussion on integrating psychosocial expertise in FACT assessments in the future, either by including a psychosocial delegate in the team, or by sensitising the individual members to psychosocial issues as part of their overall operations. ■

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Danish Red Cross 

Psychosocial support in the context of emergency response in Sri Lanka

By Margriet Blaauw, Psychosocial officer, IFRC Reference Centre for Psychosocial Support

The massive tidal waves that swept into coastal villages and seaside resorts in Sri Lanka killed thousands of people in Sri Lanka; houses were destroyed, and many people were left homeless and live in temporary shelters. All along the south and east coast people have started to return to where their houses once stood. Most houses have been reduced to rubble. Some people have begun clearing the area, some look for possessions; others just sit and stare. How to start rebuilding when so much has been lost?



How to start rebuilding when so much has been lost?
Photo: Till Mayer, International Federation

A Federation's Field Assessment and Coordination Team (FACT) was deployed to Sri Lanka, including a psychosocial delegate to gather detailed information to serve as a basis for a Plan of Action. More and more it is recognised that humanitarian assistance to people affected by disasters should not be limited to medical care, water and sanitation, shelter, and the provision of food and non-food items, but that psychosocial support should be included. Yet, the participation of a psychosocial delegate in the Field Assessment and Coordination Team did raise some eyebrows at first. Right after the tsunami hit Sri Lanka some critical voices wondered if psychosocial support should play a role in the emergency response.

This article describes possible areas for psychosocial support in the context of the

situation in Sri Lanka right after the onset of the disaster. The list is not exhaustive. Where relevant, the article will refer to and quote from the 'Humanitarian Charter and Minimum Standards in Disaster Response', 'The Sphere Project' (*1). The Sphere Project was launched in 1997 to develop a set of universal minimum standards in core areas of humanitarian assistance. In 2004 standards for mental and social aspects of health in disaster response were included.

Psychosocial support

The term "psychosocial", as defined within the International Federation of the Red Cross and Red Crescent Societies in the context of emergency response, signifies a process aimed at facilitating the resilience of beneficiaries while maintaining the health, well-being, and effectiveness of workers.

The goal of psychosocial support to people and communities that are forced to live with the consequences of disasters is to strengthen or restore social structures of care and coping within the community, and to enhance social stability through social activities, education and recreation.

Psychological First Aid

The Sri Lankan population has shown great solidarity with the affected people. There were many initiatives to provide food and clothing. However, the need for human support was sometimes overwhelming. Some volunteers of the Sri Lanka Red Cross Society (SLRCS) wondered if they were doing the right thing, and if they were doing enough. In order to provide the volunteers with some basic tools, training on Psychological First Aid will be organized within the near future.

Information

The affected population has a need for clear and relevant information on the disaster and on the relief efforts (*2). It will be easier to picture the situation and to regain control when you have a description of what happened.

"Psychological First Aid: whether among the general population or among aid workers, acute distress following exposure to traumatic stressors is best managed following the principles of psychological first aid. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing to talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This type of first aid can be taught quickly to both volunteers and professionals."

The SPHERE Project. Humanitarian Charter and Minimum Standards in Disaster Response. Standards on Mental and Social aspects of Health. Control of non-communicable diseases standard 3: mental and social aspects of health., p. 293.

The number of people in the shelters changed every day. People that wanted to return to their former homes moved to shelters closer by the sea. Some people camped near the remains of their homes. However, there were many rumours about new tsunamis. After each rumour people moved away from the coast again. The manager of a tent camp in Batticaloa told that around 200 of the 800 people in 'his' camp moved back and forth almost on a daily base. This indicates that there is a need for factual information about the disaster: What has caused the tsunami? Will there be another one?

"Access to information is not only a human right but it also reduces unnecessary public anxiety and distress. Information should be provided on the nature and scale of the disaster and on efforts to establish physical safety for the population. Moreover, the population should be informed on the specific types of relief activities being undertaken by the government, local authorities and aid organisations, and their location. Information should be disseminated according to principles of risk communication i.e. it should be uncomplicated (understandable to local 12-year-olds) and empathic (showing understanding of the situation of the disaster survivor)."

The SPHERE Project, Geneva 2004, p. 292.

There is also a need to raise awareness on normal reactions to abnormal events. Although most complaints expressed by the affected population can be considered as 'normal reactions to an abnormal events', they are **not** normal to them. The fear, the sleeping problems, headaches, and the intrusive thoughts cause considerable concerns. Some people were convinced that their complaints were caused because the seawater they had swallowed when they ran away from the waves had poisoned them. Awareness-raising should take place amongst the affected population, volunteers and professionals working with the affected population.



Many displaced people stayed in shelters with very little to do to pass the time.

Photo: Till Mayer, International Federation

There is a need to know the fate of missing relatives. The ICRC tracing teams provide essential support to all who are searching for relatives, and to all who would like to let friends and relatives know that they are fine. Unfortunately there are still many people missing. As long as the missing person is not found there is no closure. People keep on searching; giving up the search might feel like giving up the person. Not knowing what has happened to a loved-one and not being able to provide a proper farewell ceremony, during which the life and achievements of the missing person is remembered is extremely difficult. There is a risk for complicated bereavement.

Last but not least there is also a need for very practical information. One of the main uncertainties for many of the fishermen families is to know where they can rebuild their houses. The authorities are preparing new rules on how close to the sea people are allowed to build. Due to the lack of information many rumours are spread, describing building restrictions within 300 metres to even 1000 meters from the sea. These rumours caused a lot of unrest. Will the fishermen be able to live close to the sea? Will tourist resorts take all the good spots?

Activities

Many displaced people stay in temporary shelters. In the shelters there is very little to do.

Involving the displaced people in daily activities, as cooking, cleaning the shelters, providing security all gives a sense of being at least somewhat in control.

"As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities. Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities."

The Sphere Project, Geneva 2004, p. 291

Organising games for children can help bringing some normality in their lives. One option is a Child-to-Child programme(*3). In the Child-to-Child concept children are partners in the support to other children. In the current situation older children/adolescents could do play activities with younger children. Red Cross volunteers could coordinate these activities. With relatively low costs a large group of children can be reached.

Support to helpers

Red Cross staff and volunteers have been working tirelessly. They have been involved in recovering the dead, providing first aid and collecting data on dead, missing and displaced people. They all seem very supportive of each other and volunteers meet daily with a supervisor to discuss the problems they encountered. Still, they are exposed to unusual demands and very stressful situations. Information on signs of stress and guidelines of coping with stress, stress



Children are a particularly vulnerable group. Facilitating playful activities can help bring back a sense of normality in their lives.

Photo: Till Mayer, International Federation

prevention and stress management could be very useful for staff, volunteers and other relief workers. Clear guidelines for the supervision of volunteers could help prevent future problems. Peer group support can act as a formal framework within which problems and feelings can be discussed without threat.(*4)

Conclusion

The need to involve a psychosocial support component in the emergency response after a disaster like the Tsunami seems to be apparent, also to those who were not convinced right after the disaster struck. Psychosocial support can play a role in bridging the gap between the emergency and rehabilitation phase. It is important to stress that a psychosocial support component should be included in emergency preparedness programmes. Awareness-raising among policy makers might be a challenge in the years to come.■



Staff and volunteers worked tirelessly helping the victims after the tsunami. It is important that they get support as well.

Photo: Till Mayer, International Federation

*1) The SPHERE Project. Humanitarian Charter and Minimum Standards in Disaster Response. Standards on Mental and Social aspects of Health. Control of non-communicable diseases standard 3: mental and social aspects of health, Geneva 2004

*2) Ibid. p. 291

*3) For more information please refer to the Child-to-Child website: <http://www.child-to-child.org/>

*4) Community-based psychological support. A training manual. International Federation of Red Cross and Red Crescent Societies. January 2003

The British Red Cross response for UK survivors of the tsunami

By Stephen Regel, Arlene Healey and Marilyn Hahn

On the 26th of December 2004, an earthquake on the Indian Ocean floor measuring 9.0 on the Richter scale triggered a tsunami, which struck a number of countries in South East Asia and parts of Africa. The tsunami struck with a magnitude and ferocity not seen in centuries and the current death toll in the region could surpass 300,000. The epicentre was close to the northern tip of the Indonesian island of Sumatra where the estimated number of deceased is 125, 000 and the number of displaced in the region is over 500,000.

The British Red Cross response was significant in many ways, both at a national level, for example in fundraising, the establishment of a tsunami helpline for victims and families, the collection and dispersal of specific aid for affected regions, to name but a few. However, on this occasion, the British Red Cross also provided an international response through a unique collaboration with the UK Foreign and Commonwealth Office by assembling a small professional specialist psycho-social support team - the British Red Cross Tsunami Support Team (BRCTST), which travelled to Thailand within the first week following the tsunami to address the needs of British citizens affected by the tsunami in Thailand, which is a popular destination for many Europeans in the winter months. The terms of reference were broad, but essentially, it was to provide support for British citizens in a variety of contexts. The team consisted of health and mental health professionals seconded by the National Health Service (NHS), a professional Emergency Planning officer and British Red Cross personnel with specific expertise i.e. tracing. At the time of writing British casualties number 61 confirmed dead and 191 still missing. In addition, scores of others suffered minor injuries or witnessed death and destruction on an unprecedented scale.

Collaborating with British embassies

The BRCTST was based in the British Embassies in Bangkok and Phuket and worked closely with embassy staff. The Phuket office, previously a small consulate presence, was expanded considerably to address the needs of British citizens (including many expatriates in the region) and support many who travelled to Thailand seeking to find missing family members or to identify the deceased. The BRCTST arrived in Thailand in two phases, a few days apart. Two members were based in the Phuket embassy and carried out a range of diverse activities, which included, amongst other activities, direct support to victims and those in hospital, co-ordination and management of many who wanted to volunteer their help and services, support for embassy staff in their duties, such as briefing, de-briefing and support for those assisting relatives in identification and tracing missing family members and press liaison.



Photo: REUTERS/Bazuki Muhammad, courtesy www.alertnet.org

Whilst many UK nationals, including those with minor injuries, returned home after the tsunami, many others were admitted to hospitals in Bangkok after receiving treatment locally in smaller hospitals in the Phuket and Krabbi provinces in southern Thailand. Members of the BRCTST based in Bangkok worked in partnership with the Embassy Hospital Team providing consultation, support and advice as well as working directly with the survivors and their fami-

lies. Other requests for the BRCTST help were directed through them or the recently established Embassy Tsunami Response Team. When the BRCTST arrived, there were 40 British citizens (also accompanied by relatives and friends) in four hospitals across Bangkok. The BRCTST in Bangkok worked with almost all those in hospital along with their relatives and friends. These included individuals, nuclear and extended families, almost all suffering multiple injuries, many which were serious and required



*Survivors gradually started to face the reality that those who were missing would not be found alive
Photo: REUTERS/Luis Enrique Ascui, courtesy
www.alertnet.org*

extensive surgery. In addition, a number had family members missing.

Physical injuries and traumatic experiences

The injuries were very similar to those seen after motor vehicle accidents, e.g. complex fractures, crush injuries and severe lacerations. Many of these survivors had spent time in intensive care and had undergone several operations and skin grafts. A number had serious infections resulting from the poor hygiene and unsanitary conditions in the early stages of the treatment, as the rudimentary health services in outlying areas were overwhelmed. Many survivors experienced multiple traumas. They had experienced the tsunami and resulting injury, witnessed the death of friends and relatives, and been exposed to sights of death and severe injury.

Without exception all experienced varying degrees of subjective life threat, together with a fear that relatives and friends were going to die or had died. Survivors were

separated for various periods of time, for example one family was separated for eight hours. The male survivor believed that his wife and children were dead and the female believed her husband was dead. This type of experience was common amongst this group. Studies have shown that this type of experience can be a factor in the development of PTSD and other psychological responses to traumatic events. Often hospital treatment was also very traumatic in nature. Treatment involved long, complex and painful procedures. Some had to have dressings changed daily under general anaesthetic. Others knew that further surgery would be required due to further infection. Once stable enough, they also needed intensive physiotherapy. Many expected this to continue once they returned home and knew they have a long path to physical recovery ahead.

Guilt and fear

Many of the survivors were initially in a state of shock for the first week to ten days following exposure to the trauma. In time, this eased and as the numbing effect of this initial period diminished, they began to process the whole experience. Symptoms such as intrusive images, nightmares, low mood, irritability, poor sleep and appetite, were reported by many.



*Ban Nam Khem village, North of Kao Lac.
Photo: Stephen Regel*

Many reported 'survivor' guilt. This was particularly acute as often the people who had assisted them later perished in the second tsunami created by the earthquake. For some, this survivor guilt provoked feelings that they did not warrant any sympathy or

help and that they were merely taking help and services away from others. As a result they found it difficult to be in receipt of the great deal of attention they were receiving.

Some people detailed how specific images and objects were acting as psychological triggers for them. For example, survivors who spent quite a while in the water reported that there were many household items such as refrigerators and furniture floating in the water amongst the general debris. Therefore, opening a fridge would cause a wave of panic and distress. Others reported difficulty with showering and washing, describing how water on their face would often trigger a high level of autonomic arousal. Psycho-educational principles were utilised to enable survivors to make sense of both the emotional and physical reactions that they were experiencing. A variety of brief structured psychological interventions were also utilised and proved helpful.

Coming to terms with loss

In addition to extensive physical injuries, many were also dealing with the loss of family members, partners or friends. All the survivors seen were gradually beginning to face the reality that those who were missing were not going to be found. Initially they still held onto some hope but as time progressed this changed. For the initial period, discussions were centred on those who were missing. As time progressed, there was a gradual realisation and acceptance that loved ones had died.

There was also an increasing reality that body recovery and identification was going to be a long drawn out process, which may take many months. Many also face difficult decisions ahead. Those who have lost several family members now realise that whilst their bodies may be found and identified, there may be months between each recovery. Survivors are beginning to wonder how to respond. Should they have a funeral as each person is recovered? Or should they



*A British tourist talks on the phone as she waits at Phuket city hall, after surviving the tsunami.
Photo: REUTERS/Luis Enrique Ascui, courtesy www.alertnet.org*

wait until all family members are recovered, with the acceptance that some bodies might never be recovered?

This short piece describes some of the context from the perspective of work done by the British Red Cross Support Team in Thailand. In many instances, the work was specifically addressing the needs of those British citizens most affected, but also the wider needs of different communities affected, either directly or indirectly by the tsunami. Many of the reactions were those that could be seen as typical in mass casualty disasters. However, the experiences of the BRCTST relate to dealing with trauma and loss in a western European context. The tsunami affected

many thousands of individuals, families and communities in South Asia and Africa, for many of whom the prime concern is shelter, clean water, food and the loss of livelihood. Of course this will in many cases have been compounded by all the factors described above, but without many of the sophisticated support systems offered in the West. The challenge for many Red Cross and Red Crescent national societies is not only how to deal with the physical needs of those affected, but with culturally appropriate interventions for psychosocial recovery, bearing in mind the natural resilience of many non-western communities. ■

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When the volunteer is also affected by disaster

Experiences from the hurricane Ivan disaster in Grenada September 2004.

By Anne-Sophie Dybdal, clinical psychologist*

I am so tired. Yesterday I fell asleep on a bag of rice in the warehouse. I have no roof on my house, so I really have nowhere to live, but I will keep working as a volunteer. It makes me feel that I am doing something. It keeps me going.

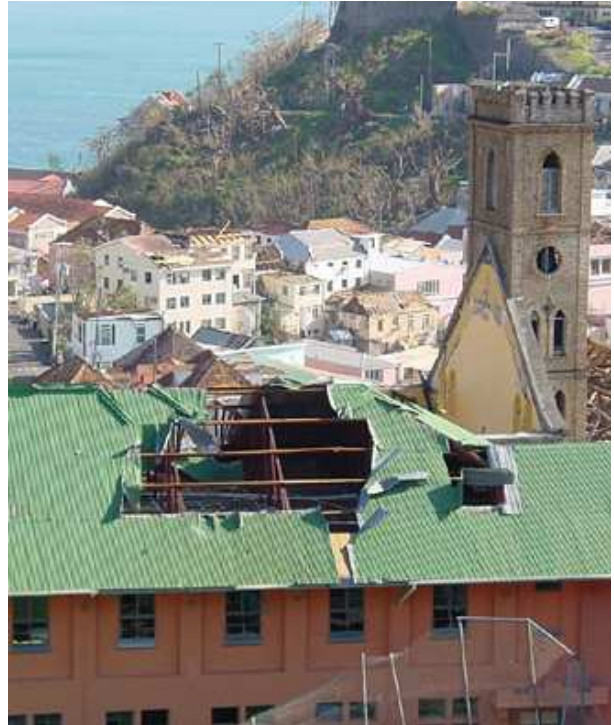
These are the words of Maryann, a long-term volunteer with the Grenada Red Cross (GRC). The feelings expressed by her, were common among the group of volunteers during the first weeks of the relief operation. This suggests that the work was not only helpful to the beneficiaries, but to the volunteers themselves.

When a natural disaster strikes a whole society, as it did in Grenada, social structures and coping mechanisms of the society become visible, for better or for worse. Some reactions, like lootings and cases of rape may come as an unpleasant surprise. In Grenada, reactions of individuals and communities also brought profound values as kindness, cooperation and generosity to the surface.

However, the sense of common solidarity also added to the chaos, as no area was left unaffected.

Many experts have stressed that the Grenadian population in general is quite resilient and has very efficient coping strategies. Christian faith plays a large role. Most people will seek the comfort and solidarity of their church and congregation, and there seems to be a deep-rooted culture of helping each other.

I observed several incidents in the distribution queue where people would desist from receiving food or tarpaulin and offer it to someone who was needier. Most distributions were very orderly, and not much aggression was observed, especially when compared to the situation in other disaster-affected countries. People would help each other with reconstruction of houses. A positive and laid-back attitude was observed, and I was told by many Grenadians that a sense of humour and the ability to maintain a positive attitude is valued in the Grenadian society.



*When Hurricane Ivan swept through Grenada with its gushing winds - nothing spared in its wake. Ninety per cent of buildings on the island have suffered structural damages, electricity has been completely cut off, and water supply was totally severed during the first days following the disaster.
Photo: British Red Cross*

Moodiness or negativity is frowned upon. The volunteers who were recruited for the distribution tasks were all part of the social structures and traditions of their culture and society. They themselves were affected by the disaster in some way or another. Many volunteers in Grenada expressed that helping others and participating was meaningful, and helped them avoid feeling overwhelmed and victimized by the disaster.

Why does it help to be involved?

Getting involved is generally known to be an efficient coping mechanism to deal with the acute stress of having your life turned up-side down by a natural disaster. GRC volunteers gave a wide range of reasons why they were involved, and most important were the sense of meaning and usefulness that it gave them.

"Nothing compares the feeling that today you have fed 500 families" - as one said.

Working as a volunteer seems to attract people who normally have a "doing something" response to stress, a type of personality that probably finds profound satisfaction in being able to contribute in a way that fits his/her strategy of stress reduction and adaptation. Volunteers in Grenada were typically people who were active and committed in their communities and inclined to start acting in times of chaos or disruption.

Like Leroy: "I never just sit back and watch bad things happen, I get up and do something about it".

Feeling part of the group was very important to the volunteers in Grenada, team spirit was appreciated, and it seems that for many of the volunteers the group also served as a secure base in a world that was chaotic.

Getting out of the home (or what was left of it) was also mentioned by several volunteers as helpful.

"When I sit under the tarpaulins at home I get worried about the future, and I argue with my mother".



Many volunteers feel that helping others and participating in the relief work is meaningful and helps them to avoid feeling overwhelmed and victimized by the disaster.

Photo: Solveig Olafsdottir/International Federation

This corresponds very well with findings from other disasters, where survivors complain that constant exposure to the sight of devastated homes, fields etc. triggers flashbacks and worries about the future, leaving no pauses or breaks. The routines of getting up and doing something every day also seemed to be very important. It is widely acknowledged that structure and a foreseeable everyday routine reduce stress. Feeling appreciated was important and sat-

isfying and a basic motivation for the volunteers:

"Ivan took my dignity, now I feel dignified when I see the gratitude in people's eyes".

Restoring the sense of accomplishment and human value, being able to have influence on your own life, is also believed to reduce stress. It brings back a feeling of not being a passive victim, but an active player in one's own life. Finally, many felt that they were doing their duties as good Christians.

What are the difficulties?

Red Cross volunteers are normally dedicated, hardworking people with a strong sense of community and motivation to do well. The flip side of the coin is the risk of burn-out and fatigue. Working in a disaster, people tend to lose the sense of how tired or stressed they may feel. Sources of accumulated stress for the volunteer are as many as there are profound satisfactions from the work.

It can be an advantage for the distribution of food and relief items that the volunteer knows the community, but it can be very complicated as well, especially in a small country where many people know each other. Volunteers in GRC felt that the most stressful aspects of their work were dealing with anger, aggression, begging or other pressures from the population. Not being able to talk about it to someone was seen as quite frustrating and lonely. When the volunteers felt that distributions were unfair or insufficient, this was quite stressful. They, as a whole, identified with the beneficiaries. Witnessing unfair, inefficient or disrespectful behaviour from other aid workers towards the population was, for some, difficult and quite provoking. They felt disturbed if policies did not reflect their own personal values and priorities.

It was seen as very nerve-racking, when some people were not showing up, and thus leaving more work for the others. Being part of a group and the sense of belonging to the "Red Cross Family" was a major incentive to volunteer and tensions that threatened the harmony of the group were quite disturbing.

Personal problems were also a concern. As the volunteers were part of the affected population; they too had worries about future accommodation and income. Some were hoping to get some free time from domestic problems while working, but could

not help thinking about their troubles much of the time anyway. Sleeping disorders were common. One volunteer said he worked hard physically so that he could sleep at night, although it was not always a successful strategy!

Any lack of appreciation from the 'Movement' or the beneficiaries was hurtful for volunteers, especially if beneficiaries were expecting benefits for themselves or their families.

How do we support the volunteers?

Structure and creating a foreseeable schedule, was the one most important strategy of support to the volunteers who worked so hard to assist during the first chaotic weeks after the hurricane Ivan struck Grenada. As a stressed person may not be very good at judging his or her own fatigue, rotation-schedules were made and duties were assigned to each person, so they could foresee what they were supposed to do that day.

Breaks and proper meals with enough to drink seem a banal procedure, but are very important to structure, as people may forget in the heat of work. This is also a way to show appreciation and caring.

Days should start with a morning session, with general information on how the work is going and the immediate plans. This is also a chance to positive feedback, and pick up on suggestions and experiences from the volunteers. In Grenada it was recommended to close every day with a "what went good, what was difficult" 10-minutes-round for all the teams. Games and fun were recommended for the sessions to promote motivation and team spirit.

Appreciation should also be shown by compensating any transportation costs for volunteers. Insecurity about benefits and salaries can spark confusion. It is important to have clear policies and make sure that the

expectations from the volunteers are clear and realistic.

Providing individual or group de-briefing for all volunteers is not always possible, but basic information about stress reactions and adaptation processes to volunteers should be prioritized.

Conclusion

When volunteers are recruited from the affected population, there are evident advantages. Volunteers will be well acquainted with the culture and traditions. Helping others helps the volunteers cope with their own stress, because it makes them feel useful, provides structure and involves them as active rather than passive victims. On the other hand, volunteers who are themselves affected are dealing with their own concerns and stress. They may over-identify with beneficiaries and this can lead to added distress. Information about normal stress reactions and adaptation should be given, as well as conflict and anger management. Volunteers should be given a chance to express feelings, thoughts and ideas in a structured setting.

Acknowledgement is vital to volunteers. It is not always easy to get appreciation in the field, so responsible leadership should find ways to ensure it.

In Grenada, as in other natural disasters, the population as a whole showed the ability and will to cope with the chaos of the situation after the hurricane Ivan. A strong sense of solidarity, mutual help in rebuilding and a positive attitude in a tightly-knit society will probably be important for the long-term recovery and adaptation of the Grenadian population. ■

** The author participated in the FACT mission 16 September - 4 October 2004*

Hurricane Ivan, the most powerful hurricane to hit the Caribbean in ten years, moved through the region for more than a week, damaging homes, buildings and infrastructure, and causing many deaths. The storm originated in the south eastern Caribbean where it gradually gathered in strength before moving towards populated land.

Ivan hit Grenada on Tuesday evening with winds of 220 kilometres per hour. Several hundred people from low-lying areas of Saint George's, the Grenadian capital, were evacuated in anticipation of potential flooding. At least 39 people died and approximately 90 percent of the country's homes sustained damage. Water, electricity and telephone services were all cut off. Approximately 60,000 people are in need of assistance and there are approximately 5 thousand people accommodated in 145 official and ad hoc shelters. The hurricane caused structural damage to nearly every major building in the Grenadian capital of Saint George's, including the Grenada Red Cross Society headquarters.

IFRC Operations Update, Caribbean Hurricane, 29 September 2004

Tackling the psychosocial impact of hurricane Ivan

By Samora Bain, Coordinator, Disaster Mental Health Unit, Jamaica Red Cross.

On Thursday, December 2, 2004, Marcia* had come to her wits end. She lived with her husband and six children aged seven to 13 years in a small, two-bedroom hut illegally erected in a poor, fishing village in Jamaica. Her life changed significantly after the devastating effects of hurricane Ivan in September 2004, and the new hardships of rebuilding her life drove her to an attempt to commit suicide.

As we stood among the remains of her make-shift home, Marcia explained that her husband's boat and nets were swept away and destroyed during the hurricane, stripping the family of their main livelihood - fishing. The empty, broken refrigerator and storage shelves of the small shop where they used to sell fish and lobster, and the fragments of the fishing nets thrown aside in the yard, testify to her story. Marcia explained that the stress of unemployment and difficulty of finding new work; the crying of her hungry children; and the destruction of property, became overwhelming and influenced her decision to commit suicide. She was found before she died and was taken to a nearby hospital for medical treatment and referral for counselling.

Marcia's story is sadly not unique. Like her, many other survivors of disasters are in need of psychosocial assistance in the aftermath of the disaster. To respond to this need The Jamaica Red Cross Disaster Mental Health Unit (JRC DMHU) was formed in 2001. It is the first Unit of its kind in the English-speaking part of the Caribbean, with a team of 28 volunteer psychologists, psychiatrists, counsellors and other mental health professionals dedicated to the task of providing psychosocial support to survivors of disasters as well as Red Cross staff and volunteers.

In the wake of hurricane Ivan, the team was particularly active, conducting interventions ranging from one-to-one counselling,

to educational talks on stress management and psychological first aid with persons in shelters, Red Cross staff and volunteers and NGO and government officials and agencies in Jamaica, the Cayman Islands, and Grenada. The following describes observations and findings that the team made as they worked in the various communities on the three islands.

Findings

The vast majority of the interventions involved helping individuals to understand that the stress reactions that they experienced were normal and that over time, as they involved themselves in rebuilding, they would be able to adjust to the reality of the changes that took place within their communities. Cases of extreme, psychologically debilitating reactions that needed urgent psychiatric care, such as Marcia's case, are rare.

The needs of special populations such as the elderly and the mentally ill were not adequately addressed in the shelter situation.



*A Jamaican family outside the remains of their home after the hurricane.
Photo: Reuters/Daniel Aquilar, courtesy of www.alertnet.org*

One of the problems encountered was that, because of the level of devastation, some of the communities became a sightseeing stop. This increased the stress experienced by the members of these communities. In one severely affected community, many

community members became upset and angry about the fact there was a constant stream of spectators that came to look at their damaged homes. This made them feel unsettled and unable to move on with their lives and begin rebuilding.

In one of the countries volunteers who were offered individual counselling shared their personal problems rather than problems associated with the hurricane. This is not surprising. The problems in their personal lives were exacerbated by the stresses caused by the hurricane and their long hours of attending to the needs of survivors.

Each of the three islands has its own culture, tradition and customs. The psychological interventions were chosen accordingly. For example, a team member reported that citizens in one country were shocked by the widespread looting that occurred after the disaster and the fact that policemen were also involved. While in another country, these occurrences were not surprising and it seemed as if it was a norm within that society.

Future Plans

The JRC DMHU hopes to expand its work within Jamaica and in the wider Caribbean by:

- Strengthening its administrative support
- Increasing volunteer recruitment
- Sustaining "in-house" training (i.e. training within the Jamaica Red Cross)
- Assisting in the establishment of Disaster Mental Health Units within Red Cross Societies in the Caribbean region through training
- Collaborating with other government and non-government disaster management agencies in sensitizing and training workers in psychological support
- Advocating for better care of the vulnerable in the aftermath of disasters such as children the elderly and the physically and mentally challenged.
- Increasing public education on the psychological effects of disasters and how to mitigate the possibility of long term debilitating effects on both survivors and disaster workers. ■

**Name changed for privacy.*

Training of trainers in Myanmar

By Nana Wiedeman, psychologist, Danish Red Cross

As elsewhere in the world volunteers from Myanmar Red Cross Society (MRCS) face many difficult tasks. Myanmar has suffered several natural disasters and the volunteers of the MRCS are engaged in disaster preparedness and disaster response. They are sometimes involved in the burial of victims; they care for landmine-victims and the victims of big fires, and they take care of people with HIV/AIDS. Working with such serious matters makes the tasks of the volunteers difficult and stressful.

One of the core activities of the IFRC Reference Centre for Psychosocial Support is assisting national societies to set up psychosocial training programs for volunteers or staff. The objectives of the training can vary depending on the expectations and capacity of the national society and the manner in which psychosocial support is already integrated in existing programmes such as first



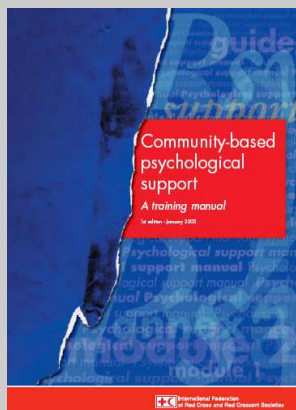
When the participants have finished the training, they are expected to pass on their knowledge to fellow volunteers in their home branches.

Photo: Nana Wiedeman

aid and disaster preparedness. Also the experience and level of education of the participants play a role in determining how best to conduct the training. The training is carried out by instructors with a professional background in psychology, medicine

Community-based psychological support

A training manual



The basis of the training in Myanmar was the “Community-based psychological support” manual. It is a training manual published by the Federation in January 2003. It contains six modules for training: Psychological Support; Stress and Coping; Supportive Communication; Promoting Community Self-help; Populations with Special Needs and Helping the Helpers. The manual is meant to be a flexible tool, which can be adapted to the situation of the training. The length and intensity of training sessions vary, so it is necessary that the instructor make the appropriate changes and priorities in the curriculum. Because the manual is very generic, it is also advisable that the curriculum is adapted so it suits the culture – behaviour which in one part of the world is a normal and culturally appropriate reaction to a traumatic event, can in another part of the world be a source of great concern.

The manual is currently available in three languages (English, Spanish and French), and is being translated into Arabic and Russian. It is also recommended if resources permit that the chapters used in the training or at least the slides are translated into the local language unless the participants have excellent skills in the teaching language, which will most often be English or French.

The manual can be freely downloaded from the Reference Centre’s website: <http://psp.drk.dk/sw2995.asp>. Red Cross and Red Crescent Societies can also request a hard copy from the Reference Centre.

National societies that are interested in integrating psychological and psychosocial support programmes can request assistance from the Reference Centre (psp-referencecentre@drk.dk).

or nursing in close cooperation with the local staff.

As was the case with the training in Myanmar, the course will often be a “training for trainers”. The local Myanmar Red Cross Society branches each picked two volunteers to participate in the training. When the participants have finished their training, they are expected to pass on their new knowledge to fellow volunteers and advocate for the importance of integrating psychosocial support in first aid and disaster preparedness or other relevant programs in their home branches.

The policy of the MRCS

The Myanmar Red Cross Society is very much aware of the need for psychological support to people affected by disasters and therefore aims to integrate psychosocial support in their Disaster Management Programme. As a first step towards this objective a training-of-trainers seminar including Psychological First Aid was organized for all community-based first aid trainers. A consultant from the Reference Centre of Psychosocial Support was invited to conduct training. The next step will be to offer pilot Psychological First Aid training programmes to volunteers. The integrated programme is expected to initiate in 2006.

The training

The purpose of the community-based first aid workshop was “to improve the teaching and training management skills of the trained RC volunteers in Community Based First Aid and Disaster Management (CBFA/DM) and First Aid Instructor trainings”. The objective of the psychosocial module was to give the participants a better understanding of the importance of psychological support in times of health emergencies or disaster, concerning both beneficiaries and volunteers.

More specifically, the training aimed at discussing

- What is psychological support
- Stress and coping
- Supportive communication skills
- Helping the helper
- How to include psychological support in first aid training

Myanmar has a population of 43 million people in 17 states. From each state two volunteers participated – some from remote regions bordering China, India and Thailand

– one male and one female. This gave the impression of a wide variety in cultural and geographical backgrounds, and also meant that the participants had very different experiences and problems in their lives as volunteers.

For most of the participants psychological support was a new concept, but during the four days that we spent together, they over and over expressed how relevant these issues were to them, how much they wanted to learn more, and how much they also needed the organisation to be aware of these matters. Many of the 32 volunteers who participated in the workshop were emotionally affected by the impact of the training. Through their work they are exposed to difficult and stressful situations. During the lectures and the role-plays, it was obvious that psychosocial support and care for caregivers were very relevant topics for all the participants. Learning about

psychosocial support (PS) and care for caregivers was only the first step in the process of integrating it in the Disaster Management Programme. It will be a challenge for the volunteers to include the psychological support in the First Aid instructors training, and to conduct this training. The evaluation showed that most of the participants needed more time to realize this.

In 2005 the output of the training will be evaluated, in order to learn how to best proceed the integration of psychological support in Myanmar Red Cross Society. Saying goodbye to the volunteers in Magwe I felt that I had learnt a lot about psychological support in a completely different cultural setting than the one I come from in Denmark. I am very grateful that I got the opportunity to share my knowledge and experiences and to learn from the volunteers.



Upcoming Events in 2005

Asia Pacific Congress on Disaster Mitigation—Capacity Building for Effective Intervention

1 & 2 April, 2005 at Hotel Savara International, Chennai, India

Organized by the Academy for Disaster Management, Education, Planning and Training, Lutheran University, India

For further information see http://www.disaster-management.info/dis_conference.htm or contact conf@disaster-management.info

Beyond Violence - Violent Conflicts, Care and Reconciliation Processes

6 April 2005, Geneva, Switzerland

Organized by Centre for Migration and Health SRC, Swiss Red Cross

Disaster Mental Health - Community Based Psychological Support and Psychological Support Practitioners Workshop

23 - 27 May 2005, Bangkok, Thailand

Organized by Disaster Mental Health Institute and Asian Disaster Preparedness Centre (ADPC)

For registration and more information about ADPC: <http://www.adpc.net/training/form.html>

8th Summer School of Psychotraumatology - Vicarious Traumatization, Dubrovnik

29th May – 03rd June 2005

Organised by IUC – Inter-University Centre Dubrovnik, Clinic for Psychological Medicine Zagreb School of Medicine, More information can be required: e-mail: bkalenic@kbc-zagreb.hr

The 9th European Conference on Traumatic Stress (ECOTS)

18-21 June 2005, Psychotraumatology, Stockholm, Sweden

Organized by The Swedish National Assoc. for Mental Health

For further information, registration and abstract submission:

<http://www1.stocon.se/ecots2005/>

Resilience in Children and Youth: International Conference

15-17 June 2005, Halifax, Nova Scotia, Canada

Organized by the International Resilience Project

For further information, registration and abstract submission:

<http://www.resilienceproject.org/cmp%5Fconference/?strCompname=theconference>

The 28th Congress of the World Federation for Mental Health: Equity and Mental Health

4-8 September 2005, Cairo, Egypt

Organized by The World Federation for Mental Health

For further information, registration and abstract submission:

<http://www.wfmh2005.com/HomePage.html>

Living with HIV Partnership

9-14 October 2005, Lima, Peru

The 12th International Conference for People Living with HIV/AIDS and the 7th International Conference on Home and Community Care for People Living with HIV/AIDS.

Organized by The Global Network of People Living with HIV/AIDS

For further information, please contact: Rick Stephen Conference Co-ordinator (GNP+)

E-mail: jazman1@worldonline.co.za



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