The International Federation Reference Centre for Psychosocial Support

Coping with Crisis

Newsletter No. 2 2008

International Federation of Red Cross and Red Crescent Societies

Hosted by Danish Red Cross

Editorial

After the quake – reaching people in the right way

With tens of thousands dead, and millions of people suffering after tropical cyclone Nargis in Myanmar and the Sichuan Earthquake in neighbouring China, we are again reminded of the immense psychosocial needs after natural disasters, and of our responsibility to fill these needs. We are also reminded that no resource is infinite, not even our massive volunteer force. As the search for survivors goes on in Sichuan and relief is brought to those affected in Myanmar, we also have to consider the psychological and social aspects of disasters and the need to care for our volunteers.

As in Haruki Murakami's *"After the quake"*, which tells stories of suffering after the Kobe earthquake in 1995, it is not only the injuries and losses that affect people in China and Myanmar. It is also the psychological shock of feeling the earth move beneath your feet or experiencing the force of winds exceeding 190 kilometres per hour ripping through your city for hour after hour. Many people have lost everything – their loved ones, homes, and their livelihoods. Coupled with fears of another earthquake or cyclone and an uncertain future, the psychosocial needs are enormous.

In both emergencies, the immediate appeals of the International Federation have pointed out the need for psychosocial support, and the Red Cross Societies of China and Myanmar are already providing such support to the affected populations, and considering how to care for volunteers and staff. It is good to see that the non-visible needs of people are increasingly taken into consideration right from the beginning. The earlier we can provide psychosocial support to those affected, the more successful we will be.

In these operations, as always, our biggest forte is our people. Thousands of volunteers have been working tirelessly around the clock, handing out relief items, purifying water, providing first aid and emotional support. And, as pointed out by Dr Margared Chan, Director-General of the World Health Organisation, the Red Cross and Red Crescent volunteers are not only characterized by *what* they do. "Your volunteers not only reach every household, moving door to door," she said during the opening of the Global Health and Care Forum of the International Federation 14. May, "*but you reach them in the right way*." When planning these responses, and later the recovery, it is crucial that we take previous experience into consideration. In this issue of Coping with Crisis, you can read about the efforts to gather psychosocial lessons learned from the tsunami. You can also learn how the issue of psychosocial support has developed and is viewed in the ICRC. Coupled with programme information from the Caribbean and a review of research concerning essential elements of mass trauma interventions, we hope to give you an informative and enjoyable issue.

Yours sincerely,

Nana Wiedemann

Nana Wiedemann,
Head, International Federation Reference Centre for Psychosocial Support

Coping with Crisis
No. 2 Summer 2008

Contents

Front page photo:
Yang Mingyuan scans the notice boards for missing persons at a reception centre for homeless earthquake survivors in Jiuzhou stadium, Mianyang, Sichuan. He's looking for his 13-year-old daughter, Yang Jing, whom he hasn't heard from for a week since the disaster. (Sho Huang/International Federation

Published quarterly by:
The International Federation Reference Centre for Psychosocial Support

E-mail:
psychosocial.center@ifrc.org

Internet:
http://psp.drk.dk

The International Federation's Health and Prisons project

The Health and Prisons project: a review of the HIV, tuberculosis and psychosocial support work of National Societies in prisons and with former detainees around the world, will be published in summer 2008 and distributed to all National Societies.

By Jennifer Hasselgård-Rowe
Until recently: International Federation Officer, Health and Prisons

The International Federation's mission is closely linked to working with prisoners. The mission of the International Federation of Red Cross and Red Crescent Societies is to improve the lives of vulnerable people. For the International Federation, people in prison or detention represent a particularly vulnerable group. Prisoners, former detainees and their families – as well as a number of variations on these classifications – are people in situations of vulnerability and exposed to harm.

At the 28th International Conference of the Red Cross and Red Crescent in December 2003, states, together with National Societies, unanimously adopted the Agenda for Humanitarian Action. It urges governments to take a number of steps aimed at reducing risk-taking behaviour and addressing particular situations of vulnerability, such as prisons. It declares:

States in cooperation with the components of the Movement, are urged to implement policies and operational measures in prisons in order to create a safer environment and reduce the risk of transmission of HIV, tuberculosis and other diseases among detainees, prisoners and staff.[1]

This led to the Health and Prisons project being launched at the end of 2006.

Prisons are high-risk environments for HIV transmission and many other infections

Living conditions in most of the world's prisons are unhealthy. Overcrowding compounded by a lack of light, fresh air, clean water and decent food is commonplace. Illicit drug use is rife, as are unsafe injecting practices, unprotected sex, violence, rape and tattooing with contaminated equipment.

There are no physical or mental illnesses that are unique to prisons, but most are more prevalent in places of detention, and made worse by the conditions of life in them. Rates of tuberculosis, HIV and hepatitis infection are much higher than amongst the general population.[2] Air-borne infections and diseases transmitted by shared needles are widespread.[3]

Aside from communicable diseases, mental illness and drug dependence are the dominant health problems among prisoners, many of whom have had little or no regular contact with health services before entering prison.[4] Prisoners are more likely to be more affected by almost any clinical problem you care to mention than people outside prison.[5]

Improving access to care for prisoners and increasing resilience

An essential part of the specific public health context of prison settings is improving access to care and building

Living conditions in most of the world's prisons are unhealthy.

resilience of former detainees and their families. In many cases, TB treatment started in prisons risks breaking down upon release with severe public health consequences. This will also be the case with anti retroviral therapy in future. It is crucial to improve and ensure adequate and appropriate access to health services for former detainees.

Mental health and psychosocial support work in prisons

About ten million people are detained in penal institutions around the world. At least half struggle with personality disorders, while one million prisoners or more worldwide suffer from serious mental disorders such as psychosis and depression. Nearly all prisoners experience depressed moods or stress symptoms and, each year, several thousand prisoners take their own lives during imprisonment.[6]

Many disorders may be present before admission to prison and may be further exacerbated by the stress of imprisonment. However, mental disorders may also develop during imprisonment itself as a consequence of prevailing conditions and human rights violations[7] such as torture and rape.

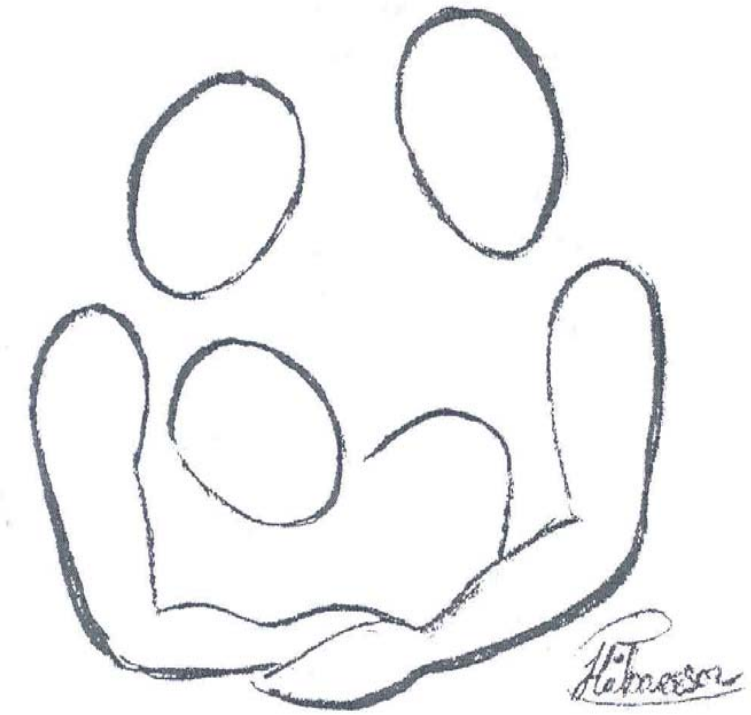
Inmates with HIV and chronic illnesses commonly suffer from depression and anxiety.[8] The high prevalence of alcohol and drug addiction among inmates further increases the likelihood of inmates having at least one psychiatric disorder.[9]

Psychosocial support activities are relevant at all the stages of prison process: pre-detention, during detention (including child and family support) and at the time of release as well as during follow-up. Psychosocial elements should be an integral part of all prison-related activities especially HIV, tuberculosis or other public health related activities.

National Societies and psychosocial support work

A number of National Societies visit prisoners, either regularly or occasionally, while other National Societies are in the process of establishing similar programmes. The Scandinavian National Societies have a long history of visiting prisoners and providing psychological support. The services started in Norway in 1959, in Sweden in 1965, in Finland in 1970 and in Denmark in 1986. The visits, which the prisoners are free to accept or decline, are made by volunteers, following a set of specific rules and guidelines. The National Society must under no circumstances impose such visits.

This service has been welcomed by the prisoners, particularly due to the neutrality and impartiality of the National Societies. When carrying out these visits, the National Societies cooperate closely with the Ministry of Justice and the prison authorities. The volunteers who visit prisoners are enlisted through recruitment campaigns. Once recruited, they are subsequently trained and meet regularly to exchange experiences.[10]



IIllustration by Catharina Håkansson from the Föräldrar i fängelse publication from Kriminalvårdens Göteborgskontor, 2000.

Other types of programmes also support prisoners. As part of its *Croix-Rouge Ecoute* (Red Cross Listens) psychological support programme, the French Red Cross launched a helpline for prisoners. The project helps people who are especially isolated and excluded from society, and

whose family and social ties have been broken. The project also aims to prevent suicides in detention, reduce conflict and violence, and encourage the rehabilitation of prisoners.[11]

Key issues: maintaining links with the community and strengthening the relationship of children and their parents in prison

Wherever possible, prisoners should be encouraged and assisted to make and maintain contact with their families and friends outside prison.[12] Family and friendship ties are important sources of support. Although imprisonment requires the imposition of some constraints on visits, letters and telephone calls, means of maintaining contact should be kept as normal as possible. Links between prisons and the outside community should be encouraged and facilitated.[13]

Evidence is emerging that programmes focusing on building and strengthening the relationship between children and their parents in prison is also of enormous value, both to prisoners and to their families.

Such programmes, which organize volunteers to accompany children from their homes on prison visits, are seen to help prisoners build confidence in themselves during their incarceration and prevent relapse into criminal behaviour after their release. They offer the chance to break the cycle of release and imprisonment. They also boost the resilience of prisoners, their families and their extended network.

The Swedish Red Cross runs the *Föräldrar i fängelse* (Parents in Prison) programme for the children and spouses of inmates, which focuses on increasing the sense of responsibility that prisoners can develop towards their children and on finding ways of building on the individual growth and rehabilitation benefits that such relationships can offer. The Norwegian Red Cross, the Finnish Red Cross and the Danish Red Cross are also active in this area. Their programmes are based on the view that improving the relationship between inmates and their children, from the very beginning and throughout the detention period, gives their rehabilitation into the community a far greater chance of success.

The welfare of prisoners' families, especially children, is very important to the psychosocial well-being of prisoners. As part of its activities for the children of inmates, the Danish Red Cross runs groups for children aged 7 to 17 years, who have a parent in prison. Every other week for two hours, the children meet with six to eight other children who are in the same situation and of the same age, together with two volunteer psychologists. This programme began in 2004 and, since 2005, the National Society has been arranging two-week summer camps for the same group of 40 children every year. The Danish Red Cross also provides support for teachers and relatives through practical, informal counselling.

These National Societies have extensive experience to share in the area of psychosocial support, providing potential models for other National Societies wishing to commence – or to develop – similar programmes adapted to their respective national contexts and needs. Sharing and building on this experience, as appropriate in the given context, is highly recommended.

For more information on this project, please contact Jennifer Hasselgård-Rowe: jenniferhasselgardrowe@hotmail.com.

Factors with a negative effect on mental health in prisons include:

- Overcrowding
- Violence
- Enforced solitude or, conversely, a lack of privacy
- A lack of meaningful activity
- Isolation from social networks
- Insecurity about future prospects (work, relationships, etc.)
- Inadequate health services, especially mental health services

References:

1 Agenda for Humanitarian Action, point 4.2.5 from the 28th International Conference of the Red Cross and Red Crescent, 2-6 December 2003.

[2] *Health in Prisons, A WHO guide to the essentials in prison health*, 2007, World Health Organization, edited by Lars Moller, Heino Söver, Ralf Jürgens, Alex Gatherer and Haik Nikogaosan, p. 10.

[3] Ibid., p. 26.

[4] Ibid., p. 16.

[5] Ibid., p. 16.

[6] Ibid., p. 133.

[7] Ibid., p. 133.

[8] Burnam MA, Bing EG, Morton SC, Sherbourne C, Fleishman JA, London AS et al. *Use of Mental Health and Substance Abuse Treatment Among Adults with HIV in the United States. Archives of General Psychiatry* 2002; 58:729-736 referred to in Canning Robert D. *A Primary Care Approach to Mental Health Care for HIV/Hepatitis-Infected Inmates, HEPP Report*, January 2003, Vol., Issue 1, p. 1.

[9] Bing EG, Burnam MA, Longshore D, Fleishman JA, Sherbourne C, Lonon, AS, et al. *Psychiatric Disorders and Drug Use Among Human Immunodeficiency Virus-Infected Adults in the United States. Archives of General Psychiatry* 2002; 58: 721-728; referred to in Canning Robert D. HEPP 2003 op.cit. p. 1.

[10] *Activities of Red Cross and Red Crescent Societies in Prisons*, International Federation of Red Cross and Red Crescent Societies in cooperation with the Henry Dunant Institute, 1994, Geneva, page 20.

[11] Referred to in *Psychological Support: best practice from Red Cross and Red Crescent programmes*, 2001, International Federation of Red Cross and Red Crescent Societies.

[12] "*Mental health in prisons*", Eric Blaauw and Hjalmar J.C van Marle p. 142 in WHO 2007 op.cit.

[13] Ibid., p. 143.

Use of violence

How to view mental health interventions in contemporary conflicts

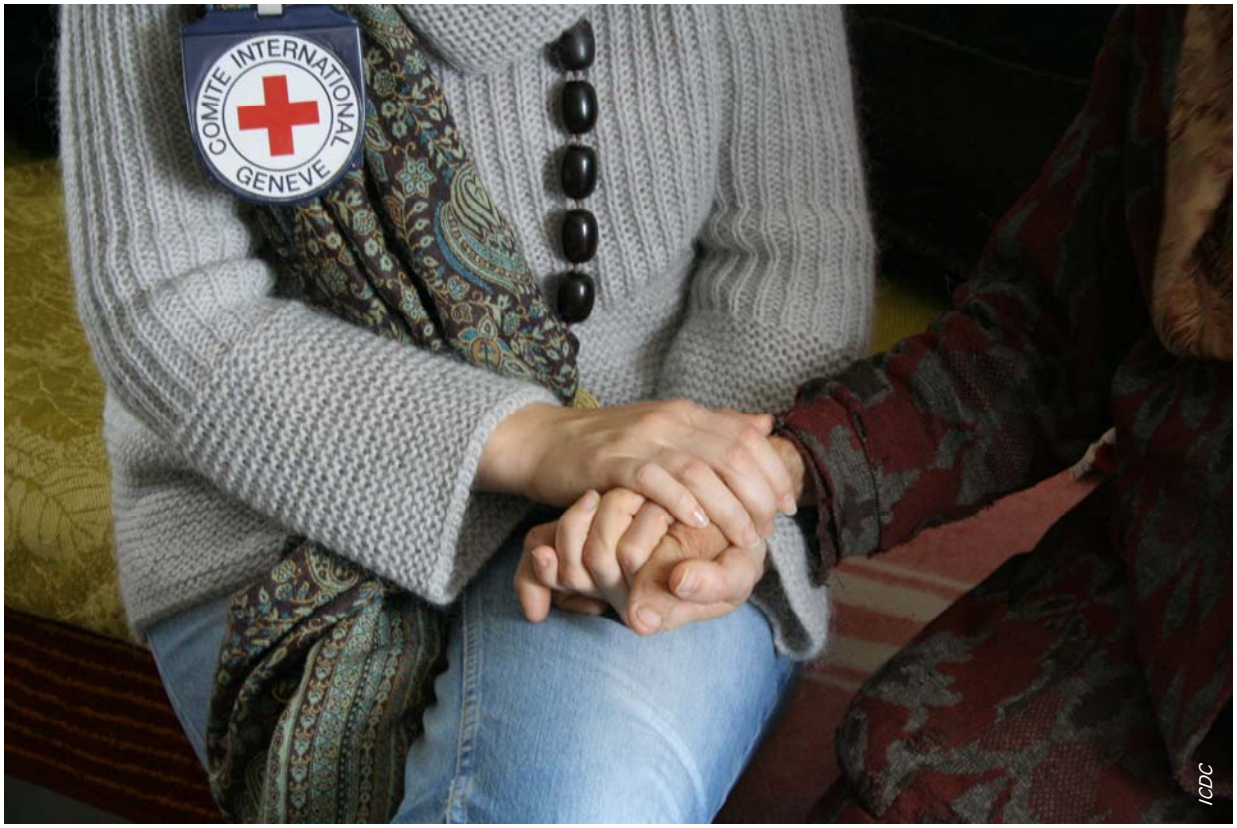
By Laurence de Barros-Duchêne
Mental health coordinator, International Committee of the Red Cross

No one can deny that war takes its toll on both body and mind. This has been amply demonstrated by the conflicts of the past century.

From the Russo-Japanese War to Viet Nam, from Yom Kippur to the Gulf and UN peace-keeping missions, military officials developed field psychiatric care in order to address "transitory" acute stress reactions (decompensation) affecting front-line troops.

It was only after American troops returned from Viet Nam, however, and health authorities raised concerns, that genuine awareness emerged of the severity of trauma caused by the horror and inhumanity of war (24 per cent of the troops that went to Viet Nam suffered from post-traumatic stress disorder within a few years of their return)[1] – an invisible trauma that until then had been treated only occasionally, without insight or real understanding, for the sole purpose of quickly alleviating symptoms so that soldiers could return to the front.

Acknowledgment of the long-lasting psychological impact of armed conflict took hold in the early 1980s with the publication of diagnostic criteria for post-traumatic stress disorder by the American Psychiatric Association in its Diagnostic and Statistical Manual, Version IV (DSM III). The criteria highlighted the negative impact of external events on the mental health of individuals.



Woman being councelled by ICRC delegate.

From military psychiatry to humanitarian action

At about the same period an alternative to military psychiatry emerged, an alternative more focused on the civilian victims of war and of natural disasters. A few international humanitarian organizations, finding themselves confronted with the invisible reality of psychological suffering, were at the forefront.

The International Committee of the Red Cross (ICRC) became a pioneer in the humanitarian psychiatry that took shape at the end of the 1970s by organizing a system of care in Khmer refugee camps in Thailand for civilians traumatized by the genocidal violence from which they had just escaped.

By treating those seeking psychiatric help, health personnel (doctors and Khmer

traditional practitioners) were able to fully appreciate the psychological hardship – frequently occurring in connection with physical ailments or with behaviour that modern psychiatry would all too readily have classified as serious disorders – endured by those who had survived the horror. The trauma was there, but concealed by the symptoms of a commonplace or undivulged health problem.

Other international organizations, in other places and other circumstances, reported similarly distressing findings, for example when faced with the heavy silence of earthquake survivors in Armenia (December 1988) and Iran (December 2003), only a few days after tragedy had struck, when nothing more could be done to save those trapped in the rubble.

It was then that the psychological trauma appears in the humanitarian world. Victimologists with a background in military psychiatry were, and still are, mainly responsible for this a posteriori recognition.[2]

Post-traumatic stress disorder, modeled on the basis of data collected from Viet Nam veterans, would serve as a frame of reference to define these psychological wounds, which had merely been assumed to exist, and to try to identify them in the crisis situations where international aid agencies were working. Humanitarian psychiatry had thus found its primary focus, at least for a time, until the intrinsic nature of the events – their massive, systematic, enduring and, more and more often, intentional nature – was taken into consideration.

Trauma induced and trauma inflicted

Psychiatric views of trauma do not take into account the whole range of mechanisms now involved in armed conflict and generalized violence, which should be distinguished from events which are not caused by man.

Natural disasters are terrifying and cause terrible harm. Survivors are confronted not only with death and substantial permanent loss, but also with feelings of guilt. The psychological violence of natural disasters has to do with how suddenly they occur and how unreal they seem. Survivors of the 2004 tsunami tried to make sense of what had happened in accordance with their cultural references, by suggesting for example that it was divine punishment, or a demonstration of the power of the elements. All of them had been struck indiscriminately and at the same time. The event had in a sense been "natural" and explainable. Thus, over time, it had become "manageable." Once the survivors had overcome their initial state of shock, they demonstrated solidarity among themselves, and mutual compassion, especially regarding the psychological suffering caused by the loss of so many loved ones, of so many material belongings and, for some people, of all hope for the future. In these circumstances, there was no animosity, hatred or resentment. There was only anger and immense pain.

Acts of violence cannot be rationalized in the same way, since they involve emotion and destructive will. Their impact on individuals and communities is not the same as that of natural disasters. They create a state of constant danger, mistrust and sometimes even paranoia. In addition, they leave scars that never fully heal, even after peace is restored.

It is not surprising, then, to observe a perpetual state of hyper-vigilance in contexts where there is real danger and such a state can be sensibly explained as a coping mechanism rather than as a (post-) traumatic stress reaction. In the eastern provinces of the Democratic Republic of the Congo, where the ICRC has offered services for rape victims, the fear and avoidance of armed men exhibited by the women seeking help appeared to be a sensible precaution, quite apart from the fact that this behaviour also revealed how very uneasy the whole Congolese society felt and indeed still feels.

Similarly, the tendency of the Palestinians to view the "victims" of the intifada as heroes could be interpreted not as a community coping mechanism but as an indication of deep and possibly pathological suffering preventing the pain and guilt felt in connection with the loss of a close relative from being expressed.

Clearly, then, psychological trauma cannot be identified, understood and treated only through the prism of psychiatric classification. In societies where the values governing relations between individuals have been deeply altered or sometimes even intentionally attacked, trauma cannot always be overcome simply by boosting individual and community coping mechanisms.

What are we to think of a community's values when – without any strategy of conquest – rape becomes systematic and affects all women, including those who are no longer of child-bearing age?[3] What are we to think when wrongdoing becomes legitimate and violence becomes both an alternative to loss of identity and a means of freely obtaining access to goods and privileges?[4]

It is obvious that we can no longer be satisfied with a simple one-dimensional understanding of psychological trauma, especially in view of the different nature of events afflicting the people we want to help. Violence intentionally directed against human beings: a new weapon in contemporary conflict. In modern conflict, civilian populations are used as a means of

achieving pre-determined objectives.

Violence is directed against civilians – not to conquer them (and exploit them as a means of production) but to use or even destroy them for political purposes or for the sake of domination.

The deliberate use of violence against a human group is a weapon as fearsome as it is imperceptible, just like the scars it leaves deep within individuals and communities. The trauma in that respect emerges from the intentionality which attacks without discernment those who belong to another group.

"When a human group is targeted, the resulting impression that death has been transformed into a mass phenomenon makes people feel they have lost their own identity. What distinguishes them from other victims? People are not targeted because of what they do or say. They risk their lives for one reason only: because they are Jewish, Tutsi or Kosovar. […] Every other part of their identity is negated."[5]

Violence of this kind targets the very basis of a community: its values, cultural symbols, social references and, consequently, everything connected with it. Congolese and Bosnian mothers' wombs were viewed not as neutral but as the basis for affiliation within a group. By means of violence and rape, the enemy sought to intentionally soil this basis – to "bastardize" – and ultimately conquer it.

The fact that this really happened cannot be ignored. Our theoretical frameworks regarding trauma and our present ways of providing care must therefore be re-examined. There can be no universally suitable way to care for victims or models applicable everywhere and in all circumstances. External factors and their impact – on individuals, their values and cultural representations, and on social relationships – must be taken into account, as must the intentions behind acts of violence, in order to make appropriate adjustments to mental health procedures.

The need to adapt to the problems encountered by recipients of humanitarian aid was brought home to the ICRC early on, first in the Khmer refugee camps mentioned above,[6] then in connection with support activities developed in recent years for the families of missing persons. Behind the forced disappearances of civilians in contexts of armed conflict or political violence lies the desire to harm and often to destroy – not only individuals but, especially, the group to which they belong.

The psychological and social consequences can be considerable. Without establishing with certainty that their missing loved ones are dead, families cannot begin to mourn. Without a corpse, there can be no funeral, which means that the name and memory of the deceased cannot be honoured by the survivors. Without a funeral, there is no social recognition of the passing. Families cannot express their sadness, communities cannot offer support and there can be no healing. Inasmuch as forced disappearances and the mutilation or physical destruction of corpses prevent funeral rites from being held,[7] they constitute deliberate acts of torture against the families; they are acts of violence and experienced as such.

In such circumstances it is no longer possible to talk of mere mourning or of post-traumatic stress. These acts, deliberately committed by one group against another, must instead be viewed as intentionally inducing trauma.[8] The specific kind of suffering involved and the specific clinical signs[9] are revealing of the destructive will that motivates them.

References:

[1] L. Crocq, "Histoire de la psychiatrie de l'avant dans les conflits armés," *Revue francophone du stress et du trauma*, 2005, Vol. 5, No. 1, pp. 43-54.

[2] D. Fassin, R. Rechtman, *L'empire du traumatisme: Enquête sur la condition de victime*, Flammarion, Paris, 2007, p. 259.

[3] Thereby conferring on them a different social status.

[4] R. Beneduce *et al*., "Violence with a purpose: exploring the functions and meaning of violence in the Democratic Republic of Congo," *Intervention*, Vol. 4, No. 1, 2006, pp. 32-46.

[5] M.-F. Bacqué, *Apprivoiser la mort*, Odile Jacob, Paris, 2003, p.129.

[6] Where care centres using both traditional and modern medicine were set up.

[7] Some Buddhist families in Sri Lanka have told of their sufferings and guilt, and of the social rejection they were subjected to, for being unable to perform proper funeral rites for deceased relatives. As Buddhists, they must "set free" the soul of the deceased so that it can be reincarnated (the ritual consists in breaking the skull). If the ritual is not performed, the soul is believed to wander eternally, and the relatives of the deceased to bear curses. See L. de Barros-Duchêne, ICRC Assessment Report, September 2005.

[8] F. Sironi, *Psychopathologie des violences collectives: Essai de psychologie géopolitique clinique*, Odile Jacob, Paris, 2007, and "Les stratégies de déculturation dans les conflits contemporains," *Revue de Psychiatrie Sud/Nord*, No. 12, 1999.

[9] Forced disappearance in situations of armed conflict or of political violence pushes families into a "no man's land" where nothing provides the basis for accepting the death of a loved one and thus to start a grieving process. In the absence of evidence or of any certainty about what happened to a relative, denial can be total and anxiety permanent. Ambivalence (the constant back-and-forth between possibly accepting a person's death and hoping for his return) can be trying and a potential source of psychological fatigue and depression.

Lessons learned on psychosocial response to the Indian Ocean Tsunami

By Pernille Hansen, PS Centre project coordinator

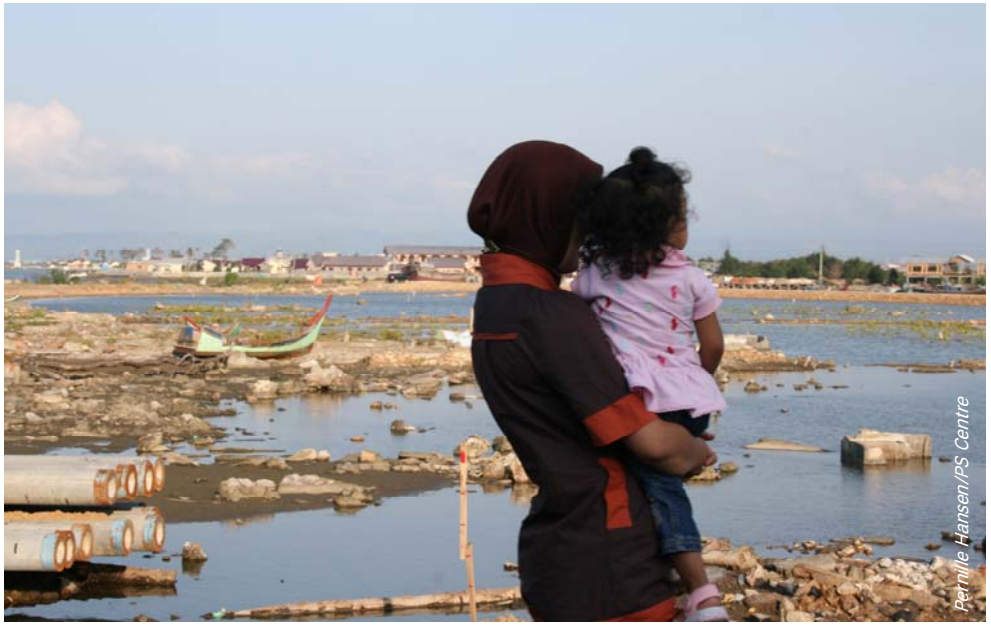
The tsunami that followed the earthquake off the coast of Indonesia in December 2004 had a devastating and life changing impact on the lives of millions, not only in the countries that were directly affected by this enormous surge of water, but worldwide. Whilst several hundred thousand people were killed, even more were displaced from their homes, lost their loved ones and were faced with unparalleled challenges and despair in the attempt to piece back their lives. The tourist nature of many of the affected areas meant that families from countries all around the world were touched by this tragedy, which also influenced the unprecedented response to the tsunami. Never before has so much money been collected in disaster response, nor have so many different organizations and individuals flocked to the affected areas wanting to help in all possible ways, including assisting in the psychosocial response.

Project of collection lessons learned

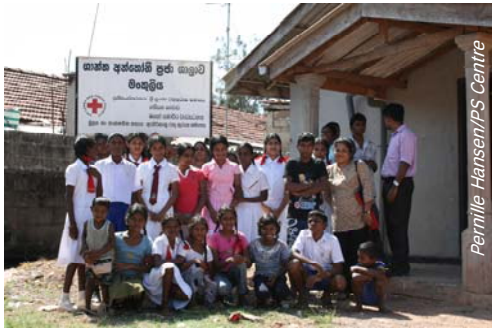
Given the scale and diversity of the psychosocial response in the entire tsunami affected region, time has now ripened for reflection and learning. American Red Cross have therefore supported the International Federation Reference Centre for Psychosocial Support to embark on a project of gathering lessons learnt from the psychosocial response, with the clear objective of improving psychosocial responses in future emergency situations. The project started in November 2007, with the first phase of collecting descriptions and evaluations of psychosocial programmes, as well as making contact with organizations and individuals presently or previously working with the psychosocial response. This was followed by exceptionally fruitful and informative visits to the five worst affected countries: Thailand, Indonesia, Sri Lanka, India and the Maldives. During the visits, trips to some of the areas still clearly marked by the damage of the tsunami were incorporated, as well as meetings with beneficiaries of psychosocial programmes, interviews with programme staff and managers and two one-day-lessons learned workshops in Indonesia and in Sri Lanka.

One-day lessons learned workshops

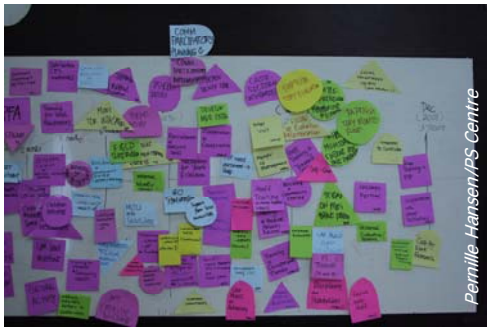
It is always an invaluable experience to share lessons learned in a forum with others working in the same field. Not only does it give participants a unique opportunity to learn from one another, it also encourages openness and freedom of expression for sharing of personal experiences, challenges and most importantly, best practises. Both of the workshops were held using the Visualization in Participation Programmes methodology, where full participation of everybody is essential for success of the workshop, and where sharing of experiences and information is presented on cards that are stuck on a wall, encouraging learning through visualisation. The major task was to develop a time line from the day of the tsunami to now, on which all participants were asked to insert various categories of information: activities, best practises, challenges and recommendations for planning, implementation, monitoring and evaluation aspects of the psychosocial responses. Participants then worked with



A mother and her child looking out over the river leading into Banda Aceh that is still full of debris from following the devastation of the Tsunami.



Community members next to a community center in Galle, Sri Lanka.



A completed day's work at the workshop showing the VIPP cards used.

this rich conglomeration of information to consolidate prioritised best practises and recommendations.

Lessons learned in Indonesia

In Banda Aceh, Indonesia, the 25 participants, representing 20 different organizations active with psychosocial and mental health programmes since the tsunami, including Indonesian Red Cross (PMI), shared challenges and best practices under the major thematic areas of: i) Contextualising programmes (using local resources and ensuring cultural and relative adaption of activities); ii) Standardisation of guidelines and tools; iii) Coordination and communication.

Whilst identifying what actions points were needed to strengthen the continuing psychosocial response in Indonesia, a strong commitment was made by all participants to participate in future events that would work to develop: a) national consensus and guidelines on community mobilisation techniques and strategies, b) national guidelines for psychosocial programming (in accordance with internationally recognised and acclaimed guidelines), and c) a book or other printed material with 'Lessons from Aceh'.

Lessons learned in Sri Lanka

In Colombo, Sri Lanka, all of the 20 participants of the workshop, with the exception of two representatives from American Red Cross, were from Sri Lanka Red Cross, representing five different branches. This did not impact the quality of learning in the workshop, but instead offered colleagues a rare and timely opportunity to meet and share challenges and best practises.

The context of internal conflict that has existed in Sri Lanka pre- and post-tsunami, to date, clearly affects not only programmatic implementation, but also levels of frustrations experienced by programme staff, as they constantly face limitations and hindrances in executing their planned activities. Even the hours of the workshop had to be cut, to ensure that all participants were able to travel home safely during daylight.

In the time available, participants engaged wholeheartedly in the tasks at hand identifying a host of important best practises and recommendations to address the many challenges. The time restrictions prevented us as a group to identify practical actions points, although there was clear desire to do this from participants. Two major thematic areas dominated the lessons learned that were prioritised: the importance of cultural relativism in design and implementation of psychosocial responses; and the need for flexibility in psychosocial programming. The latter highlights two major lessons learnt from all countries visited: the difficulties that accompany programme locking and difficulties in measuring the impact of psychosocial programmes.

Future plans:

The lessons learned workshops in both countries were embraced with dedicated enthusiasm, and clearly indicated the benefits of such fora. As a result we have now planned another lessons learned workshop in Denpasar in the first week of June, where representatives of all five visited countries, as well as participating National Societies, the International Federation and delegates who were previously posted in the affected countries will have the opportunity to meet and share lessons learned. The next Coping with Crisis will include a short results description of this workshop. Full reports with details and results of the two above-described workshops are available from Pernille Hansen at pha@drk.dk

Programme locking

This refers to attempting to predict activities in late stages of the programme in the initial programme planning phase. This is usually done as a requirement in funding proposals, and is not as problematic in other more tangible areas of programme responses, such as ordering number of vaccines needed to reach X number of children. However, in community based psychosocial programmes, where activities chosen depend on outcomes of community mobilisation activities and participation forums, it can create serious problems if programme activities are planned in early stages of programme planning. It may result in implementation of activities that are not relevant but necessary for release of funds.

Psychosocial programme indicators

Psychosocial programmes are so incredibly difficult to measure, as most countries are still struggling with clearly defining psychosocial support in their local context. This naturally impacts the definition of psychosocial wellbeing, and in turn affects the identification of measureable indicators. Attention is called to this difficulty, particularly for those funding psychosocial programmes.

Psychosocial support in Cuba

Since 2000, Cuba Red Cross has carried out a psychosocial support programme with the aid of the International Federation Reference Centre (PS Centre) and the cooperation of the Disaster Mental Health Institute, University of South Dakota.

By: Joan Swaby Atherton, Head of PSP in Cuba Red Cross

In April 2000, the first training seminar was facilitated by Mette Sonniks. In 2001 the first conference was arranged with participation of Dr. Gill Reyes from the Disaster Mental Health Institute representing the PS Centre. In 2003, the second conference included representatives from Mexico, Guatemala, Jamaica and the International Federation, while representatives from the Dominican Republic participated in the third conference in 2005. In less than one decade, Cuba Red Cross has built a psychosocial support programme that has given support to tens of thousands of people affected not only by the very frequent hurricanes, tropical storms and floods, but also in a great diversity of other stressful situations which affect the population.

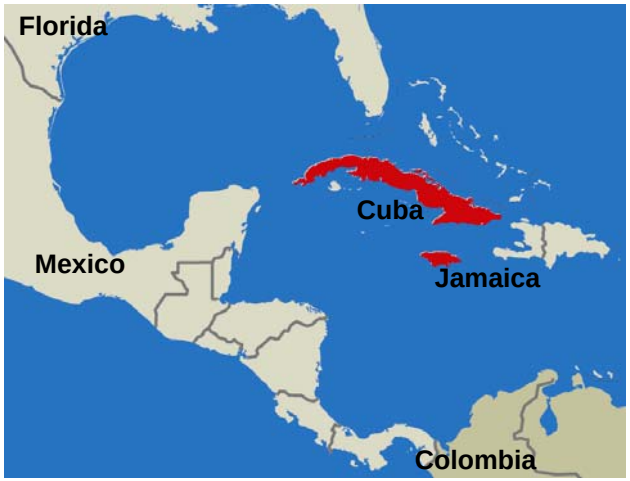
In October and November 2007, a great amount of rain chastised the eastern provinces in Cuba. Rivers and dams overflowed, causing the evacuation of thousands of families from both the countryside and the cities. The intense rains swept away thousands of houses and roofs, and caused inundation of plantations, leaving the population of homeless and with no food. Red Cross psychosocial support groups were mobilized together with other relief workers, giving help in shelters and support to the sick, the elderly, the handicapped and to those grieving about their loses.

Through the programme, preventive work is also undertaken to prepare the population and vulnerable communities. The fourth psychosocial conference will be held in May 2008 in Matanzas city. During this conference, there will be a focus of sharing the experiences and knowledge of CRC staff, volunteers and helpers.

Helping to Heal in Jamaica

Helping to Heal is a methodology for community-based psychosocial care. This tool was created in 2007 by the International Federation with support from the Jamaican Red Cross, using the broad psycho-social support programme experience from the Jamaican Red Cross.

By Stephanie Cariage, Health Assistent, International Federation Panama delegation



The idea was to design a tool that could be implemented by all interested National Societies in the Americas for the use of mental health professionals as well as non-professional volunteers. It is a complete, coherent and easy-to-use tool.

This psychosocial support tool consists of two manuals and four different hand-out brochures on several topics. One manual is intended for the Red Cross trainers and the other for the use and application of Red Cross volunteers. The brochures provide insight on several issues such as: How to deal with stress and self-care tips for survivors of a disaster; Working in stressful situations: a guide for disaster workers; Helping children to cope with disasters: a guide for disaster workers; and Psychosocial first aid: a guide for red cross volunteers.

The tool provides a checklist for all the steps necessary to create a good facilitation workshop on Psychosocial support and includes topics such as support to relieve volunteers, support to population with special needs, children, elderly, people with HIV, etc. and gives the basic knowledge to provide proper psychological support.

After being validated and field-tested in the Caribbean, this tool has been translated into Spanish and
is currently undergoing a validation process in Central America. It will be adapted to regional realities so that in a later stage in can be implemented by Red Cross National Societies in the region with the guidance of the regional health programme.

The implementation of this manual will begin in at least three National Societies during 2008, and have a broader implementation in 2009.

REVIEW

Essential elements of mass Trauma Intervention

This article reviews the recently published "Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence"[1] and discuss briefly how it may be applied within psycho-social support provided by the Red Cross/Red Crescent.

By Peter Berliner & Stephen Regel

Hobfoll et al[1] provides us with an overview – not a review with defined criteria – of selected empirical research that can support an evidence-informed practice in interventions aiming at restoring social and behavioural functioning after disasters and situations of mass casualty. The article concludes that interventions that enhance and preserve the five essential elements, *sense of safety*, *calming*, *self- and communal efficacy*, *connectedness*, and *hope*, will be the most supportive to the impacted population at the individual, family and community level. The importance of these key element or principles is to inform the designing of interventions and the setting of policies within the field. For practitioners involved in psychosocial support programmes, the comprehensive table 1 in the article may be of great use as it puts the found research results into practically applicable ideas for interventions. The table is in particular useful as it includes interventions for children and adolescents as well as for adults and entails individual, group and community perspectives.

In the Red Cross/Red Crescent we have previously summarised lessons learned from psycho-educational and community based psychosocial interventions by pointing to that they should focus on active participation of the beneficiaries, sense of control, sense of belonging, social support, meaningfulness, and human dignity. It seems promising to replace sense of control with self- and community efficacy and to replace meaningfulness with hope as these concepts may be better supported by evidence and may be operational in the field.

The article does not relate its recommendations to the IASC guidelines[2] or the Sphere Standards[3]. Psychosocial interventions are not at all mentioned, but seem to be included in the community interventions. Other essential Red Cross/ Red Crescent principles such as gender equality, capacity building, advocacy, organisational development, local ownership, adjustment to the local context and culture, protection, and the Human Rights approach are only addressed briefly or indirectly. This leaves the Red Cross/ Red Crescent psychosocial delegate or manager with the task of mainstreaming the recommendations to Red Cross/Red Crescent standards.[4, 5]

Using the article in a Red Cross/Red Crescent context, one should be slightly cautious about the inclusion of studies on front line combatants in forming the evidence-informed understanding of how to support survivors of disasters. There may be a huge difference between supporting beneficiaries and supporting soldiers in being able to continue fighting. Studies on combatants should appropriately be classified under *Military Psychology*. Studies on other staff groups may be more useful in a Red Cross/Red Crescent context.[6]

But still the article provides us with an evidence informed knowledge which can support the psychosocial and mental health during and after disaster – and which may lead to supporting what we are doing even though randomised, controlled trials may never be feasible in the context of a disaster.

References:

[1] Hobfoll, S.E. et al. (2007) Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. Psychiatry. 70 (4), 283-315. http://www.estss.org/publicat/recent_publications.htm#pibp
A number of comments on the article can also be found on this website.

[2] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. http://www.humanitarianinfo.org/iasc/content/products

[3] Sphere Project (2004). Humanitarian Charter and Minimum Standards in Disaster Response. Geneva: Sphere Project. http://www.sphereproject.org/handbook/

[4] DRC Strategic Guidelines for Psychosocial Support Programmes (PSP) http://psp.drk.dk/graphics/2003referencecenter/Doc-man/PSP-school-2007/0-DRC-PSP-Strategic-Guidelines-2007.pdf

[5] Regel, S. (2007). Resilience in trauma and disaster. In B. Monroe & D. Oliviere (Eds.). Resilience in Palliative Care Achievement in Adversity. Oxford University Press. p. 239-260.

[6] Regel, S., Joseph, S, & Dyregrov, A. (2007). Psychological Debriefing in Cross-Cultural Contexts: Ten Implications for Practice , International Journal of Emergency Mental Health. 9 (1), 37-45. http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/docs/

Peter Berliner is Associate Professor, Dept. of Psychology, University of Copenhagen.

Stephen Regel is a Principal Cognitive Behavioural Psychotherapist and Co-Director, Centre for Trauma, Resilience and Growth, Nottinghamshire Healthcare NHS Trust; Special Lecturer, School of Sociology and Social Policy, University of Nottingham, UK.

Both are members of the International Federation Reference Centre for Psychosocial Support Roster.

The International Federation Reference Centre for Psychosocial Support

is hosted and supported by the

Danish Red Cross

and supported by the

American Red Cross

Hellenic Red Cross

Canadian Red Cross

Icelandic Red Cross

Finish Red Cross

Norwegian Red Cross

French Red Cross

Swedish Red Cross

and is coorporating with the

Department of Psychology,
University of Innsbruck

Disaster Mental Health Institute,
University of South Dakota

Centre for Multi-Ethnic Traumatic Stress Research,
University of Copenhagen

Centre for Trauma, Resilience and Growth
Nottinghamshire Healthcare NHS Trust & University of Nottingham