Psychological Intervention in Major Emergencies: An Asia-Pacific Perspective

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Our aim in this paper is to examine what might constitute good practices for psychological intervention in any major or complex emergencies that can be anticipated occurring in the South-West Pacific, Australasia and southern South East Asia region. We do not believe there can be a singular 'best practice' that can be prescribed for such events, rather that through discussion broad guidelines can be developed to inform decision makers about what would constitute probable good practices when a major emergency occurs.

Definitions

The events we are concerned with are termed major or complex emergencies. The term complex emergency being defined by the United Nations Convention on the Rights of the Child, Article 38 as situations in which the capacity to sustain livelihood and life are threatened, particularly when high levels of violence are involved (Heller, 2006). Within these categories of emergency we include all events, whether caused by human agency, natural events, or major technological failure, which have a significant negative impact on a large proportion of the population of an area or region. It is a major emergency for the international community when the events exceed the ability, capacity, or the willingness of local authorities to respond effectively. This event may be *acute,* such as a storm, earthquake, tsunami, armed conflict or rebellion, or it may be a *chronic* event such as an on-going armed conflict or military occupation, famine, drought, extreme poverty, or government repression. Major emergencies will have a psychological impact depending on the level of threat involved, the visibility of the event to the population as a whole, and the duration of the threats involved. The consequent psychological stress and distress will relate to these factors and, at both an individual and community level, may also be acute or chronic. In chronic states of emergency, the threat, and any consequent stress may be chronic at a moderate level with intermittent periods of very high stress. The consequences of the stress will be moderated by factors that promote individual and collective resilience.

Victims of an emergency may be homeless, or lack safety or sustenance because of an emergency but may still be residing in their original location; they may have had to move to another location in their own country and are regarded as internally displaced persons (IDPs); or may have had to seek the protection or sustenance offered in another country and can be formally recognised as refugees.

Likely Major Emergencies in the Region

In the Asia-Pacific region geological and geographic forces are the most likely agents of major emergencies, although armed conflict has lead to recent emergencies in the Solomon Islands, Vanuatu, Timor Leste, Bouganville, and Fiji. The civil impact of the armed conflict in East Timor is the most recent significant major emergency in the region attributable to this cause. Baingana, Bannon, and Thomas (2005) report on the high correlation between poverty and conflict which suggests that conflict is likely to occur in the poorer countries of the region. J. De Jong (2002) reports that, of the 127 'wars' since 1945, 125 have been in poor countries. The recent armed conflicts in Bouganville, Timor Leste, and the Solomon Islands, and attacks in April 2006 on Honiara's 'China Town' in the Solomon Islands, are consistent with this history.

Storms, leading to destruction and flooding; earthquakes, with or without resultant tsunami; and volcanic activity, are the most likely natural causes of major emergencies in the region. With ocean levels rising due to global warming, storm-driven flooding is likely to increase as a cause of disaster in the islands of the region. Australia is geographically unique and fires, floods and droughts are the most likely causes of natural disasters there. A serious threat across the region as a whole is that of pandemic disease either in humans, or in domestic birds or animals.

Serious poverty and government repression may be relevant for sub-groups within countries. Examples are the ethnic Indian population of Fiji, and ethnic or religious minorities in areas

such as the Philippines. The chronic poverty and related poor health status of the Australian Aboriginal population would also fit within the definition of chronic major emergency that is proposed.

Psychological Risks in Major Emergencies

Major emergencies have impacts in three ways. There is the psychological impact of immediate threat to life and well-being that the acute phase of an emergency entails, as well as the longer term effects of loss and bereavement, or the effects of ongoing threat. Secondly, while, by definition, major emergencies will impact directly on individuals, they also have a major impact on the social, economic and physical infrastructure of their country or locality that will lead to continuing deprivation and psychological suffering. In a report for the World Bank, Baingana et al. (2005) stated that mental health does not 'bounce back' when immediate needs such as food, shelter and physical infrastructure are met. They recommend psychological intervention as an essential step toward full economic recovery, and recognise that economic recovery in turn affects mental health and the well being of the population. The World Bank estimates that a psychosocial programme would cost $8 (US) per person but would improve the economy by $40pp by returning people to productive activity.

Thirdly, becoming a refugee or an IDP cuts an individual off from their community and from health, education, and other services that might otherwise enhance individual and collective recovery. The process of displacement itself is psychologically harmful (Holtzman & Nezam, 2004; Porter & Haslam, 2005) and is likely to lead to poverty and further psychological suffering in an amplifying feedforward process.

The psychological consequences arising from disasters and displacement are culturally influenced. Not only is there a likelihood of culturally specific disorders and culturally weighted emphasis on some symptoms (e.g., somatoform symptoms in some cultures) but the meaning that individuals make of a disaster or conflict is strongly shaped by pre-existing cultural factors such as cultural and religious interpretation of the event. This affects both psychological resilience and vulnerability. It is clear that resilience is a feature of culture and vulnerability and resilience is culturally specific (Jang & LaMendola, 2006). J. de Jong et al., (2003) found lower rates of mental illness in Ethiopian people exposed to conflict than in other countries with similar levels of violence and reported that this correlated with lower rates of mental illness in the Ethopian population as a whole. Kosovar civilians who had family members killed in the war which their side eventually won, identified their losses as the fitting martyrdom of the loved one, which appeared to improve their coping (J. de Jong, 2002). Punamaki (1996) also found that local political involvement, religious and political belief, and strong social connectedness improved mental health amongst Palestinian women and children exposed to Israeli military activity. In addition, not all disasters lead to psychological or psycho-social cost for all people and there is growing evidence for the phenomenon of post-traumatic growth. This is the concept that long term well-being may be improved after an emergency.

Vulnerable and Resilient Sub-groups in a Population

An emergency will place some population sub-groups within the region in more vulnerable situations than others. It is possible to generally predict the likelihood of greater negative effects on some sub-groups (Porter & Haslam, 2005). The poor, women (WHO, 2005b), children (Moss et al., 2006; WHO, 2005c), those with disability, and the elderly, are generally more vulnerable in war and other armed conflicts, as are those who were mentally ill before the onset of the emergency (Mollica, McInnes, Sarajlić, Lavelle, Sarajlić, & Massagh, 1999; Silove, Solvig, & Mollica, 2000). For reasons of physical strength and low status women died in greater numbers in the Indian Ocean tsunami and have been disadvantaged in many ways in the recovery process (Oxfam, 2005).

An armed conflict or government repression, possibly including summary killings, imprisonment and torture, may be focussed on a specific political, religious, cultural or ethnic group making members of such a group at high risk. Famine and drought are likely to affect the elderly, children, and those without family support, more significantly than other groups. Tenant farmers may be impacted differently from land owners. Cultural constraints on the activities of women in the occupied Palestinian Territories mean that young men and boys are the specific target of military action and imprisonment by the Israeli occupation army. Sarraj and Qouta (2005) reported on rates of PTSD symptoms in Palestinian children and found that young males tended to have higher rates than girls (58% compared with 42%). Children living in refugee camps, which have higher levels of both poverty and military activity, experienced more symptoms than their peers who were living in non-refugee circumstances (84.1% compared with15.8%). Adult Palestinian women, who were found to have higher rates of PTSD than adult males (J. de Jong et al., 2003) are exposed to nightly military incursions, violent house searches, restrictions on movement and exaggerated poverty when their men are in Israeli custody. Natural disasters and armed conflict tend to have a greater effect on those who had high levels of poverty before the event, although Porter and Haslam (2005) found that, for those who become refugees, people from both higher pre-displacement socioeconomic status groups and poor, rural residents had worse mental health outcomes. Being female and having a higher education also were risk factors.

J. de Jong et al. (2003) found that PTSD related not only to experience of conflict but also to refugee experiences in the populations they studied. This illustrates the need to consider separately, first the impact of the direct trauma of an emergency and then the impact of any consequent displacement or refugee experience. It is likely that, on the socio-economic continuum, there is an inverse-U relationship with those at each end of the continuum being more at risk of mental illness in refugee or internal displacement situations. Cultural factors may contribute to higher risk for some disorders and different rates of symptoms may present. For instance, alcohol abuse is a commonly co-morbid with PTSD but is of low prevalence in cultures,

such as that of Ethiopia or the occupied Palestinian Territories where alcohol use is proscribed by the dominant religion (J. de Jong et al., 2003).

When the existing fabric of a society is disrupted women and children have the additional risk of being the victims of sexual crime (Rees et al., 2005), and those in war zones may become victims of rape as a weapon of war (Bouta, Frerks & Bannon, 2004; Physicians for Human Rights, 2002).

Community and Individual Resilience

Individual and collective resilience will also be a factor in the degree of psychological risk arising from a major emergency. There is good evidence that the following are factors in enhancing resilience, namely, having a positive outlook; a sense of mastery (including the ability to ask for help when it is required); stability and cohesion in the family; and having an effective and accessible social network. A community that promotes resilience will have values that promote a view of an individual, or family in a collective society, as being competent and able to respond to problems; will have means of providing accurate and trusted information; will provide practical help and social support; and will promote a world view through political, religious or other beliefs that enhance individual or collective autonomy and mutual care. In a strongly family or clan-based society certain individuals who fall outside a close network (e.g., those from small or impoverished families, or divorced or widowed women in some societies) may be vulnerable.

Being a member of an active religious group may be of benefit but, as Gillard and Paton (1999) describe, a religious congregation may place demands on its members after a disaster. In their study this was in the form of a demand to put resources into rebuilding religious structures or into assisting others. Members of some religious groups experienced receiving direct aid from their religious organsiation while members of other religions experienced demands from their group. Religious leaders in one disaster suggested that moral transgression by the community had lead to the disaster, which may have lead to delayed recovery and did lead to a value conflict with aid workers (Taylor, 1999). Being in a community that values and can quickly re-establish education is beneficial to the mental health of children (J. de Jong, 2002). Readiness for a major emergency should include research to better understand these cultural factors in advance.

Contextual Constraints on Intervention

However well-adapted to local culture and customs, all interventions into complex major emergencies are powerfully constrained or enabled by economics, local and national politics, racism, and media attention (e.g. Cambodia, Rwanda, Ethiopia). Hurricane Katrina in Louisiana and Hurricane Stan in Guatemala happened in the same season and had similar destructive force and caused similar loss of life, but they were quite different events in the political and media response they drew. An acute disaster such as the Dec 26th 2005 Indian Ocean tsunami raises a different emotional, media, political and psychological response in potential donor countries compared with a slow or chronic emergency such as 'low key' ongoing conflicts, famine or serious poverty. In 1998 the international community pledged 9 billion dollars (US) for reconstruction in Central America immediately following Hurricane Mitch, however only a small proportion of this amount was ever given to the countries in the area once the acute phase was over (Falhun, 2006). Quite clearly the nature of the intervention and any support offered in major emergencies must also suit the geography and culture of the affected region and will be shaped by local and international political concerns. A recent example of political constraint on aid is the initial limitation on intervention in the Aceh province of Indonesia and in the area of Sri Lanka held by the Tamil rebels following the 26th December tsunami. In both cases national governments did not want aid to go to populations allegedly loyal to rebel groups.

A well-meant intervention from a wealthy external neighbour may have unforeseen implications for a population who may either welcome it or may resent the intrusion of strangers into their recovery. They may perceive such an intervention to be patronising or colonialist; a perception that will be influenced by culture, religious and political beliefs, local history, and by the pre-disaster relationship between the neighbours.

The 'Trauma Dialogue'

Political constraints internal to the aid community and to psychology may also have a significant current influence on psychological intervention in major emergencies. One example is the 'trauma dialogue'. In psychological and other professional bodies of literature, as well as in serious and popular news media publications, there is an on-going discussion about how and what, if anything, should be done to address the psychological harms of the emergencies we have described. This also includes discussion of who should intervene and, to a lesser extent, when in the disaster-response-recovery process intervention should take place. A frequent assumption in the dialogue is that psychological intervention should be large scale, urgent and immediate. The dialogue appears to be based on the presumption that doing anything at all is better than doing nothing. As with any contentious dialogue, positions have been taken and have been challenged and are now, in some circles, held with the force of conviction rather than reason or research (Gist, 2002). This dialogue is also clouded by the strength of feeling that major emergencies can raise and by the difficulty of conducting effective evaluative research in situations that are inherently either highly fluid and unpredictable (natural disasters) or very difficult to access (government repression and conflict).

The assumption that traumatic experiences will result in large numbers of people needing mental health care appears to be incorrect. *Distress and suffering is not a psychiatric illness* (Petevi et al., 2001, p1). Petevi and her colleagues did not make this statement to dismiss the nature of this suffering but to seek an appropriate and non-pathologising response. WHO (2005) notes that in a major emergency such as

the Indian Ocean tsunami most of the distressed population will recover in time. The prediction by WHO in early 2005 was that the tsunami would see an overall increase of 5-10% of psychiatric disorders over the whole affected population. It concluded that there was no justification to use psychiatric intervention on the entire population and there was no justification for a programme aimed specifically at PTSD or trauma-related anxiety disorders (WHO, 2005a, p2). The accuracy of this particular prediction will be tested in time.

In a long term follow-up of individuals exposed to war and civil violence in Ethiopia, Cambodia, occupied Palestinian Territories and Algeria, de Jong and colleagues (J. de Jong et al., 2003) found significantly high levels of risk of a range of mental disorder in those exposed to these impacts. Nevertheless, *it is difficult to justify a program focusing exclusively on trauma reactions in the absence of a system of care for other forms of severe mental disturbance* (Weine et al., 2002, p 161). Further to this, in a context of ongoing stress such as extreme poverty, government repression or ongoing conflict, it is difficult to justify a focus on acute or recent trauma when earlier trauma may be as significant, or more so, for many individuals.

An extensive review of the current practice by major aid organizations (van Ommeren et al., 2005) concluded that, while the place for a trauma-focussed emergency response based on premises about the risk of PTSD and the ability of such interventions to prevent it is still contentious, a number of discrete recommendations could be made. These are: the need for contingency planning in this area as much as any other part of the emergency response; the need for assessment of population risks and needs at the very early stages of response; that any programme should have a long-term perspective which includes future funding and sustainability; that it should be set up with close collaboration between agencies; it should be integrated into other aspects of the emergency response, especially primary health care; it should operate on the principle of open access to all in need; there should be a commitment to training and supervision of staff; and the programme should include an integral monitoring and review process.

The Psychiatric Versus Psychosocial Dialogue

The trauma dialogue has a parallel in the debate over whether response to psychological trauma should be based on theories pertaining to psychiatric disorder or whether the underlying understanding should be at a psycho-social level. It is common in Western countries to refer to the bio-psychosocial-approach to psychiatry and mental illness. The term 'psychosocial' has been taken up by aid and humanitarian organizations and has been given a specialized meaning in that context to distinguish it from a medical/pathological approach to emergency response, a meaning that has a much broader and (they would claim) less pathologising effect. Examples include IRC et al. (2005); K. de Jong (2005); Sphere Project (2004); Petevi et al. (2001); and Silove (2005) who see activities such as developing self-help groups, re-establishing cultural and religious activities, re-establishing schooling, and encouraging common interest and productive activities in the community, as being psychosocial activities which are rightly the function of humanitarian aid workers concerned for promoting a return to mental health. For K. de Jong (2005) psychosocial health, and thus the foci of a psychosocial intervention, includes physical, mental, social, spiritual and moral health components, a perspective highly compatible with indigenous views of health among Maori in Aotearoa/New Zealand (Durie, 1994).

As with the trauma dialogue, disparate positions have been taken and defended. K. de Jong (2005) recommends that closely integrated psychosocial and mental health programmes be included in any emergency response. An example is in Indonesia following the tsunami when the communal rebuilding of fishing fleets was supported as a priority around which a number of community activities and a mental health programme developed. It was also around such a community activity that programmes for immunization and health education were delivered. However psychosocial programmes require awareness and planning. Rees et al. (2005) report that rebuilding fishing boats in Sri Lanka returned village men to gainful employment, but fishing is a male-only activity so this development over-looked the needs of previously employed women in these communities. They needed bicycles to replace those lost in the disaster to resume their role of getting the fish to market. We agree with K. de Jong that this dialogue should not be one of psychological/psychiatric 'versus' psychosocial, but rather one 'with' the other in a contiuum of care.

Cultural Needs and Demands in the Region

In the region we are considering there are diverse risks in terms of types of risk of emergencies but also diversity of cultures. The cultures range from the multi-ethnic, wealthy and Western such as Australia, to a poor multi-ethnic country such as its neighbour, Papua-New Guinea. This mix results in the need to take account of a wide range of cultural considerations and the varied financial and political contexts in which a major emergency may happen.

A cultural assessment by an anthropologist or experienced cross-cultural psychologist can be a beneficial component in the early stages of an intervention. Such an assessment can provide essential information for planning an intervention that will be readily acceptable to the affected community. Without such an assessment the intervention may have only marginal success (Marsella & Christopher, 2004). Whatever assessment and intervention is undertaken, Western practitioners will need to adapt their practice to suit local languages, values and mores (Taylor, 2003). Some useful information is provided in Love and Whittaker (1997) and Evans, Rucklidge, and O'Driscoll (2007), and information specifically relevant to working in Pacific cultural contexts is provided in Kingi-Ulu'ave, Faleafa, and Brown (2007).

Local healers, tohunga, and other recognised culturally or religiously

based helpers will still be in the community after an emergency if they have survived. People seek these helpers and a well-planned psychological and psycho-social intervention will find a way to work in collaboration with them. Similarly local rituals and traditions for coping and grieving should be encouraged.

Assessment of Needs

Prior to, and during, intervention there is a need for a systematic understanding of need to ensure that the right resource is directed to the right population groups, to ensure that no harm is done by the wrong interventions being applied, and to ensure that both resilience and need are understood. There are several tested tools for the assessment of population risks and needs following disaster or conflict. One example is Petevi, Revel and Jacobs (2001) which proposes assessment from the very early stages of response. Screening has to be based on kinds and levels of symptoms experienced in the population as a whole. Standard diagnostic screening and assessment tools may be of little use in the early stages of recovery. Such tools are often linguistically and culturally constrained, and individually focussed but, more importantly, by definition, conditions such as PTSD or Major Depressive Disorder cannot be diagnosed until symptoms have been present for a month. In addition the assumption that there is a response to disaster that is common across cultures must be avoided. There may be no culturally equivalent response to those identified by a generic assessment tool (Brislin, 1986; Norenzayan & Heine, 2005; Triandis, 1996).

Similarly, many of the countries and communities in the region are multi-ethnic and are composed of many religious groups. An assessment (and subsequent intervention) should avoid the risk of seeing a community as a homogenous whole. It is particularly tempting to over-look this kind of complexity under the demands of an acute emergency.

Avoiding premature diagnosis may be a challenge to some clinicians and the need to do so must be included in briefing before they leave for the field. Later in recovery, diagnostically focussed assessment tools may be of value in establishing rates of mental illness in the recovering community and this may assist with planning and monitoring of treatment programmes. Even then care needs to be taken; it cannot be assumed that symptomatology and coping are directly related. In 25% of a sample of war-affected children from Serbia, Jones and Kafetsios (2002) found no correlation between symptoms reported in checklists and their overall wellness as assessed by an in-depth, independently evaluated, qualitative interviews. The risk with diagnostically driven services is that individuals who are not coping may not receive a diagnosis and miss out on care they need, and others who are coping may receive a diagnosis of pathology and subsequent services that are beyond any real need they may have. Assessment includes the degree to which there is a pre-existing and surviving mental health infrastructure, especially in the form of suitably qualified staff not directly impacted by the emergency. This will have a major effect on need and external service requirements in a disaster or conflict.

Programme managers and psychologists may come under pressure from medically oriented humanitarian organisations to evaluate their progress on the basis of singular diagnosis and treatment outcomes. These NGOs may be more familiar with the readily and rapidly quantified treatment of tuberculosis or malaria, or enumerating deaths and injuries after a disaster or conflict, and the complexities of a psycho-social programme may elude them (Renaud, 2006). Well-informed psychologists are very well placed to advise those who may be planning and carrying out early and later assessment to include appropriate tools for assessing mental health needs in their planned response.

When to Intervene

There are a range of time-related schema to describe major emergencies. WHO (2005a) describes the '4R' approach with a *readiness phase,* an acute *response phase* of up to about three weeks, followed by a *reconsolidation phase* of varying length depending on the degree of damage to the social and capital infrastructure, followed by a *recovery phase*. WHO suggests there is little use for a psychosocial programme on the ground in the acute response phase, but a need for assessment at a population level and intense planning and preparation. WHO suggest it is in the reconsolidation phase that such programmes are required. However we would agree with K. de Jong (2005) who suggests the use of psychosocial approaches in the acute phase, with activities such as providing information about the disaster, and psycho-education of key people (teachers, emergency staff, health workers) so they can react in an adequate manner and inform the population about normal reactions to abnormal situations. These community awareness activities should be developed as early as possible.

Intervention on Two Continuua of Care

We suggest that intervention can be thought of along two continuua of care. One as a continuum of time from initial response through reconsolidation to recovery and long term care, and the other across modalities of psychological intervention on a continuum including the range from psycho-social to directly clinical aspects described below (Table 1). For convenience we describe these modalities as 'clinical/medical', psychosocial, and community mobilization. While the description alludes to three components a psychologist with appropriate clinical, community, and organisational skills could work in all three. Clearly, to be complete, the dialogue should not be limited to psychology and should include structural, sociological and economic analyses, and thus be genuinely inter-disciplinary in focus. Obviously this is only a loose guideline and will need to be adapted to suit the nature of the emergency and the cultural, political, and geographic context in which it has occurred. This guideline also assumes an acute emergency with a distinct time of onset. Many emergencies and conflicts develop gradually and the population may still be exposed to the threat when intervention begins.

In the acute stage of response the clinical/medical component will focus

Table 1. Nature of intervention over time

	Acute	Consolidation	Recovery	Phase out
Clinical	Assess need of a sample of the population	Begin to accept referrals Aim at psycho-education, symptom management and self-regulation	Initiate treatment - pre-existing conditions - conditions precipitated by the emergency	Hand over treatment to local M.H. Services. Ensure on-going training and support
Psychosocial	Assess community need Psycho-education for key people in community (teachers, religious leaders). Psycho-education via radio and other media	Training local outreach staff. Continue community education Begin developing local groups around churches, schools etc	Educate, supervise and support local workers and agencies	Hand over education and support responsibility to local agencies. Ensure development toward self-sustaining operation
Community mobilization	Assess social, economic infrastructure	Begin to re-establish capacity of local agencies	Support, resource and advocate for local agencies	Hand over agency management responsibility to local agencies. Ensure development toward self-sustaining operation
Assess and monitor all stages of the intervention Continually monitor mental well-being of all staff				

on assessing community need in the form of symptoms experienced by the exposed population and the survival and the capacity of existing mental health services, local organizations and informal networks. Initial clinical intervention may begin with those with pre-existing mental disorders and those very seriously affected by the disaster or emergency with referral for the cautious use of appropriate psycho-active medications. The psycho-social response will build on this information to start the process of informing the public through key actors such as teachers and local health workers, and through surviving news media, of health promoting social and psychological responses to the emergency. Community mobilization efforts will follow from the assessment of community social infrastructure such as the possibility of re-opening schools, childcare centres, mental health services, and other local social agencies.

As recovery progresses and moves into reconsolidation, at about week two or three, the clinical component can begin to accept referrals and to support the psychosocial component as it moves into training local health workers, teachers, and local staff who can be employed specifically for a mental health programme. Employment of international and national staff should take account of the special needs of the population. If sexual vicitimisation of women has been a feature of the emergency then priority may need to be given to employing women staff. A multi-cultural society may need to be reflected in the ethnicity, languages, and national staff employed. We do not believe there is a function for the 'de-briefing model' in these circumstances. It may be culturally inappropriate (Dwairy, 2005), there may not be time to effectively and safely deal with emotions raised (de Jong et al., 2003), and there is insufficient evidence of its effectiveness in unprepared civilian populations.

Local workers can be the outreach arm of the intervention by going to people's homes to gather information for individual and population assessment and identifying the most affected individuals. Direct intervention can continue at this stage with those seriously affected by the emergency benefiting from the full range of clinical tools. It is necessary to avoid limiting the clinical response along rigid agency 'party lines' or entering into theoretical turf wars. The community mobilization effort continues to support re-establishing the capacity of local agencies to respond to the recovering population. Establishment of support and supervision of national staff, such as local health workers and translators, is also important. Assessment and information gathering is a continuous process integrated across all three components and in close liaison with other health care actors. Information should also be sought on culturally appropriate ways to respond and links made with local healers and religious leaders where this is indicated.

In medium term recovery (one to three months post the start of intervention) the psycho-social component can educate, support and supervise local health workers and educators whose job is promoting recovery of the population and to identify those individuals requiring more skilled clinical intervention. The local health workers can work through existing groups and networks (e.g., school parents groups, work places, community councils) to provide psycho-education and supportive counselling. We believe that such counselling should be aimed toward symptom management, self-regulation, and problem solving. The clinical component can continue to assess the degree of recovery of the population and to work with those identified as needing more specialized

care than that offered by the psycho-social component. Community mobilization will continue with close liaison with other aid agencies to integrate the recovery of the physical and the social infrastructure as is relevant for the context.

Medium to long term recovery (three months to a year) begins to aim toward a sustainable response and ultimate withdrawal of the aid effort by replacement of external staff with local people. Depending on the degree of local training existing before the emergency this may require advocating for advanced training for some local staff over a time period of several years. Some of this training may require extensive funding and the need for local staff to train in other countries. The clinical component continues to treat those with treatable conditions using methods adapted to suit local cultural norms. The psycho-social component gradually withdraws from hands-on practice as day-to-day operations become the responsibility of local health workers but continues to provide oversight, training and supervision to workers in partnership with local organisations. Community mobilization continues at a level of resource provision to, and advocacy for, local organisations. Assessment continues both for ensuring that local needs are met and as a tool for providing information to funders and to future planners of future emergency interventions.

Monitoring the well-being of national and expat staff is a continual function through all stages for the psychologist and for their agency. Further, the need for personal monitoring of one's own safety and risk tolerance, and initial and ongoing assessment and monitoring of the host agency's policies and practices with impact on staff safety and wellbeing, is emphasised by Heller (2006), especially where there are high levels of violence or armed conflict. Habituation to danger, modelling of risk-tolerance or risk-seeking by other individuals (especially if of perceived high status), and being caught up in the achievement of team goals or aspirations while discounting risk, are all dangers to which psychologists, by virtue of their training, should be particularly aware.

At each step the psychologist will experience challenging ethical problems to do with such issues as allocation of scarce resources; conflict with religious and other social norms they are uncomfortable with; the need to direct expat staff to return home if they become psychologically unable to work in the setting; the need to sack incompetent or psychologically disabled local staff when jobs are very scarce; personal safety; and conflict with the practices of local or central government in the country in which they work. The latter raises the challenge of whether the psychologist or their agency should speak up about particular government action, such as a government directing aid to one particular ethnic or political group, or officials stealing aid supplies, or overt oppression of political opponents, and thus risk being kicked out of the country, or whether they should turn a blind eye in order to continue to provide a service. Aid and humanitarian work is always political and always has an ethical component, no matter how neutral the actor tries to be, and aid actors can be drawn into political positions not of their making.

Evidence for Good Practice in Intervention and Support in Major Emergencies

Writing for the Red Cross and Red Crescent Societies, Walker and Walter (2000) made an urgent call for setting standards to ensure relief efforts are better structured. We made reference earlier to the 'trauma dialogue' and 'psycho-social dialogue' around the issue of psychological and psycho-social intervention in major emergencies. There are several reports by NGOs, as well as a number of books and articles that seek to find a sound basis in psychological knowledge for offering guidelines on response to psychological need in major emergencies. Examples come from the World Health Organisation (WHO, 2003); World Bank (Baingana et al., 2005), Médecins sans Frontières (de Jong, K., 2005), and Sphere Project (Sphere Project 2004) as well as several books (de Jong, J., 2002; Green, B. et al., 2003; Orner & Schnyder, 2003; Mollica et al., 2004). These publications collectively make the point that psychological intervention cannot be seen in isolation and must be linked to (1) community interventions; (2) other health interventions; (3) other psychosocial interventions such as restoring schooling and other forms of education, and (4) to re-establishing economic productivity (Mollica et al., 1996).

With respect to (1), playing a useful role in life and connecting with others are important for the mental health of disaster affected or displaced people. Rebuilding the structures that support economic capital assists with building the factors of social capital that are disrupted by conflict and disaster.

> *Conflict destroys positive social capital. Once conflict erupts it undermines interpersonal and communal trust, destroys the norms and values that underpin co-operation and collective action, and diminishes the capacity of communities to manage conflict without resorting to violence.* (Baingana et al., 2005. p 9)

While this quote refers to conflict, similar effects can be expected to occur in major natural disasters.

With respect to (2) and (3), many psychologists already work with educational and other health agents in their daily work and recognize the importance of such collaboration. Point (3) is clearly within the orbit of what aid agencies refer to as a psycho-social intervention.

With respect to (4), organizations, and organizational psychology, play useful roles in the re-establishment of economic productivity. Before a disaster, NGOs, multilateral organizations and bilateral aid partners, may be involved in helping to build capacity for responding to emergencies when they later happen. This requires organizational learning (from previous emergencies) and research archives to store organizational memories of the learning (Marsella & Christopher, 2004). During emergencies, NGOs raise funds (Bolitho et al., 2006), and often foster teamwork between different agencies international and local, through liaison processes termed "harmonization" (World Bank, 2005). Harmonized organizations involved in disaster relief do not duplicate each other, thereby reducing any risk of becoming unnecessary drains on local resources. After an emergency has passed, humanitarian organizations

may be involved in the process of reconstruction, including getting people back to work through rebuilding damaged local industries or establishing new ones (MacLachlan & Carr, 2005). As well as the organizational psychology of strategic planning, job selection and training trainers, reconstruction includes a consultative process of "alignment". NGOs and other forms of humanitarian organization align their activities and strategies with what the local community requires rather than vice versa (Carr & Sloan, 2003). Alignment by definition requires organizational communication, perspective sharing, and intercultural skills that are areas in which organizational psychologists have potentially useful roles to play to regenerate economic prosperity.

Mental Health of Humanitarian Aid Workers

Acute civil disasters may have a significant effect on mental well-being of a range of people other than those directly involved. Emergency services staff, family members, friends, and witnesses may all be subject to negative impact (Taylor, 1987). In major emergencies those who come from the outside to assist may also be at risk of psychological ill health (McFarlane, 2004; Cardozo et al., 2005). NGOs such as MSF, Oxfam, UNICEF and many others rely on two groups of staff for their aid programmes. Most visible are the international staff, usually with professional skills, who are brought in to see to the needs of the distressed population. Whether they are running an emergency hospital, a psychological intervention, or restoring water and sanitation these people will be exposed to traumatic sights and to the traumatic stories of survivors. However, these NGOs cannot operate without staff employed from within the country where the emergency has occurred. These people, working as translators, drivers, security staff, cooks, etc, can be as exposed to the same traumatic sights and stories as the international staff but may be more at risk of psychological trauma since they are culturally, socially and linguistically closer to the people affected. Translators in particular hear the stories first hand and are likely to lack training in the professional distance that offers some psychological protection. National staff are usually permanent or semi-permanent employees in the aid programme meaning that the expats may go home after a few months but the national staff may stay on for years.

McFarlane (2004) found the following to be factors in terms of psychological risk for national and international humanitarian workers: Timing within the period of employment (including the time involved in repatriation for international staff); the quality of organisational briefing and preparation; the risk of violence and threat of injury or death; adaption to the specific cultural and geographical context of the emergency; the presence or absence of organisational support; systemic role conflicts; and interpersonal relations in the team. In addition to these is the potential in some contexts for high levels of physical and emotional demand in the work itself.

Conclusions

In a general summary we can draw the following conclusions for our region. They are presented in the form of a set of summary guidelines based on van Ommeron et al (2005) and WHO (2003). Emergency response requires:

- contingency planning;
- assessment of population risks and needs at the very early stages of response;
- a long term perspective including future funding;
- close collaboration between agencies;
- integration with other aspects of the emergency response;
- operation on the principle of open access to all in need;
- commitment to training and supervision of staff;
- integral monitoring and review

To these we would add first, that assessment and intervention should be delivered in a way that is appropriate to the cultures of the region we have defined, and second, that the specific mental health needs of the humanitarian aid workers, both expatriate and national, should be monitored and attended to if necessary.

Preparedness and contingency planning are essential, particularly as it may appear that 'debriefing' and 'grief counselling' have replaced food and water as the preferred and popularized first response to a disaster or conflict. If such responses are to be provided they must be conducted in a planned, structured and potentially effective way. Community, cross-cultural, I/O and clinical branches of psychology can offer planners in NGOs and government bodies, advice on good response planning in the psychological and psycho-social areas.

An obvious area of readiness for psychologists is to conduct research on potential assessment tools not only to see that they are prepared in local languages but, more importantly to see that there is some form of cultural equivalence for the underlying concepts they involve. Equally, a better understanding through research of cultural responses to stress, distress and disaster can open the way to finer tuning of interventions should disaster occur.

Assessment of population risks and needs following disaster or conflict must be conducted with an emphasis on the kinds and levels of symptoms experienced and avoiding formal diagnosis until at least several months have elapsed. By such time a formal diagnosis may be able to be legitimately made and by then may be helpful in guiding further treatment and response. Integral to assessing risk is the assessment of population and individual resilience, and ensuring that responses build on these as much as responding to symptoms of disorder.

As part of both planning and actual operation, integral monitoring and review should be regarded as essential and should be continuous with initial assessment. As the value of a psycho-social response has been increasingly recognized, so too has the importance that such a response is integrated into other aspects of the emergency response (K. de Jong, 2005). This will call for flexibility at every stage by any psychologist involved in planning and operations. Too many humanitarian actions have been marked by inter-agency and interdisciplinary turf wars. Examples can be found in Weissman (2004) who discusses the various pressures that can lead humanitarian agents to avoid offering aid to an officially unfavoured but needy sub-group.

Any intervention should have a long-term perspective. As the World

Bank concluded, it may take five years (or more) for a population to recover from a major event such as a conflict. Any intervention that a psychologist or psychological body proposes or conducts should obviously be carried out in close collaboration with other agencies which may be involved in planning and in intervention in a major emergency, and undertaken from the first in the knowledge that it may be a long-term commitment.

Psychologists can offer a particular commitment to training and supervision of staff which is relevant at every level of an operation in a major emergency context. The discipline already supports ongoing training and supervision, particularly in the clinical area. However there needs to be a balanced approach to what is regarded as adequate training, particularly for staff local to the affected region, which balances the need for a prompt response with the need to be effective.

As already mentioned, each stage of an operation needs to be framed in a way that is suitable to the cultures and other aspects of the context of the region. Where the dominant culture is Polynesian or Melanesian a collective culture can be expected. Social evaluation might need to have a greater focus on the existence or destruction of this resource in these cultures. Equally, intervention, both initial and long term, needs to be appropriate to local culture or cultures. In some parts of the region this could include steps such as using local religious rituals as part of a psychological process.

To our knowledge disaster or emergency response is not included in training in clinical or other schools of psychology. We do not suggest that disaster response is squeezed into crowded curricula but psychological response to emergencies is not the same as other practice of psychology, mistakes have been made by practitioners called in to assist where they did not have skills for the task, and there is a very clear need to train interested psychologists to provide an adequate response.

The mental health needs of the humanitarian aid workers, both expatriate and national, has often been over-looked (de Jong, K., 2005; McFarlane, 2004) and monitoring these needs should be planned for and integrated into operation. Consideration should be given to planning for the length of time any one person should be operational without a break, the frequency of supervision, and the need for post-operational follow-up for all workers. Self-monitoring and supervision for maintaining personal wellbeing and appropriate levels of risk-tolerance need to be included in training and operating policies and practices. Psychologists of disparate specializations and backgrounds, and their professional organizations, all have potential, and valuable, roles to play in any humanitarian response to complex, major emergencies in our region.

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