Responding to the Psychological Consequences of Disaster: Lessons for New Zealand from the Aftermath of the Georgian-Russian conflict in 2008

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The authors report experience in providing trauma-focused CBT training to 10 Georgian psychologists and psychiatrists following the 2008 Georgian-Russian conflict, and the experiences associated with the practicum involving victims and the actions of government and international agencies in the aftermath of that conflict. This serves as a backdrop to suggestions relating to the human issues that arise in the aftermath of the Christchurch earthquakes and for the delivery of post-disaster services in New Zealand. It is argued that psychologists should be included in our disaster response planning and in the response to any major disaster.

We have been involved in training, researching, and developing services for children in Georgia for 15 years and have established Children of Georgia, a non-governmental organisation (NGO) which advocates on behalf of and for orphaned and disabled children in that country. Georgia became involved in a five-day military conflict with Russia over long-disputed territory in August 2008 and we had just left Georgia before the conflict broke out. Two months after the cessation of hostilities we returned to Georgia to assist in the provision of psychological trauma services for conflict victims. Over 160,000 people were displaced from the two regions of Georgia, Abkhazia and South Ossetia, caught up in the fighting. In addition, many Georgian residents in the adjoining regions came under air or artillery attack and, in some instances, intrusion by Russian troops. The surviving victims of the struggle were in shock. Many had experienced or learned of unexpected and sudden death of family members, injury, rape, beatings, incarceration, loss of home, livelihood, separation from family and friends. Some had the additional strain of two to three days and nights trekking towards Georgian-controlled territory while trying to avoid capture by the South Ossetian militia or their Russian allies.

In the aftermath of the conflict, the dispossessed and displaced persons faced placement from rural communities into tent villages or abandoned Government buildings in cities which frequently were unfit for habitation due to broken windows and lack of adequate cooking, toilet and bathroom facilities. Often, where families were intact, several generations were sharing single rooms. Many of them also faced a number of relocations over the following months, anxiety about the fate of missing family and friends, and a lack of social and mental health support services, minimal financial support, and no opportunities to work. Children who had been uprooted from village life eventually found themselves placed in unwelcoming urban schools, isolated from friends and peer group, and living with distressed and, in increasing numbers, angry and depressed adults, some of whom (mostly males) turned to substance abuse and domestic violence. After 12 years involvement in Georgia, we were aware of the absence of psychologists and psychiatrists with training in cognitive behaviour therapy (CBT) or knowledge of diagnosis and treatment of psychological trauma. We were also aware that the initial international disaster response would most likely last for a maximum of three months, leaving the small and essentially under-qualified and largely unprepared local mental health services to pick up the burdens of post-war trauma that would continue to emerge with the passage of time. Consequently, we returned with the intention of offering an intensive programme of trauma-focussed CBT training that would train mental health professionals as both therapists and competent trainers. This was in keeping with the philosophy of our work in Georgia, which has always been to leave behind locals with knowledge and skills for both

independent practice and dissemination to others.

From this Georgian experience we identified some relevant strategies for application to disaster response in New Zealand which, due to its vulnerability to significant seismic, volcanic and climatic events, needs to have available psychological services to meet the human consequences of natural disasters. We foreshadowed some aspects of this in an earlier paper (Parsonson & Rawls, 2010) and expand upon them here.

Establishing a Training Programme

Our first action was to make contact with regional UNICEF and the World Health Organisation (WHO) teams co-ordinating the mental health responses to the conflict's victims by local and international NGOs. It was evident that there was no planning for the longer term trauma that would surely emerge over time. Nor was there any financial provision to support training of personnel for that eventuality. The entire focus was on psychological "first aid," often involving essentially untrained individuals who were tasked with setting up activity centres for children and "counselling" for adults. Thus, the need for training in trauma-focused CBT was evident so we planned a curriculum and began to recruit potential trainees.

The trainees

Seven female psychologists with post-graduate training in clinical psychology and one female and two male psychiatrists (one still an intern) were selected for the programme following a call for expressions of interest. All met the training criteria in that they had some experience of clinical work and all spoke and read English well enough to understand the lectures and course readings. They also had to be available to stay in the programme for six days per week and for the planned duration of seven weeks. Given the need, their various employers were keen to involve them in the programme and agreed to these terms. While no trainees had been directly involved in the conflict, all had had contact with family, friends, or associates who had had more direct experience or some experience of clients seeking help for trauma related disorders as a result of involvement.

The training programme

The seven week programme was designed to provide skills for assessment and intervention with trauma victims. It comprised lectures, discussions, problem-solving, set readings and research reviews as homework, supervised practicum and practice at teaching and disseminating the newly learned skills. Participants were graded on participation, homework completion, practicum performance and dissemination skills. The final examination activity involved presenting a team seminar on trauma and CBT to staff of NGOs and international organisations likely to benefit from training they could now offer. In addition, from the beginning, there was agreement that we would protect each other from personal traumatisation from course content or processes.

The initial focus was on training in assessment, including clinical interviewing using systematic modes of information gathering on demographics, trauma exposure, problem identification and what symptoms were present, when, where, how often they occurred, etc., and use of data gathering methods such as SUDS (Subjective Units of Distress), to obtain a quantitative measure of intensity of experienced emotional response. There was also coverage of the diagnosis of trauma-related disorders, especially acute and later-emerging trauma-related symptoms, and the commonly associated disorders such as depression, panic and anxiety disorders, sleep disturbance and phobias. In addition, identification of such collateral problems as substance abuse, self-medication and domestic violence was included.

Once trained in assessment and diagnosis, the trainees were taken to two "Collection Centres" for internally displaced persons (IDPs) set up by the hastily formed Georgian Ministry for Refugees, one in Tbilisi and one in Gori. Here they consulted with community leaders and centre organisers to identify potential adult and child clients. Once informed consent was obtained, these persons were interviewed and diagnosed under our supervision and planning of appropriate interventions was undertaken in the setting of the class. The trainees had to learn to cope with the very distressing revelations of these clients, mostly the elderly, women, and children, and to comprehend the great losses experienced and the current life challenges that they faced. Potential male clients typically denied symptoms or problems described by their wives or mothers and all refused to participate.

Concurrent with ongoing assessment and initial intervention planning, training in CBT was initiated. This focussed first on basic knowledge of CBT and then on building skills in a range of techniques including anxiety, panic and sleep-disturbance management through diaphragmatic breathing and deep muscle relaxation, graduated exposure and systematic desensitisation to assist with reducing avoidance, phobias and panic. Managing re-experiencing, normalising and reinterpreting trauma responses such as numbing and hypervigilance via cognitive restructuring, and CBT strategies for depression and anger management were also included. As these skills were gained, the trainees, again under our supervision, began the planned interventions, primarily for sleep-disorders, re-experiencing, panic and anxiety attacks, avoidance and hypervigilance, as well as for anger and depression.

Some clients presented with psychosomatic symptoms, in part because this is a more socially acceptable expression of psychological disorder in Georgian society. Naturally, we found that each client had responded differently to their personal experience of trauma. We found that the trainees became captivated by the observed and reported changes in their clients, signalling that the efficacy of their newly acquired skills had won their understanding of how beneficial this approach to intervention could be.

Following successful completion of their training, a number of the graduates went on to work with NGOs and mental health services, providing both interventions and training within those organisations. In addition, they helped establish a Georgian Association for Cognitive Behaviour Therapy to encourage and support the expansion of local interest in CBT.

Outcomes of the training relevant to New Zealand

Firstly, it was evident that mental health professionals without prior knowledge of CBT could be trained within a short but intensive period of time to a good level of competence using the training model we applied,. This meant a core group of trainers of trainers could be available to go to a disaster zone and both contribute to interventions for traumatised persons and up-skill local professionals so that they, in turn, could continue to offer effective psychological trauma intervention services to the community over the longer term.

Secondly, the Psychology Department of the Tbilisi State University asked us to adapt our training programme to enable their staff to deliver it to clinical psychology graduate students so that it could be incorporated into a broader course on CBT. We successfully trialled this adapted programme with Georgian graduate students in 2009 and shared the curriculum with the University. This suggests that our New Zealand post-graduate clinical, educational, and other professional practice psychology courses could very usefully incorporate trauma-focussed CBT into their programmes as a contribution to future disaster response capacity. These potential contributions from clinical psychology are especially important given that post-traumatic symptoms may affect a significant proportion of a community exposed to a major traumatic event (Bal, 2007; Briere & Scott, 2006 and may continue to evidence themselves long after the traumatic event(s) (Bal, 2007; Koenen et al., 2008) .

Coordinating the Mental Health Response

Any disaster of significant magnitude cannot be coped with by local organisations and service providers alone. In Georgia there was a massive international response involving the International Red Cross (IRC), Médicines sans Frontièrs (MSF) and a number of smaller aid organisations such as Terre des Hommes. These and local NGOs offering mental health services were co-ordinated by the World Health Organisation (WHO) mental health cluster panel which we (as part of the Children of Georgia NGO response) joined. What this cluster approach did achieve through its weekly meetings was a record of who was doing what and where and how many IDP ‘collection centres’ were being served and by whom. It was also possible to monitor where there were gaps in the service provision and what new issues were beginning to become evident. For example, increases in domestic violence and substance abuse were identified early, as was the emerging problem of serious and untreated trauma among the military and emergency service personnel. The absence of any local specialist services that could recognise and address these problems within the community or the military and emergency services was a major concern that remained unresolved at the time.

On the downside, we quickly discovered that while it was a sound idea to invite participation in a coordinated approach to service delivery, there was a distinct lack of mental health expertise among most of those organisations represented at the meetings. In addition, there was no process for determining who could actually offer appropriate services to the large and widely dispersed population of internally displaced persons flowing into Georgian towns and cities from the conflict zones and the associated “buffer” zones bounding the disputed territories. In addition, it was evident that major international aid organisations, such as the IRC and MSF, initially did not actually collaborate or co-operate with local service providers. For instance, our offers to train local psychologists for MSF were rebuffed and their chief mental health professional had not heard of CBT and insisted on a psychoanalytic approach. We also encountered “territorial” challenges from MSF when we began training our team because they considered one of the IDP ‘collection centres’ was in “their” area, even though no service was provided at this location by their staff. Fortunately, the latter situation was resolved amicably at the local level and our training effort and the subsequent work in that centre by members of our team went unhindered.

The WHO cluster meeting also allowed for planning around data gathering and follow-up in the affected communities. A subgroup, which included members of Children of Georgia, World Vision and the local branch of the Global Initiative in Psychiatry (GIP) worked on a survey designed to assess the impact of the conflict, the adequacy of the post-conflict service delivery, and access to, and availability and quality of, essential mental health services in IDP and “buffer zone” communities. The data from this survey were analysed and reported back to the WHO (Rawls, 2009), revealing the need for more effective, community-based diagnostic and intervention services into the buffer zone and identification of the barriers to services that confronted persons located outside of the major population centres, where most of the available services were concentrated. When IDPs presented with trauma-related disorders, available medical services commonly prescribed out-dated, , medications, such as benzodiazepines, despite psychiatrists warning against such use. Perhaps this was all that was available. A complication is that such disorders were often presented by patients as physical symptoms to avoid the stigma of mental illness.

Outcomes of coordinating a mental health response

Firstly, having a coordinated response and monitoring procedure, such as that of the WHO mental health cluster, was good: it provided a degree of oversight, organisation, and order in the service delivery process.

Secondly, it allowed for a degree of sharing between participating service providers over what services and skills were available and education on the nature of appropriate (best-practices) and inappropriate responses to trauma.

Thirdly, it pointed to the need for disaster response co-ordinators to have some process for evaluating the quality and likely efficacy of support services that a wide range of organisations were prepared to offer.

It is now well established (e.g., Amaya-Jackson & DeRosa, 2007; Foa, Keane, & Friedman, 2000) that CBT is the most effective intervention for trauma and that approaches such as post-event counselling can actually interfere with recovery (Foa et al., 2000). While psycho-educational programmes are likely to be effective for some, there need to be diagnostic and triage systems in place for identifying and referring more severe cases of trauma to appropriate psychological services.

In addition, the community survey revealed a need for a multi-level response to trauma identification and referral. For example, teachers, public health nurses, and some local community service providers needed to be trained to recognise emerging trauma symptoms and to know where to refer potential clients to appropriate services. In more isolated or small-town rural communities, primary health care providers needed training in provision of psychological first aid and in the diagnosis of trauma disorders. In some instances, the training of teachers, selected parents, or even older school children in school-based disaster preparation could help in this process.

It is evident from the Georgian experience coordination is important, to prevent friction between different service providers and to avoid overlap and concentration of services in some areas and an absence of services in others. The community survey also identified previously unrecognised barriers to service access, such as distance, isolation, lack of transport or funds to pay for services, gaps in the service provision outside of main centres, and areas of unaddressed need, such as lack of adequate food, heating and blankets in collection centres in the face of an impending winter.

There needs to be an awareness that psychologically traumatised people left without the means to access diagnostic and treatment services will often resort to self-medication, either misusing prescription medications or opting for alternative, non-prescription drugs or substances. There is a need to educate GPs in appropriate forms of medical care so that prescription of psychotropic medication is not the sole or primary intervention for persons presenting with symptoms of trauma or trauma related disorders following a disaster. Finally, the Georgian situation also highlighted the need for central and regional government and the disaster response coordination body to have representation by appropriately qualified psychologists and for these bodies to be prepared to hear and respond to human needs and concerns rather than to primarily focus on damaged infrastructure alone.

The Relocation Phase

With large numbers of distressed people in temporary and/or very poor quality housing, with inadequate resources, services and support and the onset of winter around the corner, the authorities, already overburdened by the enormity of an unexpected event, took far too long to put together a systematic approach to identifying and relocating families and communities. As a result, anger, resentment, further distress and a loss of faith in the authorities emerged. These emotions were typically expressed very strongly to any agency, especially those involved in disaster relief and welfare, visiting centres where the people felt abandoned and disenfranchised. Sometimes the response by the authorities was to simply avoid or abandon such centres, which only had the effect of increasing both distress and anger in the effected population.

As its response following the conflict, the World Bank provided USD20 million in housing redevelopment aid, along with approved plans for construction of dwellings for IDPs on government land in rural areas, some within sight of the South Ossetian lands from which the IDPs had been evicted. The houses were small, built in long rows and had shared outdoor long-drop toilet facilities, with one toilet between every four houses. Water was not reticulated to homes; communal hand pumps, drawing water from the aquifer, were provided. The overriding focus was on getting a roof over peoples' heads within relative safety. There was a complete absence of urban or social planning, with no provision for schools, churches, shops, community centres or sports fields. The rural location meant that access to work (if there was any), schools, and services was only possible with some form of vehicular transport. Due to a lack of consideration of the need for social planning, there was no deliberate component in the World Bank response to try to assign people from the same villages or neighbourhoods into the new settlements, ignoring the traditionally strong Georgian affiliations with their home villages and neighbourhoods. This failure in planning exacerbated the great sense of social disruption that overwhelmed many of the displaced families. Often, after visiting these houses, families chose to stay in their existing inadequate collection centre housing and wait for a promised government grant to fund the purchase of their own accommodation. This often led to their expulsion from their temporary accommodation and some are still waiting for relocation and/or the government payout. Others simply chose to return to unsafe areas dubbed "buffer zones" and live in a constant state of vigilance as the price of providing shelter for their families.

Outcomes of relocation relevant to New Zealand

Firstly, after a major disaster, such as that in Christchurch, it is essential that already traumatised and distressed persons have good information and access to services in the immediate aftermath and that there is ongoing consideration of their needs, along

with identification and rapid resolution of barriers to accessing services and to housing and employment problems. Normalisation is an important component of the trauma recovery process. The longer people are left to their own devices, with their lives in tatters and no sense of an end to the abnormal conditions in which they find themselves, the greater the social upheaval and emotional distress they are likely to experience.

Secondly, promises made need to be promises kept. Anger, disappointment and disaffection with the bodies responsible for getting people back on their feet are all likely to provoke in the population a deep sense of disapproval of the efforts of the authorities and a belief that no one is listening to their cries for help, further adding to their trauma.

Thirdly, when relocation does occur, it needs to have been planned in the context of cultural and social structures that existed in the original communities from which the persons have been displaced. Keeping families and neighbourhoods together so that they can maintain or re-establish bonds and relationships has to be a consideration when re-housing people from destroyed communities, as does planning for meeting the social, educational, religious, occupational, and lifestyle needs of those communities in the new setting. This points to a clear need for social and community psychology contributions and also broader social science input into the needs assessment and planning for newly constructed communities, rather than limiting the focus to urban planning, architecture and essential services, matters which seem to dominate reconstruction efforts.

Conclusions

Although the Georgian experience arose out of war rather than a natural disaster, some of the lessons learned from the way the aftermath was handled can be seen to have bearing on the pre- and post-natural disaster planning in New Zealand. There is a need for:

- training of the health professional workforce in effective, evidence-based short- and long-term trauma interventions
- including psychologists in the disaster response planning process
- having psychologists assist with coordination of mental health services and service provision so that these operate efficiently
- use of psychological knowledge and research skills in evaluation of post-disaster needs and in planning and seeing through any resettlement programmes that are necessary.

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