The International Federation Reference Centre for Psychosocial Support

Coping with Crisis

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International Federation of Red Cross and Red Crescent Societies

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Editorial

When the emergency is over

Psychosocial support programmes often start with an emergency – natural or man-made, and get a lot of focus in the response phase and into recovery. When things are back to normal, it is not always evident how to take care of newly developed resources. We do not, however, have to look for long to see that these capacities, if managed well, can make all the difference next time around.

As we follow the tense situation in Southern Caucasus with psychosocial eyes, we see how training and experience allows quick response to emergencies. Thanks to the psychosocial focus after the Beslan tragedy in 2004, the Russian Red Cross is aware of this aspect of response. The Beslan operations not only gave the National Society skilled psychosocial support staff and volunteers, but also raised awareness that lead to more training at central level in Moscow. As the displaced cross the border from South to North Ossetia, the Russian Red Cross is ready to care for their psychosocial well-being as well as their other immediate needs. Currently (15.08.08) a Russian Red Cross team of 17 psychologists and 15 volunteers are supporting an estimated 1000 displaced children, organising trips, games and activities, and monitoring children who seem to be distressed.

Without the Beslan experience, the Russian Red Cross would not be able to provide the same quality psychosocial support immediately to these displaced children. However, this experience alone is not enough. What makes the difference is the willingness of the National Society to keep focus on the psychosocial support after the emergency, and to keep building its capacity through training and awareness raising.

In this issue of Coping you get the first account of the International Federation psychosocial support delegate in Myanmar and also some other examples of psychosocial support in recent emergency operations. Furthermore, you can read about current efforts to increase psychosocial capacity in the Middle East and North Africa zone, in many ways initiated by the need to respond to the millions of displaced Iraqis in the region.

Also in this issue is an article about critical incident stress management as a staff and peer support strategy in a humanitarian context. The PS Centre encourages experience-sharing, and therefore invites readers to submit articles describing other, concrete approaches to meeting social support needs of staff and volunteers, both groups and individuals, after stressful situations in emergency settings.

Yours sincerely,

Nana Wiedemann

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A woman affected by the conflict between Georgia and the Russian Federation rests on a bed.
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A glimpse into Myanmar after Cyclone Nargis - the psychosocial situation

By Christina Bitar
PSP Delegate, Cyclone Nargis Operation, Yangon, Myanmar

On the seashore of Bogale Township, in the early morning, a child stares tirelessly at the sea. A few hours later, he is still observing the silence, studying the waves crashing into the shore and making their way back to sea. At sun set, the child is standing in the same position, looking at the same waves. No, he did not lose track of time, and he is definitely too young for poetic endeavours; the child is waiting for the sea to return his parents. He believes she had abducted them when she laid her furious waves on his village three months ago, and that if he stands there long enough, the sea will pity him and send them back.

Myanmar was hit by Cyclone Nargis on 2 and 3 May, 2008. The extreme wind was exacerbated by a 12- foot storm surge, and as a result, 130,000 men, women and children lost their lives and nearly 20,000 were injured. The disaster did not just stop at fatalities; more than 50 townships were affected, resulting in 800,000 displaced with some 260,000 living in camps or settlements; official reports indicate that 2.4 million people have been severely affected by the cyclone. In addition to widespread destruction to homes and critical infrastructure such as roads, fuel supplies and electricity; a large number of water supplies were contaminated, and food stocks, as well as entire crops and rice fields, the main source of income for the villagers, were damaged and destroyed.

Multiple challenges

Three months after the cyclone, the population is still suffering; perhaps now more than ever. According to the PONJA assessment[1], 65 per cent of the population surveyed reported health problems, and about 80 per cent of respondents indicated that they lived within an hour's walk or boat ride to a health facility. The shortage of supplies, drugs and medical personnel is aggravating the situation. Psychosocial assessments conducted in the field confirm that cyclone survivors are in a fragile psychosocial state for many reasons besides having to survive the cyclone itself. In addition to death separations, secondary separations are emerging as parents and caregivers are sending their children to the Department of Social Welfare and faith-based institutions for education and shelter. Furthermore, after the substantial number of dead mothers, additional burdens have settled on fathers trying to take care of their children; this also applies to young children taking on increased responsibilities for their siblings.

A trained psychosocial support volunteer of the Myanmar Red Cross Society extends psychosocial support to a woman in Bogale Township, July 08.

Myanmar culture is characterized by a high level of unity and social cohesion. Immediately after the cyclone, private sectors, monasteries and ordinary people mobilized trucks and vans laden with clothes, biscuits, dried noodles and rice into the delta. As fortune would have it, immediate psychosocial disorders were not

Psychosocial volunteers of the MRCD volunteers trying to reach villages in Bogale Township.

felt until the early stages of recovery. However, assessment reports from Médecins Sans Frontières, the University of Yangon, and the Myanmar Red Cross Society (MRCS) highlight a large variety of trauma symptoms. These include stress, depression, anxiety, somatic complaints, and other behavioural changes that inhibit the recovery and return to "normal" life. Recurrent dreams about the disaster are haunting especially children, who are experiencing endless crying episodes and startled reactions. As for the parents, they simply do not want to return to their villages. They are better off in the camps, they choose not to see the destruction, the loss, the death. Perhaps, they would like to go on believing that their loved ones are still alive and live on in their respective villages, or perhaps, there are simply no villages to return to.

Scaling up capacity

Immediate survival and relief support was the main focus of the initial response of the MRCS as psychological support was provided by the MRCS staff and volunteers as soon as they started distributing immediate relief items to the families in the temporary shelters/camps and monasteries. The MRCS, supported by the International Federation of Red Cross and Red Crescent Societies, is planning a wide scale psychosocial support programme to start this month. Already a large number of volunteers have been trained in delivering psychosocial assistance; and in September 2008, 90 additional psychosocial support trainers and 270 Red Cross staff and volunteers as well as community representatives (nuns, monks, teachers etc) will be trained to extend psychosocial assistance to the affected community. In addition, drama and theatre activities will be conducted with children in and out of schools. A large scale psychosocial assessment is being prepared - trained Red Cross volunteers and staff will collect information from the nine most affected areas. The data collected will be used to further strengthen the future activities and approaches of MRCS.

Volunteers supporting families in Bogale township.

From September onwards, Red Cross staff and volunteers will have information and education material to support their psychosocial activities, and more than 40,000 brochures and posters will be distributed throughout the delta. Preparations are underway to distribute 900 psychosocial support community kits and more than 4,000 psychosocial family kits in the near future. Psychosocial support will not only be extended to the affected community - more than 260 Red Cross staff and volunteers will be debriefed by independent professionals at the end of 2008.

The MRCS staff and volunteers as well as the International Federation team are working at a pace that knows no time and limit; the headquarters in Yangon is more like a bee hive, operating day and night, overflowing with "angels of mercy" from all around the globe. The outside world may think that very little relief and recovery is happening in Myanmar, but the truth of the matter is that there is a gigantic task force of international and national organizations in this country, working side by side to support the affected population. The Red Cross, with its fleet of volunteers, is at the frontline.

References:

[1] Government of Myanmar, Association of South East Asians, United Nations, *Post-Nargis Joint Assessment (PONJA)*, July 21, 2008

Critical Incident Stress Management in a humanitarian context

A review and description of a recent training programme within the ICRC

By Stephen Regel & Normand Lessard

Introduction and background

It has been accepted that caring in any capacity is a potentially stressful process. Working for a humanitarian aid agency, whatever its mandate, will inevitably at some point bring people into stressful situations which at times may exceed their natural resilience and coping abilities. We know that working in a humanitarian context has a significant potential to be stressful, and that there are times when this stress can be exacerbated and magnified by traumatic events experienced at work. We also know that stress impairs well-being and that poor well-being impairs organisational effectiveness and performance. Therefore, it goes without saying that good management practices with regard to stress and staff support will enhance effective working practices.

This article describes a recent training on Critical Incident Stress Management (CISM) and Psychological Debriefing (PD)[1] for the International Committee of the Red Cross (ICRC), undertaken in collaboration with the International Federation Reference Centre for Psychosocial Support in Copenhagen, Denmark (PS Centre). It also explains the concepts of CISM and PD, and argues for the use of these techniques as valuable and well accepted staff support strategies following exposure to traumatic events.

Staff support has been highlighted as a key issue in humanitarian work, and its inclusion in the Inter-agency Standing Committee (IASC) task force on mental health and psychosocial support in emergency settings has emphasised the need for care of staff members working in emergency settings. The IASC guidelines[2] recognise that many aid workers often experience insufficient managerial and organisational support and that this tends to be the biggest stressor[3]. However, groups and individuals working for those organisations are also often confronted with daily horror, threat and human misery (especially in complex emergencies or conflict areas), which can be both emotionally challenging, demanding, and have the potential to affect the mental health and well-being of both volunteers and paid staff, whether they are international or local. The guidelines suggest support should be provided to staff that have experienced or witnessed extreme events (critical incidents, potentially traumatic events)[4].

Critical Incident Stress Management and Psychological Debriefing (CISM) and Psychological Debriefing (PD)

Many organisations utilise CISM and PD as staff support when groups or individuals are exposed to work-related critical incidents. CISM refers to a comprehensive, systematic and integrated multi-component crisis intervention package, which enables individuals and groups to receive assessment of need, practical support and follow up following exposure to traumatic events in the workplace. Therefore, CISM programmes should comprise of pre-crisis education,

Working in a humanitarian context has a significant potential to be stressful. In the photo we see a International Federation worker responding during the 2006 Pakistan earthquake.

assessment, defusing, Psychological Debriefing (PD) and follow up for ongoing psychological support if appropriate and necessary.

Both CISM and one of its main components, Psychological Debriefing, have proven to be controversial over the past decade, because of two pieces of research with injured, primary victims (road traffic accident and burn trauma survivors) which appeared to demonstrate negative effects. However, there is clear evidence from a number of organisations that the process continues to be in widespread use, but has been 'renamed'. In other words, PD continues to be used in many countries within the context of organisational support for personnel in a variety of situations e.g. emergency services, the military etc. It is often provided on a peer support basis. PD represents a structured form of group crisis intervention, with a discussion and review of the traumatic event or critical incident.

The technique has been described by Mitchell (1988)[5], who called it Critical Incident Stress Debriefing (CISD) and Dyregrov (1989)[6] who coined the term Psychological Debriefing. Since then, the terms (especially in Europe) have become interchangeable. The main difference (apart from the names of some of the phases) is that Dyregrov places more emphasis on process than does Mitchell. PD has also been developed within a European context and therefore reflects a different tradition for groups and structure than that of the United States. The other difference is the use of the word 'psychological', which may in some organisational and cultural contexts have negative connotations. The technique of PD is facilitated through a series of seven phases with some differences in the names of the latter phases (see fig. 1)

Mitchell (1988) stages of CISD	**Dyregrov (1989) stages of PD**
1. Introduction	1. Introduction
2. Facts	2. Facts
3. Thoughts	3. Thoughts (and expectations)
4. Reactions	4. Reactions (and sensory impressions)
5. Symptoms	5. Normalisation
6. Teaching	6. Future planning and coping
7. Re-entry	7. Disengagement

Figure 1. The seven stage technique of Psychological Debriefing and CISD

The technique was developed for groups of emergency service workers but has since been used far widely. Dyregrov defined PD as: 'a group meeting arranged for the purposes of integrating profound personal experiences, both on the cognitive, emotional and group level, and thus preventing the development of adverse stress reactions'. A typical PD would take 1.5 – 3 hours to facilitate and would usually be held 72 hours to 14 days post-incident. The aim of PD is also to provide education about normal and pathological reactions to traumatic events, indicate resources for further help and support if necessary, and begin to facilitate the process of coming to terms with the event. Most importantly, it was designed to facilitate early help seeking and also aims to facilitate normal recovery as resilience in personal growth. PD was never intended as a 'stand alone' intervention or as a substitute for psychotherapy and counselling, and was certainly never intended as a 'psychological treatment'. One of the most significant problems in terms of the research in this area over the past decade has been to treat the process as a 'psychological treatment'. This is an extremely important distinction, because not only has it influenced and driven the research methodology so far, with the inevitable problematic outcomes, but also leads consistently to the process being described in the academic literature (and in the media) as a treatment or 'counselling'. Inevitably, and equally important, this also influences the thinking behind the development of policy in terms of support mechanisms with the context of staff support, health and safety and occupational health and welfare provision. Given that CISM and PD have been used as a method of organisational support, it begs the question 'why provide support within organisations?'. Firstly, there is overwhelming evidence from 30 years of research that social support is a major protective factor following stressful life events and trauma. Secondly, there are different types of social support, e.g. informational, practical and emotional. Thirdly, the type of social support required is a function of context and individual needs and will vary over time. It is important to match provision to need.

In 2002, the British Psychological Society (BPS)'s Professional Practice Board Working Party produced their report on Psychological Debriefing[7]. The report highlighted two important areas for consideration. The BPS viewed provision of PD as a community support and cohesion strategy rather than as a treatment intervention to prevent Post Traumatic Stress Disorder (PTSD). Another important conclusion was that if PD was to be successful, it had to be undertaken by competent practitioners within an appropriate context and setting, with adequate training, supervision and support.

It is interesting that even the current best practice guidelines in the UK published by the National Institute for Health and Clinical Excellence[8] on the assessment and management of PTSD and early interventions for trauma, acknowledge that '… there is a paucity of methodology

The IASC task force on mental health and psychosocial support in emergency settings has emphasised the need for care of staff members working in emergency settings. In the photo, the ICRC distributes aid to the displaced population in Eastern Chad.

sound early intervention studies, containing detailed descriptions of training and fidelity checks on interventions used'[9]. Therefore, CISM and PD are used primarily as an organisational support cohesion strategy in many organisations and not as a preventative measure against PTSD. The ICRC peer support programme and training reflect this ethos.

Use of CISM and PD in the ICRC

The ICRC is one of the leading humanitarian aid organisations and faces a significant number of challenges in relation to the work that it does all over the world, particularly in conflict areas. The organisation has over 11,000 local and international staff in the field all over the world, working in a variety of contexts and settings. The organisation has had a Stress Unit since 1993, which is linked with security under operations. This Stress Unit has an advisory role to operations and provides training, stress management and CISM. Within the CISM process of the ICRC, psychological debriefing is described as 'Debriefing Emotionnel'. Whilst essentially the same as PD, the terminology has remained the same as its meaning is well recognised and understood throughout the organisation.

CISM and PD training at the ICRC

The training was held in November 2007, at the ICRC training centre at Ecogia, just outside Geneva. The training was facilitated by the authors (SR representing the International Federation Reference Centre) and included 10 participants, all experienced medical and nursing personnel working as health delegates for the ICRC. Participants were at the time of the training working in locations as diverse as Darfur, Colombia, Sierra Leone, Senegal and Geneva.

The training course in CISM and PD used with the ICRC has been developed by the Centre for Trauma, Resilience and Growth in Nottingham, UK[10]. It has been facilitated for over ten years with a variety of organisations in the UK and abroad. The training aims to provide a sound theoretical foundation and skills base for current developments in trauma and CISM, together with the most recent developments in PD techniques, practice and research.

This intensive five day training programme was specifically designed to provide participants with skills based training, and evaluation of practice using audio visual feedback. The first two days concentrated on theoretical issues, allowing opportunity for discussion and questions, then moved on to concentrate on the practice of PD, providing opportunities for practice and reflection on practice. Theory covered common responses to trauma; the nature and characteristics of post traumatic stress; the nature of traumatic stressors; assessment of risk and vulnerability factors; the effects of trauma on the individual, family and communities; the role of attitudes, beliefs and attribution factors in the development and maintenance of trauma. A combination of teaching and learning methods were used, of which the most important was the use of videotaped feedback for participants following the group exercises and experiential learning. Each participant was required to facilitate a 50 minute role-play of the PD process and to be part of a 'debriefed' group, and also had the opportunity to observe the process. A recently developed tool for assessing competency in the PD process (PD Competency Checklist) was used, which gave participants detailed feedback on their fitness for practice.

The training was extremely well evaluated by participants, all of whom felt that they had gained valuable skills in the process. Most importantly, there was the recognition that this was a valuable crisis intervention tool and process and *not* counselling or therapy. The identification of risk factors and psycho educational components, together with the encouragement of personal coping resources were identified as being

valuable aspects of the process, as was the understanding of use of PD as a means of organisational support with in a CISM process. Furthermore, the distinction between PD and operational debriefings was well established, the former being for supportive and other reasons mentioned above.

Conclusion

The academic literature is less than helpful for our understanding of early interventions for trauma with a persistent tendency to quote the same studies, without any clear understanding of the history, development, aims and use of CISM and PD. There are also a number of studies which attest to the effectiveness of the process[11] and the fact that CISM and PD is in widespread use[12] is clear evidence that it is and continues to be a useful and well accepted staff support strategy following exposure to traumatic events. Finally, many major international humanitarian aid agencies utilise CISM programmes. The United Nations Department of Safety and Security Consultative Working Group approved the use of CISM in 2007. In addition, many other law enforcement agencies and emergency service providers in Europe, Scandinavia, the US and Australia use CISM. In the UK, the British Royal Marines have also adopted and adapted CISM/PD to suit their needs.
This provides ample evidence that it has utility in the context of post trauma support in the workplace. Calls for the cessation of CISM/PD in the emergency services and similar contexts have been demonstrated to be premature. It has an important psycho-educational role and facilitates identification of individuals experiencing acute stress reactions (who are at greater risk of developing longer term disorders). It is also clear that CISM and PD ca only be effective as a crisis intervention strategy with adequate training, support and supervision for those acting as peer supporters. Finally, the clinical practice recommendations with the NICE Guidelines indicate that:

"…we do recommend the good practice of providing general practical and social support and guidance to anyone following a traumatic incident. Acknowledgement of the psychological impact of traumatic incidents should be part of healthcare and social service workers' responses to incidents. Support and guidance are likely to cover reassurance about immediate distress, information about the likely course of symptoms, and practical and emotional support in the first month after the incident. Abandoning CISM and components such as psychological debriefing sends out a dangerous message that doing nothing for individuals and groups following traumatic events is acceptable, leaving employers neglecting an important duty of care.[13]"

Further Reading:

Deahl M. et al (2001) Evaluating Psychological Debriefing: Are We Measuring the Right Outcomes? *Journal of Traumatic Stress, Vol. 14. No.3, 527-529*

Dyregov A. (2003) Psychological Debriefing: A Leader's Guide for Small Group Crisis Intervention. Chevron Publishing Corporation, Ellicott City

Dyregrov A. (1997) The Process in Psychological Debriefings. *Journal of Traumatic Stress Vol. 10, No. 4, 589-605*

Dyregrov A. (1999) Helpful and Hurtful Aspects of Psychological Debriefing Groups. *International Journal of Emergency Mental Health Vol. 3, 175-181*

Everly G.S., Mitchell J.T., (2000) The Debriefing "Controversy" and Crisis Intervention: A Review of Lexical and Substantive Issues. *International Journal of Emergency Mental Health Vol. 2, No. 4, 211-225*

Regel, S., Dyregrov, A., Joseph, S (2007) Psychological Debriefing in cross cultural contexts: Ten implications for practice, *International Journal of Emergency Mental Health, 9(1):37-45.*

References:

[1] Also known as Critical Incident Stress Debriefing (CISD), but the two terms refer to the same technique. Fr the sake of clarity the term Psychological Debriefing will be used throughout this article

[2] IASC (2007) Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, IASC.

[3] IASC (2007), Action Sheet, 4.4, p87

[4] IASC (2007), Action sheet 4.4.6, page 90

[5] Mitchell J.T. *(1988)* Development and Functions of a Critical Incident Stress Debriefing Team *Journal of Emergency Medical Services, , 43-46*

[6] Dyregrov., A (1989), Caring for Helpers in Disaster Situations: Psychological Debriefing. *Disaster Management, Vol. 2, No. 1, 25-30*

[7] Psychological Debriefing (2002) Report by British Psychological Society Professional Practice Board Working Party. British Psychological Society, London

[8] www.nice.org.uk

[9] National Institute for Health and Clinical Excellence (2005) Post Traumatic Stress Disorder: The Management of PTSD in Children in primary and secondary care. Gaskell and British Psychological Society, London

[10] www.nottinghamshirehealthcare.nhs.uk/trauma

[11] Richards D. (2001) A field study of critical incident stress debriefing versus critical incident stress management. *Journal of Mental Health Vol. 10. No. 3, 351-36;*, Deahl M., Srinivasan M., Jones N. (2000) Preventing psychological trauma in soldiers: the role of operational stress training and psychological debriefing. *British Journal of Medical Psychology Vol. 73, 77-85;* and Dyregrov A., Gjestad R. (2003) A Maritime Disaster: Reactions and Follow-Up. *IJEMH Vol 5, No. 1, 3-14*

[12] Regel, S., (2007) Post Trauma Support in the Workplace: The Current Status and Practice of Critical Incident Stress Management (CISM) and Psychological Debriefing (PD) within organisations in the United Kingdom. *Occupational Medicine, Vol. 57, 411-416; and* Jones N., Roberts P., Greenberg N. (2003) Peer-group risk assessment: a post-traumatic management strategy for hierarchical organisations. *Occupational Medicine Vol. 53, 469-475*

[13] NICE. (2005) op.cit, chapter 7, 87

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Tsunami lessons learned - Denpasar multi-country workshop

By Pernille Hansen, International Federation Reference Centre for Psychosocial Support.

In the previous edition of Coping with Crisis, the ongoing project of collecting lessons learned on the psychosocial response to the tsunami was presented. The latest activity in this project was a three day workshop held in Denpasar, Indonesia in June 2008. The 35 participants included psychosocial programme representatives from Operating National Societies (ONS) in the five countries worst affected by the tsunami: Thailand, Indonesia, India, Sri Lanka and the Maldives; as well as from the International Federation and the Participating National Societies (PNS) of America, Denmark, Belgium, Canada and Turkey.

Clear advice

An incredible enthusiasm and commitment to the tasks at hand led to three successful days of discussions and presentations that considered best practises, challenges and lessons learned, leading to very concise and exact recommendations for five different levels of programme operation: field (branch) and headquarter level in an affected country; PNS psychosocial delegation; Geneva/PNS headquarter; and for the PS Centre. The recommendations clearly reflected common challenges experienced across country borders and concerned planning, implementation and monitoring and evaluation procedures of psychosocial programming. Important issues that recurred at all levels were:

Cultural appropriateness: not only of activities, but also communication styles; entry to the community; assessment methodologies; and ways of engaging full community participation and ownership
The need for ongoing capacity building: of programme staff, volunteers and of other local counterparts to serve as a long term skills-investment and an opportunity of sustainability for psychosocial support activities beyond project lives
Coordination and partnership: with stakeholders nationally and internationally to promote collaboration and thus enable holistic responses that are according to international standards and guidelines
Volunteer management: to secure volunteer interest, motivation and well-being
Advocacy: and promotion of psychosocial support issues and responses both nationally and internationally

A few solid recommendations were also made for psychosocial aspects of disaster planning and preparedness. These focused mainly on the establishment of a clear policy environment with minimum standards for psychosocial support programming, and guidelines and tools that could support such developments. The PS Reference Centre was encouraged to develop a global framework for the Red Cross Red Crescent Movement as part of promoting international standards.

35 participants from National Societies and the International Federation spent three intensive days in Denpasar, Indonesia, to discuss and produce recommendations.

Follow-up of recommendations

The very useful recommendations are presently being used in preparation for a meeting with partners to be held in Washington in early September 2008. This meeting involves management representatives of the above listed PNS who have been central in the psychosocial response, as well as other major stakeholders such as UNICEF, Save the Children, IMC and WHO. Strategic issues identified through the Lessons Learned project will be discussed, with the ongoing aim of improving future psychosocial responses. This activity goes hand in hand with the finalisation and production of practical tools for future planning and implementation of psychosocial programmes, also based on the findings of the Lessons Learned project. Links to these tools will be included in the next Coping with Crisis.

Side note: The full report of the workshop in Denpasar can be obtained from pha@drk.dk

Psychosocial support in the Middle East and North Africa Zone

By Naglaa Rashwan, regional psychosocial coordinator, MENA Zone

The Red Crescent and Red Cross Societies and other humanitarian actors are increasingly aware of the importance of integrating psychosocial support into their emergency response mechanisms. Integrating psychosocial strategies has been identified as important for National Societies in order to enhance the resilience of vulnerable populations, protect and ensure the psychosocial well-being of staff, volunteers and the larger community.

In this context, psychosocial support is a strategic priority of the new MENA Zone management. A meeting of the regional psychosocial support network was organized in cooperation with the PS Centre and hosted by the Syrian Arab Red Crescent Society in Damascus from 7-8 November 2007. The outcomes of the meeting included the reactivation of the regional network; an aim to prioritize psychosocial support in the National Societies; and the articulation of the need for a zonal plan of action.

After the network meeting, a preparatory group consisting of psychosocial focal persons from five National Societies in the region set clear objectives and an agenda which were then discussed in the next network meeting in Libya 19-22 April 2008. It had the following four outcomes:

A regional plan of action 2008-2009 focusing on establishing psychosocial support units in National Societies, strengthening the psychosocial support programme model, and integrating psychosocial support in other relevant programmes

A psychosocial support model for National Societies to adopt, containing guidelines for the development of psychosocial support programmes. The model covers the issues to be considered in the planning of such programmes, including the psychosocial concept, strategic objectives, target groups, levels of interventions, mechanism of implementation, methods for evaluation and follow up, and recommendations on helpful resources appropriate to the culture and context of the zone.

The establishment of a regional psychosocial support team to support the implementation of the plan of action and the development of the psychosocial model in the region. The regional team consists of seven National Society psychosocial focal persons, and will strengthen psychosocial support in the region through providing trainings, encouraging coordination and collaboration in the region, and intervening with other regional teams during emergencies. The team will conduct research on relevant topics, introduce recent development in psychosocial interventions, and do evaluations and follow-up of these. The team met for the first time in Jordan in the middle of August (in the production period of the current issue of Coping with Crisis) to establish its plan of action.

Participants of the MENA psychosocial network meeting in Libya, April 2008.

The appointment of a regional psychosocial support programme coordinator who will support the regional team in implementing its plan of action, and also support the regional network, coordinate work with the National Society focal points, provide technical support, and support country level planning and training. The coordinator will also encourage sharing of information, experiences and best practices both among the National Societies in the region and with other humanitarian partners.

The MENA Zone will provide continuous support for the psychosocial support work of National Societies. The revitalization of the psychosocial network is one way to ensure this support. From the zonal point of view, the network meetings are the key instrument for technical staff to meet and to develop collective priorities for psychosocial support in the region. The network will be the regional body to pursue technical and operational excellence, and it will serve as a bridge between global strategies and local actions. The network will develop action plans to be followed up at both national and regional level.

Psychosocial support in operations funded by Disaster Relief Emergency Fund

By Elizabeth Soulié, Operations Support Department , International Federation

The Disaster Relief Emergency Fund (DREF) of the International Federation provides immediate financial support to National Red Cross and Red Crescent Societies responding to disasters. Allocations are made either as a loan of start-up funds for major disaster response operations for which an emergency appeal is launched, or as a grant to cover to costs of smaller-scale operations for which no appeal is launched. The amount of allocations made to support small-scale relief operations is growing and represented 60 per cent of the total in 2007.

Psychosocial support for people affected by disasters and for the volunteers and staff who bring assistance to them is an important part of relief operations and the costs can be covered by the DREF allocation. As the number of DREF operations increases, the numbers of examples of psychosocial support given by National Societies also increases in DREF reports. Some recent examples are given here.

The Kazakhstan Red Crescent Society was called to support miners and their families in January after an explosion of methane gas in the Abay mine in Kazakhstan's Karaganda region and consequent fires left thirty miners dead.


Kazakhstan Red Crescent

The Russian Red Cross brought its expertise to assist the Kazakhstan Red Crescent and trained 13 volunteers from the Karaganda branch to carry out a psychosocial support programme. An excellent report on the operation can be found on the International Federation public website: www.ifrc.org/docs/appeals/08/MDRKZ00101.pdf

In South America the **Argentine Red Cross** (ARC) has responded to flooding both this year and in 2007.


Argentine Red Cross

Psychosocial support was part of the assistance that the ARC brought to families who lost their homes and were evacuated to shelters, especially for the children. Although psychosocial support was previously perceived by the ARC as an activity to be carried out by professionals, strengthening the capacities of volunteers in this area proved to be very positive and successful and greatly appreciated by the communities affected. www.ifrc.org/docs/appeals/rpts08/MDRAR00301.pdf

The **Uganda Red Cross Society** (URCS) is frequently called upon to carry out response operations for outbreaks of epidemics. In November 2007, they responded to an outbreak of Ebola in the south-western part of the country. Through the support of the World Health Organization, 130 volunteers were trained in psychosocial support to enable them support the affected households, who had been subjected to discrimination and stigmatization within their communities. The psychosocial support offered by the URCS volunteers went a long way in resolving the stigma. The trained volunteers provided counselling services to 140 families and continually monitored their progress. Eventually, the communities were able to integrate those affected as a result of higher levels of awareness of the outbreak through the vigorous anti-stigma campaigns carried out by the National Society volunteers. www.ifrc.org/docs/appeals/07/MDRUG007fr.pdf

Announcement:

Ananda Galappatti, a psychosocial practitioner for the past 12 years from Sri Lanka has been awarded the 2008 Ramon Magsaysay Award for Emergent Leadership. Galappatti has done consultancy work for among others the American Red Cross and the International Federation Reference Centre for Psychosocial Support. He is being recognized for "his spirited personal commitment to bring appropriate and effective psychosocial services to victims of war trauma and natural disasters in Sri Lanka."


Pernille Hansen/PS Centre

The awards are given in six categories annually to Asian individuals and organizations for achieving excellence in their respective fields. The Award for Emergent Leadership honours "individuals, forty years of age and below, doing outstanding work on issues of social change in their communities, but whose leadership is not yet broadly recognized outside of these communities.

REVIEW

Risk and vulnerability factors following exposure to stressors

A recent report on mental health in the UK indicated that 16.5 % of people aged 16-75 suffer from some form of mental illness, with depression and anxiety making up the largest proportion of sufferers[1]. What this suggests is that whilst many people will be resilient and cope well with adversity, there may be many who do not have the human or social capital to draw upon.

By Peter Berliner & Stephen Regel

It is well documented that there are significant risk factors for the development of traumatic stress following disasters and emergencies[2,3,4]. It is also generally documented that changes, sometimes rapid, are taking place within many societies and cultures, and that there is a greater sense of isolation, alienation and withdrawal amongst some communities. Resilience at the community, family and individual level may be challenged by this[5].

Many of the studies reviewed by the two most significant meta-analyses of risk factors[2,3] do not include studies with victims of disasters in different cultural contexts and settings. Therefore, these may need to be interpreted with some degree of caution when examining risk and vulnerability to trauma across cultures. However, it is noteworthy that the risk factor with the highest effect in all the studies reviewed was that of a lack of social support.

Groups of risk factors

It is important that these risk factors are considered when planning and implementing psychosocial programmes, both in general and when providing support for particularly vulnerable groups. The risk factors can be broken down into two groups. The first can be considered general risk factors for developing post traumatic stress reactions. These include:

- Previous stressors
- Previous psychological problems
- Family psychiatric history
- Poor social support
- Gender (the risk is higher for women)
- Younger age groups
- Acute stress response
- Lack of education and lower socio-economic status
- Childhood abuse and adverse childhood circumstances

The second group of risk/vulnerability factors are those that are often considered to be 'peri-traumatic', i.e. factors which occur around the specific time of the event and these often include:

- Proximity to the event
- The individual experiences a loss of control
- Subjective life threat – they believe that they were going to die at the time of the trauma
- Guilt - often this takes the form of survivor guilt or over acts of commission or omission i.e. with the latter, the person believes that as a result of their actions or inaction a catastrophe befalls others
- Event involves death, serious injury or near miss
- Peri-traumatic dissociation – which can be described as a range of processes that involve disruption of the usually integrated feelings of consciousness, memory, identity or perception, e.g. the person may describe feeling as 'if time has stood still', 'everything was happening in slow motion'

Often it may be the complex and multifaceted interplay between many of these factors which dictate social and psychological outcomes. .

References:

[1] Centre for Economic Performance (2006). *The Depression Report.* The Centre for Economic Performance, London School of Economics and Political Science. http://cep.lse.ac.uk/research/mentalhealth

[2] Brewin, C. R., Andrews, B., and Valentine, J. D. (2000). Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults. Journal of Consulting and Clinical Psychology. Vol. 68 (5),748-766.

[3] Ozer, E. J., Best, S. R., Lipsey, T.L. & Weiss, D. S. (2003). Predictors o Posttraumatic Stress Disorder and Symptoms in Adults: A Meta-Analysis. Psychological Bulletin. Vol. 129(1), 52-73

[4] Perkonigg, A., Kessler, R. C. & Storz, S. (2000). Traumatic Events and Post-traumatic Stress Disorder in the Community: Prevalence, Risk Factors and Co-morbidity. Acta Psychiatrica Scandinavica. Vol. 101, 46-59.

[5] Orford, J. (2008) Community Psychology – Challenges, Controversies and Emerging Consensus. Wiley: Chichester.

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