КОНФЕРЕНЦИЯ
«ПРОБЛЕМЫ ПОДГОТОВКИ СПЕЦИАЛИСТОВ СИЛОВЫХ СТРУКТУР И ПСИХОЛОГОВ-ДОБРОВОЛЬЦЕВ ДЛЯ РАБОТЫ В ЧРЕВЫЧАЙНЫХ И ДРУГИХ СЛОЖНЫХ ЖИЗНЕННЫХ СИТУАЦИЯХ»

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COMMUNITY-BASED PSYCHOLOGICAL RECOVERY IN COMPLEX EMERGENCIES: OPERATIONAL GUIDELINES

Expansion and diversification of field MH (mental health) programs transformed the landscape of relief work and underlined the need in conceptual framework and evidenced-based practices. Recognition of accomplishments offset by controversies surrounding understanding MH needs in complex emergencies. Incorporation of recovery-oriented paradigms shifts emphasis to community recovery, where the success of individual psychological recovery largely determined by quality of community supports providing secure sense of self, supportive relationships, empowerment, social inclusion, and meaning (SAMSHA, 2004). Proposed model of Community-Based Psychological Recovery in Complex Emergencies aims to facilitate the sustainable community-level impact by strengthening community supports and recovery resources and by sensitizing community to the needs of vulnerable groups.

K e y w o r d s: Disaster, complex emergency, mental health systems, community trauma, psychological recovery, role of volunteers, sustainability.

Introduction

Over the past decade, many international aid agencies have come to realize the crucial importance of mental health relief work in reducing mortality and morbidity. “What do you do if there is enough food, but no one wants to eat?” Asked Kaz de Jong, mental health advisor to Doctors without Borders (MSF). “Sometimes people are unable to eat because they no longer want to live. They may have witnessed the killing of their family” [8]. Mental health programs that initially started as an emergency response in the aftermath of natural disaster and war quickly expanded to non-emergency settings, such as support treatment of chronic diseases (HIV, TB), and advocacy for victims of genocide, torture, and gender-based violence. Later, they also began educating health providers on how to recognize severe depression, trauma, serious mental illness or suicidal behavior in patients, and when to provide the appropriate supports and referrals. The expansion of mental health programs in the field transformed the landscape

of humanitarian work and highlighted the need in both conceptual frameworks and evidenced-based practices. Further developments in community mental health shifted the emphasis away from treatment, symptoms and functioning, to a recovery-oriented paradigm where the recovery is understood as a self-directed process of reclaiming meaning and purpose in life when an individual strives to reach full potential even in the most difficult circumstances [7]. The recovery-oriented paradigm prioritizes the significance of community supports that provide a secure sense of self, supportive relationships, empowerment, social inclusion, and meaning [11].

Role of the community

The *Community-Based Psychological Recovery in Complex Emergencies* model (CBPR) [2] is built on the assertion that a person can cope with almost anything if there is adequate personal and community support. A functional and resilient community facilitates and supports the psychological recovery of its members and provides support for those with special needs or in crisis. On the contrary, the incapacitated and demoralized community compromises individual recovery, and creates ground for violence and re-victimization.

The CBPR goal is to facilitate psychological recovery and create community-level changes by re-building or restoring the cultural, social and psychological systems of support that were rooted in the community but destroyed in a complex emergency. This can be achieved by assisting the community in identifying, reclaiming, and mobilizing psychological survivorship resources, including effective and self-directed problem solving, and compassionate care for its members, especially those with physical and mental disabilities. This model was first developed and implemented in Liberia in the summer of 2011 as part of a Tiyatien Health project established to assist communities with integrated health care in the aftermath of the C te d'Ivoire refugee crisis. There it quickly became obvious that the community itself is in a unique position to address massive mental health. The project was aimed at increasing psychological competencies by engaging local community leaders, training health care providers and the community, identifying the most appropriate format for mutual supports based on the community and cultural traditions, and facilitation of sustainable support groups run by peers.

Mental health needs in complex emergencies

Complex emergencies are defined *as situations of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large-scale movements of people, in which any emergency response has to be conducted in a difficult political and security environment* [13]. A complex emergency challenges the community's capacity to protect and care; it destroys the social and psychological infrastructure and results in higher mortality, population displacement, and infliction of individual and collective trauma. The complex emergency evokes a sense of hopelessness and helplessness; it disempowers the community and overwhelms its capacity to protect and care for its members. This increases the members' sense of vulnerability, which becomes a contributing factor to further victimization, marginalization of victims, and perpetuation of violence.

Mass trauma associated with complex emergency carries a systemic impact on the individual, family, and community life. Most trauma reactions are not pathological and are normally expected. The multitude of resultant psychological effects include: mood and behavioral changes, severe sleep problems, anxiety, depression, flashbacks, intrusive recollections, hyper vigilance, an increase in uncontrolled anger and violence, and a surge of psychosomatic complaints which overwhelm primary care [9]. Severe traumatization undermines help-seeking behavior and elicits hopelessness, helplessness, self-neglect and non-adherence to essential medical treatment; which in turn indirectly increases mortality and morbidity and contributes to substance abuse, violence and suicides.

On the other hand, effective coping with trauma can advance personal growth and enhance the ability to understand and help others. The mature community that collectively survived and overcame traumatic event becomes more resilient, caring and supportive to its members, and better equipped to handle future adversities.

Addressing mental health needs in relief work

Diversification of mental health programmatic modules revealed controversies in understanding psychological trauma, and highlighted the question of whether trauma reactions in complex emergencies are all pathological and require treatment, or if they are predominantly normal, expected responses to life adversities that require no psychological intervention. Another concern shared by many is that Western approaches to conceptualization of trauma (including the whole notion of PTSD and depression, its assessment and treatment) are being imposed upon different cultures with little consideration to their appropriateness and the natural course of coping [12]. Summerfield concluded that any external mental health interventions only serve those who craft said interventions. In addition, the pathologizing of suffering and overuse of psychotropic medications to treat normal stress can disempower and discourage individuals from taking responsibility for their own recovery, and fosters dependence on external assistance. De Jong & Kebler's [9] outlined the *psychosocial approach*, which proclaimed that psychological well-being can be achieved only when basic needs are met and that psychological and social needs must be addressed concurrently. High effectiveness have been demonstrated in integrated care models based on the idea of integrating of mental health into the primary care system. There are many advantages to this approach:

Many trauma survivors have medical conditions that must be addressed concurrently;

Primary care providers identify and make referrals for those with additional mental health needs: somatic complaints are often the initial reason for seeking treatment;

Mental health service carries a stigma, but seeking physiological medical services is more socially acceptable. Participation in standalone mental health programs may expose survivors just by virtue of seeking treatment and can be unsafe.

The integrated model allows for focus on those with more severe impairment and identification of "non-medical" sufferers, but also needs to be backed up by the development of an aftercare and health care referral system in order to ensure sustainability.

Community-based psychological recovery in complex emergency

The community-focused framework of psychological recovery aims at strengthening community supports to achieve sustainable community-level impact.

Within this framework, the success of recovery is determined by quality of community support which becomes the salient protective factor mitigating social ills. As such, the CBPR model prioritizes the importance of psychological recovery of the community. An important part of this work is mobilization of community's recovery potential and sensitizing the community to special mental health needs of vulnerable groups. The ultimate goal of this framework is to restore the community's capacity to independently support its members that was compromised by complex emergency. This goal can be achieved by concurrently addressing multiple levels of communal functioning, ranging from restoration and mobilization of pre-existing, traditional and culture-bound supports, psycho-education, and restoration or development of new life routines along with improving access to professional mental health services for those in need.

The *Community's Recovery Potential* is determined by psychological, social and logistic resources, community strength and resilience. This includes past experience of survivorship, problem solving tools and decision-making scripts, cultural healing and helping traditions (e.g., funeral rituals, supporting someone who experienced loss or was victimized), attitudes of key players in the community, and role models. Available support systems such as a council of elders, spiritual leaders and traditional healers, village or town forums, and similar resources also serve to solve collective problems and improve the well- being of a community. Often the functional community has systems in place to prevent victimization. In many traditional cultures, a battered woman can seek protection from older men in the community. In remote villages in East Liberia are expected to introduce newcomers to the community via the host family at the village gathering, where the host family also assumes full responsibility and pays fine if this person commits a crime [4, 6].

Complex emergencies accompanied by mass trauma carry the potential to interrupt social routines and trigger negative group dynamics: scapegoating, mass victimization, vigilantism, or perpetuating violent cycles. This can destroy the social and psychological fabric and structure of communal life and demoralize a dismantled community that is no longer able to provide protection to its members. The complex emergency or mass forced migration marginalizes the community and its members, weakens their sense of social inclusion and increases personal vulnerabilities, making members more susceptible to both victimization and becoming a victimizer. To counteract this and to re-claim the communal safety, the refugees in the camps at times resort to vigilantism: a group voluntarily takes charge of organizing self-defense and executing punishments. While vigilantism sometimes creates illusion of order, it can become problematic if it replaces legal structure and may result in additional victimization of voluntaristicly designated "scapegoats" [1].

The well-functioning community, on the other hand, provides a sense of safety, security, social inclusion, and psychological comfort for its members. Cultural and social routines and traditions ensure smooth social functioning for the majority; they

often include protocols for crisis interventions and the format for conflict resolution (e.g., *Palava* — meaning organized talk or discussion — in West and East Africa). The community prescribes behavioral norms and contains scripts for enforcing them: For example, rape can result in expelling from the community not only the rapist, but also the rapist's family. In some instances, where physical survival depends on the community, this becomes the equivalent of a death sentence for the whole family. This being said, persons with disabilities are often still excluded from communal social life due to stigma and prejudice [3].

Effectiveness indicators

The effectiveness indicators for this CBPR model are yet to be determined, and this task boils down to how we identify a community that is functional and able to cope with adverse life challenges. While there is no clear definition of what constitutes a functional community, some parameters include the community's self-determination, support and referral system, conflict resolution and victim protection protocol, and demonstrated compassion toward vulnerable and special need groups. The functional community discourages violence, and enforces social norms; it offers supports for routine life events such as illness, death, and loss of property or violence. There is a respect of different cultures and subgroups: in North Caucasus, before the first Chechen war, there were over 65 ethnicities sharing the same small piece of land. According to one teacher from a small village in the region, the community identity carried more importance than even ethnic identity, or was at least equal to it. Growing up together in such a multi-cultural environment, the children looked forward to all the holy days - Christmas and Navruz just meant they would get double the treats [5]. Another facet of positive change in the community is the increased competence and knowledge about mental health and how a person with serious mental illness or severe trauma can be supported when there is no access to medications or specialists. The set of characteristics attributed to functional community are:

- Strong community identity;
- Mutual support;
- Respect for other cultures;
- Feelings of safety, support and protection within the community;
- Compassion for special need groups;
- Sharing social and logistic resources and knowledge;
- Conflict resolution protocol;
- Valuing of self-reliance.

Guiding principles

The CBPR framework is based on the following postulates:

- Most of the traumatic reactions during the complex emergency are normal, expected and do not need any treatment, interventions or even supports;
- Most of the traumatized individuals and communities possess enough strength, flexibility and resilience to recover if they receive support;

• Special needs groups, such as the disabled, elderly, children, those with severe trauma reactions, or serious mental illnesses, may need additional supports;

• A community strives to achieve recovery, stabilization, and self-reliance. A small change can have a systemic ripple impact and yield significant results;

• Every community has both formal and informal leaders who, in an emergency, will step up, take charge of recovery and inspire and carry on values of kindness, compassion, sharing, caring and helping others;

• Refugees bring with them the psychological prototype of their community. In a new place they tend to replicate the routines, traditions, social and psychological connections which include the collective survivorship experience, but also include myths and misconceptions;

• The sources of strength come from:

— past survival experience;

— community, social and cultural history, values and traditions;

— concern on the part of key community players for the well-being of the community;

— customs of self-reliance, mutual support, resource sharing, and trust;

• Any humanitarian aid (logistics, services, food, or medications) is temporary and may discontinue at any time without much notice;

• Any helping intervention or aid carries the potential to impinge upon community self-reliance by creating dependency on external sources.

Goals and Objectives

Goal: The Community-Based Psychological Recovery model of mental health assistance in complex emergencies prioritizes the restoration, or re-building of the community's capacity to support its members, and restoration or development of systems of prevention, referral and aftercare.

This goal can be achieved by mobilizing the community's own recovery potential and is broken down into the following objectives:

• Research of the community's past experiences of survivorship, identification of historical and present culturally-bound, community, family and individual strengths and coping skills, the hopes and the vision for the future;

• Strengthening the community's role in recovery by promoting its ownership, leadership, and responsibility for the well-being of its members;

• Active engagement in the recovery tasks through available support systems, community leaders, local specialists, and cadres;

• When possible and beneficial, collaborating with government and public health organizations, spiritual leaders, and traditional healers;

• Empowering, encouraging, and fostering compassion, care, and mutual support in the community;

• De-stigmatizing people with mental health problems. This involves educating the community and health care providers and challenging misconceptions (such as

myths about their perceived dangerousness, contagiousness of epilepsy and blaming people and their families for mental health problems);

• Increasing the psychological competencies in the community by training of local cadres;

• Designing a program that includes a strategy and plan for program termination to ensure the sustainability of the recovery process and reduce dependence and reliance on NGOs.

The objective can be achieved through:

• Concurrent multi-level psycho-education and skills-building to achieve practice consistency across the system. Different training modules can be developed for:

— Officials and other community leaders;

— Specialists and para-specialists: teachers, nurses and other direct health care and outreach workers;

— Supervisors and peer volunteers;

— Community members;

• A varied training curriculum primarily focused on psychological recovery, compassionate trauma-informed care, and recognizing and supporting persons with severe trauma or serious mental illness. The training should also be designed in a way that allows trainees to challenge the misconceptions and prejudices and further disseminate this knowledge to the public;

• Initial organizational support and promotion of grass-root initiatives contributing to the development of supportive community, such as:

— General support groups, that offer a forum for regular meetings to network, discuss current issues, and share solutions, resources, and supports. In communities where such meetings have been traditionally employed to problem solve, the additional value is the psycho-education geared toward self-help and inclusion of persons with special needs and their family;

— Focused support groups for victims of gender-based violence, persons with mental health issues, severe depression and trauma, and epilepsy, facilitated or co-facilitated by trained peers. This also includes expressive arts groups for children;

— Intermediate care for those with greater mental health needs, such as individual counseling, integrated primary health care, special programs, aftercare and community outreach;

• Follow up. While there is an expectation of independent sustainably in the functioning of support groups, the ongoing support, supervision and re-trainings for the peer volunteers is very important;

• The availability of psychiatric care and medications for persons with severe mental health issues, and awareness on the part of community members as to how and when to refer. This is an essential component — when there is no feasible access to psychiatric services, the community still needs be educated on the nature and causes of mental illness, trained on how to support persons with serious mental illness and their overwhelmed families, and how to manage immediate risks. It is also important to unassumingly and realistically evaluate existing practices from the harm-reduction

point of view: in the absence of antipsychotic medications, in some instances persons with psychotic disorders have been kept physically restrained to prevent them from wondering away and being raped or even killed.

Operational guidelines

Operational guidance determines the scope of services, and defines and prioritizes tasks. It suggests the best practices and standards, bringing consistency in the approaches. In order to achieve community-level systemic sustainable recovery-oriented changes, it is important to consider the following steps and modalities in the CBPR-based program design:

- Examine pre-disaster community social and psychological functioning, their strengths and shortfalls;
- Detect recreational activities effective for strengthening community identity and cohesion. In many communities sports serve this function;
- Research the cultural and communal history of hardship and survivorship;
- Analyze traditional and presently functioning systems of support, both formal and informal;
- Identify vulnerable groups in the community and assess community attitudes toward them and the available supports;
- Identify key community players and leaders and map their social interactions and hierarchy;
- Identify and train leaders and peers interested in volunteering and providing support for vulnerable or victimized persons;
- Educate the community and service providers on the nature and effects of trauma, depression, and mental illness, as well as their natural course, coping and recovery;
- Support them in promoting community mutual support, de-stigmatization, and sensitization to the needs of the vulnerable groups i.e., persons with serious trauma, mental illnesses and other disabilities.

Conclusion

In the community mental health, community-based and trauma-informed support systems are one of the most important factors shaping psychological recovery. Psychological recovery is understood as the process of change through which individuals strive to improve their own health and wellbeing, live a self-directed life, and achieve their full potential. The community mitigates the success of individual recovery, to a great extent. Complex emergencies target the very core of recovery potential, destabilizing or destroying the community's social and psychological infrastructure, in turn shattering the routine of daily functioning. They overwhelm community resilience and coping capacities and heighten systemic vulnerabilities, which has significant implications for psychological and social recovery.

The community-based psychological recovery approach (CBPR) views an individual's trauma recovery as a sustainable process of changes within community support systems that can enhance coping with current and future challenges. Exclusive focus on

individual survivors without systemic and substantial changes in community supports carries a high potential for re-traumatization as the de-humanization and stigmatization of victims continues. The capacity building and self-sustainability of community-based psychological supports are achieved by enforcing the role of the community, where the community assumes ownership and accepts leadership in recovery. The CBPR model facilitates, assists and enhances the community's natural recovery process by offering education, engagement, and empowerment, capacity building and ongoing support [10].

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РЕСУРС СООБЩЕСТВА (МИКРОСОЦИУМА) В ДЕЛЕ ПСИХОЛОГИЧЕСКОГО ВОССТАНОВЛЕНИЯ НАСЕЛЕНИЯ ПОСЛЕ ЧРЕЗВЫЧАЙНЫХ СИТУАЦИЙ

В статье рассматривается роль микросоциума в процессе поддержания психологического благополучия конкретной личности, пережившей экстремальное или кризисное состояние. Автор анализирует элементы структуры общества, влияющие на психологическое восстановление после психотравм различного вида, и концентрирует их в модели (CBPR — the community-based psychological recovery approach), концептом которой является тезис о том, что человек может справиться практически с чем угодно, если есть соответствующие средства индивидуальной и общинной поддержки.

Ключевые слова: сообщество, психическое здоровье, сложные чрезвычайные ситуации, психологическая реабилитация, массовые травмы, восстановительный потенциал социума, кризисное состояние личности.

За последние десятилетия многие международные агентства по оказанию помощи пришли к пониманию важности психического здоровья. Количество людей с признаками психологического и психического неблагополучия, вызванного различного рода чрезвычайными и кризисными ситуациями, постоянно увеличивается. Гуманитарный ландшафт меняется и влечет за собой изменение подходов в оказании психологической помощи населению. Одной из современных тенденций в этом проблемном поле является переход от системы традиционного лечения к разработке и исследованию иных подходов, в том числе основанных на оптимизации ресурса сообщества.

Большинство травматических реакций не являются патологическими. Однако последствия, которые они влекут за собой, могут сильно осложнять жизнь. Это поведенческие изменения, серьезные проблемы со сном, тревожность, депрессия, галлюцинации, навязчивые воспоминания, сверхбдительность, увеличение неконтролируемого гнева и насилия, всплеск психосоматических жалоб и, как следствие, рост наркомании, насилия и самоубийств.

Модель CBPR (the community-based psychological recovery approach), концептом которой является тезис о том, что человек может справиться практически с чем угодно, если есть соответствующие средства индивидуальной и общинной поддержки, является одним из актуальных психологических подходов, направленных на решение вышеупомянутой проблемы.

Она может стать по-настоящему рабочей в случае, если психологам удастся построить эффективные каналы коммуникации с тем или иным сообществом, члены которого нуждаются в помощи специалистов. Опытом такой работы располагают сотрудники организации «Врачи без границ», их силами этот проект был реализован в Либерии и Кот-д'Ивуаре, переживавшим в разное время стихийные бедствия и глобальные социально-политические катаклизмы. В этих странах были реализованы мероприятия, нацеленные на повышение психологической компетентности населения путем вовлечения местного

сообщества лидеров, обучения медицинских работников, выявления наиболее подходящего формата для общения и т. д.

Зрелые сообщества, имеющие прошлый массовый травматический опыт, социальные и логистические ресурсы, устойчивые культурные традиции (например, похоронные ритуалы, традиции горевания), как правило, более «упруго», эффективно хранят своих членов. С одной стороны, это очевидно, а с другой, на сегодня в научной плоскости нет четких критериев эффективности данной модели, поскольку до конца не определено, что же собой представляет функциональная общность. В свою очередь, глобализация и повсеместный мультикультурализм усложняют эту задачу, сбивая устоявшиеся формы поведения общины, на которые можно опереться при анализе ресурса сообщества в деле психического восстановления его членов.

Однако полевая работа и многолетние наблюдения, проведенные в различных «горячих точках мира», позволяют обозначить алгоритм действий, необходимых для оптимизации ресурса сообщества. Прежде всего это изучение прошлого опыта выживания общины, ее история, опора на лидеров, сотрудничество с государственными и общественными организациями в области здравоохранения, духовных лидеров и народных целителей, поощрение и воспитание сострадания, заботы и взаимной поддержки в обществе, повышение психологической компетенции, обучение местных кадров. Отдельного акцента в этом перечне требует разработка специальной программы, которая включает в себя факторы обеспечения устойчивости процесса восстановления и уменьшение зависимости от психологов-волонтеров из различных некоммерческих организаций.

Таким образом, инфраструктура общины может стать сильнейшим восстановительным ресурсом для каждого конкретного человека, пострадавшего в той или иной чрезвычайной ситуации. Модель CBPR (the community-based psychological recovery approach) позволяет комплексно рассматривать эти ресурсы; принципы, заложенные в ней, усиливают естественный процесс восстановления общины посредством образования ее членов, расширения прав и возможностей на основе постоянной взаимной поддержки.