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An assessment of the capacity of the Red Cross National Societies to address the psychological and social needs of survivors of disasters and complex emergencies in Central and South America

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An Assessment of the Capacity of the Red Cross National Societies to Address the Psychological and Social Needs of Survivors of Disasters and Complex Emergencies in Central and South America

By

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THESIS

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Abstract

This qualitative evaluation examines the capacity of the Red Cross National Societies in El Salvador, Nicaragua, Panama, Colombia, Peru and Argentina to address the psychological and social needs of the survivors of disasters and complex emergencies. Specifically, the study explored how individuals working with the Red Cross perceive the services that are currently being offered, what are the strengths and limitations of these services, and what they believe the Red Cross can do to enhance its capacity to effectively assist vulnerable populations to deal with the traumatic effects of disasters and complex emergencies?

Field research was carried out over a 15 week period in six Latin American countries. Thirty-four semi structured interviews were conducted, and five round table discussion sessions hosted. Participants varied on gender, socioeconomic status, education level, and represented differing regions of their respective country – rural and urban. All participants were members of the Red Cross and functioned in either a paid or voluntary capacity – each having been an active participant in a recent or historic Red Cross humanitarian aid initiative.

It quickly became evident that while the Red Cross and other aid agencies can learn much from experts as to how to carry out relief, rehabilitation and recovery initiatives on a global level, the true experts to whom such organizations should listen are those who work in the front line and who are members of the affected communities. These individuals are sensitive to the local context, more attuned to the needs of the

local population, and aware of the strategies that need to be employed to promote healing among affected populations.

This strategy for healing reportedly entails a holistic and integrated approach that focuses on community capacity building and training, with the utilization of local resources (human and material) and the establishment of partnerships within the community. It was believed that such an investment in creating community capacity would not only aid in attending to psychological and emotional wellness directly following a disaster, it would also promote the long term sustainability of such services. Further, it was argued that working with and empowering communities, humanitarian aid agencies would ensure that the programs and services offered are culturally sensitive and respectful of local realities.

No longer can we view members of the affected communities as auxiliary supports and/or passive recipients of aid. These individuals need to be viewed as invaluable agency resources and active agents in the community healing process.

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This project would not have become a reality without the dedication, commitment, and guidance of Dr. Anne Westhues, a lady who I feel privileged to have had the opportunity to work with and learn from. It was through her belief in my capacity and consistent and unswerving support that I was able to understand that my aspiration could become a reality. In addition, I want to express a sincere thank you to Carol Stalker and Cheryl-Anne Cait, members of my thesis committee for their ongoing support and assistance – your efforts will not be forgotten.

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I too want to express my gratitude to the staff at the Canadian Red Cross National Office, the amazing team at the Pan-America Disaster Response Unit, and members of the International Federation of Red Cross and Red Crescent Societies (Regional Delegations and/or Participating National Societies) throughout Latin America who facilitated my journey; without your support, technical assistance and personal guidance a project of this magnitude could never have materialized.

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Listing of Acronyms

ASD – Acute Stress Disorder

CBT – Cognitive Behavioral Therapy

CIS – Critical Incident Stress

CISD – Critical Incident Stress Debriefing

CISM – Critical Incident Stress Management

DSM – Diagnostic and Statistical Manual

IDP – Internally Displaced Person

ICRC - International Committee of the Red Cross and Red Crescent Societies

IFRC - International Federation of the Red Cross and Red Crescent Societies

IO – International Organization

NGO – Nongovernmental Organization

NS – National Society

PADRU – Pan American Disaster Response Unit

PD – Psychological Debriefing

PNS – Participating National Society

PTSD – Post Traumatic Stress Disorder

SCHR – Steering Committee for Humanitarian Response

UN – United Nations

USD – US Dollars

WFP – World Food Program

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Chapter 1 - Introduction

In this thesis research, I aspired to explore how Red Cross National Societies address the psychological and emotional needs of survivors of natural disasters and complex emergencies in Central and South America. In this process, I utilized qualitative methodologies to solicit information from six Latin American countries (El Salvador, Nicaragua, Panama, Peru, Colombia and Argentina). A multiple method research model was developed that combined reviews of existing data with information collected from semi-structured interviews and roundtable discussions with key disaster and emergency services personnel throughout Latin America. This design allowed for a diverse gathering of data and has yielded a wealth of insights about both the nature of humanitarian responses and the lived realities of affected populations.

Existing research clearly demonstrates that exposure to traumatic events can have an array of adverse impacts upon affected populations (Enrenreich, 2002; Everely & Mitchell, 2000; Herman, 1997; Morgan, 1997; Mitchell, Stewart, Griffin & Loba, Murphy & Dolan, 2003; Sprang, 2002.). Further, it is known that the psychological and emotional effects of traumatic events can amplify the devastating effects of a disaster and stifle one's capacity to recover, thus augmenting the direct impact of such crisis situations, both in the short and long term. While this awareness exists, relatively little has been done to integrate the insight into humanitarian aid practices. A primary focus in humanitarian aid efforts has been placed on tangible relief initiatives such as reconstruction of damaged infrastructure, water sanitation programs and distribution of aid items to meet basic needs, rather than holistically attending to the impacts of an event and addressing its less visible human impacts.

Over the past seven years I have been actively involved with the Canadian Red Cross and have participated in many Red Cross initiatives at a local, national and international level. Each endeavor has not only provided me with a broad scope understanding of and appreciation for the Red Cross and the work we do, but also a deeper awareness of the vast effects of disasters and complex emergencies upon exposed populations. Following the September 11th tragedy in the United States, I had the privilege to offer direct assistance to the victims. My offering of assistance began at a localized level only hours after the terrorist attacks when, as a member of the Canadian Red Cross Disaster Response Team we received thousands of passengers diverted to Newfoundland following the shutdown of US airports. Two weeks later I found myself offering a different type of direct assistance to the victims when I was seconded with the American Red Cross Disaster Response team to join the relief effort in New York. This experience, as with other previous experiences, clearly illustrated the traumatic impacts of disasters and complex emergencies and the unique needs of people who must cope with these experiences.

Following my time in New York I entered into a process of critical reflection and began to reflect on the manner in which we, as disaster response personnel, offered humanitarian assistance. Following this process I was not content with what I observed; this discontent fuelled my decision to pursue higher education as a means to heighten my understanding of the needs of people during crisis situations and to explore strategies that humanitarian organizations can employ to more effectively offer humanitarian support and assistance.

Once in an academic arena, a whole world of new understanding began to emerge and my desire to learn was nurtured. I quickly discovered that my personal observations were not unique. Various bodies of research on the topic clearly articulate that exposure to disasters can have a

variety of adverse effects. These impacts far exceed the scope of conventional interventions that are grossly ill equipped to address such phenomena. These findings not only echoed my lived experience (and frustrations) in working with vulnerable populations, they also provided clear direction for my future research investigations.

The goal of my research was to explore the capacity of the Red Cross to address the psychological and social needs of the survivors of disaster and complex emergencies in Central and South America. Specifically, how do vulnerable populations experience these events from a psychological and emotional perspective? How do they cope? What are their needs (both immediate and long-term)? And, what can the Red Cross do to strengthen its capacity to effectively assist vulnerable populations in dealing with such incidents?

Latin America was chosen for this project for a number of reasons. The chief reason relates to the prevalence of disasters and complex emergencies in the region. In addition to the sheer frequency of such occurrences within this region, there is a great deal of variety in the nature of the occurrences, ranging from various natural phenomena such as earthquakes, volcanic eruptions and flooding to other man made crisis situations such as guerrilla warfare, gross economic instability and masses of displaced peoples.

I subscribe to the notion that there are similarities in how we as humans experience various kinds of traumatic events and how a traumatic experience impacts an individual's behaviours, emotions, physiological responses, and psychological well-being. I also believe that a person's lived reality will mitigate and/or compound the impact of such experiences (past exposure, current context, etc). Thus, just as there is variance in different individuals' responses to a traumatic incident within our own cultural context, I feel that a similar continuum exists globally and that such experiences are unique to each individual. Only by giving voice to these

individuals and their experiences can we begin to deconstruct the complex nature of the phenomenon and begin to understand the impact of such events upon people and communities.

Through the use of qualitative methods, my research aims to give voice to individuals and to communities. Having had the privilege to work in the past with vulnerable populations from whom I have learned a great deal about the impacts of disasters, I hold great respect for the unique character of each individual and the unique nature of each encounter. By employing qualitative methods (and sensitivity) in my research I aspired to capture both a depth and breadth of data that would honour and respect each person's unique experience. While such data cannot be representative of the experience of all people who endure a traumatic event, it is hoped that my research sheds new insight about the dynamic nature of response to traumatic events and the means through which we attempt to attend to the needs of people during disasters and complex emergencies in Central and South America. These insights may be used to guide subsequent Red Cross humanitarian efforts in those regions and elsewhere.

Chapter 2 - Literature Review

Disasters and Complex Emergencies

The term disaster has become widely used to categorize a variety of phenomena that disrupt the normalcy of our daily lives, disruptions that range from the devastation of an apartment complex by fire to the furry of a tornado. Despite the widespread utilization of the word disaster, and our degree of familiarity with the concept, there is little consensus among academics and human services practitioners on what the word "disaster" actually means. In fact, there are over 40 definitions of the term within current literature. Although many definitions exist, each contain similarities and concurs that a disaster is an occurrence that results in widespread destruction that typically exceeds the capacity of local communities to manage its effects (Disaster Mental Health Response Handbook, 2000, p.5). The World Disaster Report (2003) states that between 1993 and 2002 there were 5,402 disasters (both natural and man made) recorded globally. In total, these events affected over 2,496,811 people, resulting in the loss of life for approximately 623,927 individuals and over $663,749 million US in damage (pp. 181-184).

In addition to "disaster", the term "complex emergency" has been coined in recent years to classify phenomena that do not fall under the conventional definition of a disaster, but have numerous adverse effects upon exposed populations. The Orientation Handbook on Complex Emergencies, published by the Office for the Coordination of Humanitarian Affairs (1999) provides the following definition of a complex emergency:

> A complex emergency is "a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting

> from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country program." (IASC, December, 1994). Such "complex emergencies" are typically characterized by: extensive violence and loss of life; massive displacements of people; widespread damage to societies and economies; the need for large-scale, multi-faceted humanitarian assistance; the hindrance or prevention of humanitarian assistance by political and military constraints; significant security risks for humanitarian relief workers in some areas.

While complex emergencies have many similarities to disasters, in that both are associated with loss of life, impact upon physical, social and economic structures, and generate an inability of local organizations to manage their effects, there are two chief differences between disasters and complex emergencies. First, disasters can be attributed to acts of nature and to the actions and/or inactions of humans; complex emergencies are solely attributed to human actions. Second, in complex emergencies, while some effects are similar to those of disasters, they are often further compounded by the nature of the occurrences and its assault on victims' views of humanity, personal safety and security. This notion was clearly articulated by Milgram (1986):

> Apart from the enormous destructiveness and loss of life, war poses an unusual threat with respect to target and sources. It threatens the permanence of cherished entities (people, property, pursuits, institutions, and values) and by implication it threatens the fundamental belief in our ability to control our destiny and to control ourselves. It's source, unlike natural disasters (earthquakes, floods and hurricanes), is goal-directed behavior by human beings acting in concert to destroy other human beings (pp. 3-4).

Although a distinction can be made between disasters and complex emergencies with respect to potential effects, many of the effects are similar. Furthermore, while either kind of event may only last from seconds to a few days, such occurrences increase the vulnerability of affected regions (Hewitt, 1997; Wisner & Luce, 1993; Bohle, Dowing, & Watts, 1994; Cutter, 1996.) and the "effects on communities and individuals can continue for months to years during the extended process of recovery, reconstruction and restoration" (Young, Ford, Ruzek,

Friedman, & Gusman, 2000, p.1). Such a disruption can be observed at both a macro and micro level and often inhibit a communities capability to access resources and draw upon internal strengths to aid in mitigating both the short and long term impacts of the occurrence. These impacts are often further exacerbated in regions where preexisting vulnerabilities are evident. As a result, factors such as political and economic instability, poverty, unsafe living conditions and inadequate basic services needs to be accounted for when devising humanitarian aid interventions (Panafrican Emergency Training Centre, 1998, p.12).

Standards for Intervention – the SPHERE Project

The Sphere Project, launched in 1997, was an international project under the direction of the Steering Committee for Humanitarian Response (SCHR). With the support of several key humanitarian organizations, each of which drew upon their own experience, a set of universal minimal standards in core areas of humanitarian assistance was developed. Titled the "Humanitarian Charter and the Minimal Standards", its purpose

> … to increase the effectiveness of humanitarian assistance, and to make agencies more accountable. It is based upon two core beliefs: first, that all possible steps should be taken to alleviate human suffering that arises out of conflict and calamity, and second, that those affected by a disaster have a right to life with dignity and therefore a right to assistance (McConnan, 2000, p.1).

As a working document for international relief and recovery agencies, the SPHERE project outlines several key concepts with the aim of promoting mutual understanding and consistency at the international level among all aid organizations and affiliated actors.

SPHERE defines a disaster as a "situation where people's normal means of support for life with dignity have failed as a result of natural or human made catastrophe" (McConnan, 2000,

p. 273). Based upon this definition, SPHERE outlines several basic principles related to the allocation of humanitarian assistance - the "provision of basic requirements which meet people's needs for adequate water, sanitation, nutrition, food, shelter and health care" (McConnan, 2000, p. 274). The first key principle of the SPHERE project is the notion of "impartial assistance". Impartial assistance has been defined as "assistance is that (is) given on the basis of need alone and makes no distinction as to race, creed, nationality, sex, age, physical or mental disability" (McConnan, 2000, p. 274). Disaster affected people include "all people whose life or health are threatened by disaster, whether displaced or in their home area" (McConnan, 2000 p. 273).

SPHERE also declared that disaster affected people are entitled to a minimum standard of service to be delivered by humanitarian agencies - the "local or international nongovernmental organization, UN body or donor institution whose activities support the provision of humanitarian assistance" (McConnan, 2000, p.274). Further, this assistance must be delivered in a manner that adheres to a set of core humanitarian principles; "prevention and alleviation of suffering, protection of life and health and respect for human dignity" (McConnan, 2000, p.274).

A major strength of the SPHERE project is its desire to develop and promote evidence based disaster relief and recovery strategies. As such, the project outlines several indicators that can be used to support aid agencies and local authorities ["government or leaders who are known to be in be in charge of the country or area in which an incident has occurred" (McConnan, 2000, p. 274)] – in determining whether their efforts have been effective and whether the standard agreed to has been met. These indicators not only provide a means to measure aid effectiveness and accomplishment of prescribed goals, they also provide a universal means to communicate findings to key stakeholders regarding effectiveness, impact and implications of their work, and strategies employed during the aid operation.

Classification of Victims

Taylor (1989) articulated a framework for classifying affected populations following a large-scale disaster or complex emergency. His model organizes people into six broad categories based upon the nature of their exposure and the impacts. He described "primary victims" as individuals who were directly exposed to an occurrence where there was a potential for loss of life, property damage and a disruption to their social networks and personal relations. "Secondary victims" were defined as individuals who have close personal relationships with the primary victims - family members and close friends who themselves have the potential to be adversely affected by emotions of primary victims such as grief or guilt reactions. "Tertiary victims" were identified as individuals who became involved in the event due to their professional role to aid in the relief, recovery and rehabilitation efforts within a given community.

Taylor identified three more classifications of victims associated with being directly exposed to an occurrence or assisting in the aftermath of a major occurrence. "Quarternary" victims refer to individuals who are adversely affected psychologically due to their proximity to and/or indirect exposure to the disaster event, such as good intentioned individuals who over-identify with the victims and go out of their way to offer support and assistance – even if beyond their means financially or otherwise. "Quinterery and sesternary" victims refer to individuals who are not directly exposed to an event but in some way become involved in or affected by the aftermath of the occurrence. These individuals can be members of a group or organization that somehow feels a sense of guilt or responsibility due to a perceived involvement in the occurrence and/or individuals who take steps to offer support and assistance by means such as sending aid products (Taylor, 1989, pp. 17-18).

While Taylor's classification system is not the only one available to identify and categorize affected populations, it provides a comprehensive and inclusive framework to explore the far-reaching effects of an occurrence upon those directly affected and on a society as a whole. It can aid in exploring the different effects of a disaster on affected populations.

Impacts of Disasters and Complex Emergencies

Whether by acts of nature or by acts of man, catastrophic events can overwhelm human beings' ability to cope and result in a variety of post-traumatic responses (Chu, 1998, p.7). Ehrenreich (2002) states:

> When a disaster occurs, the physical consequences are obvious. Buildings are destroyed; workplaces, livestock, and other means of making a living are wrecked; schools and hospitals and power stations are destroyed. The direct effect on the bodies of the victims is equally evident. People are killed or severely injured. The immediate emotional effects – shock, numbness, anger – are also evident. As the days and weeks go by, the physical effects of the disaster may fade. Houses are rebuilt, roads repaired, communications systems restored. For most survivors, the bodily wounds, too, heal. But the emotional wounds – the wounds to the heart, the wounds to the soul - may last (p. 3).

This statement speaks volumes to the potentially adverse impacts of disasters. In addition, Ehrenreich (2002) points out that post disaster relief and recovery efforts typically focus on the "obvious" but fail to attend to the less obvious, frequently deep rooted, psychological effects on the affected population. This can clearly be seen in policies and protocols that govern relief, recovery and rehabilitation programs such as the previously mentioned SPHERE project, which does not address the psychological effects of disasters and complex emergencies. As a result of these oversights, little effort had been exerted by international aid agencies to devise and implement consistent and long-term strategies to deal with psychological phenomena.

A Brief History of Psychological Trauma

The concept of psychological trauma is not new; it has been the topic of exploration, debate and controversy for many years. As one traces the evolution of the concept and the basis of our current awareness of the psychological aftermath of trauma, it can be noted that this awareness has differed significantly over time and "the conceptualization of trauma responses has often been influenced by the social and ideological movement of the day" (Bryant & Harvey, 2000, p.3).

Herman (1997) traced the history of our exploration of trauma and cited several key moments that have contributed to our current recognition and understanding of psychological trauma. She noted that it was during the late 1800's and early 1900's that the concept of psychological trauma was established, as practitioners such as Freud, Breuer and Janet explored the link between the symptoms of hysteria and childhood sexual abuse. The attribution of psychological symptoms to external causes paved the way for new insight and understanding. During World Wars I and II, the concepts of "shell-shock" or "combat neurosis" were coined to account for a series of symptoms exhibited by combat soldiers. They were attributed to the sometime grotesque nature of the daily experience faced by soldiers. While these conditions did not receive much attention by mainstream practitioners at the time, the basic recognition and labeling of such complaints contributed significantly to our current understanding of psychological trauma and its impact. It was not until the late 1970's and early 1980's that the topic resurfaced amongst mainstream practitioners. Herman (1997) credits this resurfacing to the efforts of American Vietnam war veterans and to members of the feminist movement of the time. They identified and spoke of the traumatic nature of war upon combatants and the adverse effects

of sexual & domestic violence upon its victims. A new appreciation for and growing understanding of the complexity of trauma evolved from their efforts.

In 1984, this knowledge and insight was formally compiled by the American Psychiatric Association and a new disorder - Post-Traumatic Stress Disorder (PTSD) - became an official diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).

Psychological Responses to Disasters and Complex Emergencies

As previously noted, disasters and complex emergencies can have severe psychological consequences upon affected populations that are often not readily evident among survivors. They have not traditionally been attended to in post disaster relief, recovery and rehabilitation efforts.

Several shared characteristics of traumatic events such as natural disasters, acts of war, and terrorism were identified by Enrenreich (2002). First, each occurrence bears similarities based upon the sheer magnitude of the events that generally make them impossible for any one individual to control. Second, each of these occurrences can pose great threats to individuals and/or their loved ones, often resulting in death or severe injury. Third, the events create feelings of intense fear, helplessness, terror or horror. Further Enrenreich states:

> In many cases (e.g., an industrial accident) the traumatic event is relatively brief. In other cases (e.g., an earthquake), the event may be brief but the physical consequences may be long lasting and may be a source of as much stress as the initial event. In still other cases (e.g., war, ethnic cleansing) the event may go on and on, a chronic nightmare with no end and no escape (2002, p.5).

Each of these factors contributes to the sometime overwhelming impact of the event upon the affected population, frequently resulting in a spectrum of post trauma responses.

Naming and Classifying Post Trauma Responses

Three labels have emerged in the attempt to name and categorize post trauma psychological and emotional responses. These include Critical Incident Stress (CIS), Acute Stress Disorder (ASD), and Post Traumatic Stress Disorder (PTSD). Each framework articulates the potential impact of psychological trauma upon affected individuals, and can be seen to lie on a continuum. See Appendix 1. They are described briefly below.

Critical Incident Stress and Acute Stress Disorder

Critical Incident Stress (CIS) is "a generic phrase that refers to a very broad range of stress responses that occur after a stressful experience" (Bryant & Harvey, 2000, p.165). It is typically viewed as a normal reaction to an event that overwhelms an individual and impedes their normal coping mechanisms, and is characterized by a variety of cognitive, psychological, emotional, and behavioral signs and symptoms. Examples of these signs and symptoms can be found in Appendix II. While these responses impede a person's ability to cope, the inability is typically diminished within a couple of weeks of the traumatic experience (Mitchell & Everly, 1997, p.3).

Similar to Critical Incident Stress, Acute Stress Disorder (ASD) is a classification used to describe a person's immediate response to a traumatic experience. While both CIS and ASD recognize similar cognitive, psychological, emotional and behavioral signs and symptoms, the key difference between the two is that ASD is categorized as a disorder and is included in the DSM-IV. By contrast, CIS is not considered a disorder and lacks a standard definition. See Appendix III for the indicators of ASD.

ASD has many commonalities with PTSD in its understanding of causes and symptoms of psychological trauma. The key difference between the two perspectives is an important

diagnostic criterion. While a diagnosis of ASD can be made as soon as the symptoms have persisted for two days following a traumatic event, thus allowing for a more prompt diagnosis and early intervention, a diagnosis of PTSD cannot be made until symptoms persist for over one month (Mitchell & Everly, 1997, p.34).

Post Traumatic Stress Disorder

The official diagnostic criteria for the Post Traumatic Stress Disorder were first introduced in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM III) of mental disorders in 1984 (Mitchell & Everly, 2000, pp. 97-99). Similar to other disorders in the DSM III, diagnosis of PTSD does not merely entail the identification of a single symptom. Rather, the disorder is characterized by the presence of a series of symptoms over a specific time frame and requires the reported exposure to a traumatic event for the diagnosis to be supported.

PTSD entails "an extreme response to a severe stressor, including increased anxiety, avoidance of stimuli associated with the trauma and a numbing of emotional responses" following a traumatic experience (Davidson & Neale, 2001, p.151). The current DSM IV defines a traumatic event as "an event in which a person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others", and, "the person's response involved fear, helplessness or horror" (p. 427-428). In addition, the DSM IV states that for there to be a diagnosis of PTSD, the traumatic event must be persistently experienced by the victim through occurrences such as frequent flashbacks, distressing dreams, re-experiencing the event, and other symptoms of psychological distress. See Appendix IV for the indications of PTSD.

Co-morbidity

While PTSD includes a series of behavioral, psychological and cognitive responses that in isolation can constitute a grave impairment of normal daily functioning, numerous studies have shown that in addition to these manifestations, other associated psychiatric conditions are also readily evident amongst PTSD sufferers. "Clients who suffer from chronic PTSD have higher prevalence of associated psychiatric conditions such as substance abuse and dependency, major depression, personality disorder, panic disorder, agoraphobia, generalized anxiety disorder, social phobias and bi-polar disorder" (Khouzam & Donnelly, 2001, p.1). These experiences not only complicate the lived reality of sufferers of PTSD, they also pose a challenge when devising intervention strategies to manage the condition. In addition to the issues identified above, "PTSD can substantially change numerous aspects of psychological functioning. Several of these changes have been linked to poor health" (Schnurr & Green, 2004), further compounding traumatic effects.

Prevalence

In recent years much research has been executed in an attempt to heighten our understanding of the impact of disasters upon affected populations (Herman, 1997; Litz & Gray, 2002; Suar, Mandal, & Khuntia, 2002; Freedman, Gluck, Tuval-Mashiach, Brandes, Peri, & Shalev, 2002; Stephens, 1997; Sprang, 2000.). These studies report similar findings - chiefly, disasters have the potential to have severe adverse psychological effects, and that there are a number of factors that increase one's susceptibility.

In 2001 Norris compiled a report that represents one of the most comprehensive reviews of disaster literature ever carried out. Results for 160 samples of disaster victims were coded as

to sample type, disaster type, disaster location, outcomes and risk factors observed, and overall severity of impairment. Samples - articles, chapters and books - for the study were derived from quantitative empirical research conducted on the mental health consequences of disaster that were published in English between 1981 and 2001. These works focused specifically on acute, collectively experienced events and covered 29 separate countries or territories and various types of occurrences - 88 samples (55%) experienced natural disaster, 54 samples (34%) experienced technological disasters and 18 samples (11%) experienced mass violence. Within the 160 samples, 109 samples (68%) covered adult survivors, 27 samples (17%) discussed school aged youth, and an additional 24 adult samples (15%) consisted of rescue and recovery workers such as fire fighters and body handlers.

Of the160 samples used (books, chapters and articles) 109 (68%) were derived from studies that had only a single post-disaster assessment – seven of which had pre-measures - and 51 (32%) were drawn from studies that had two or more post-disaster assessments. All samples were taken from studies conducted over time frames ranging from immediately following the occurrence to 7 years post disaster, with 60% of the samples having carried out an assessment within 6 months.

Norris (2001) reported that specific psychological problems were evident in 121 (77%) of the 160 samples. Specifically, PTSD was found in 109 (65%) of the samples, depression or major depression disorder was found in 58 (36%) of the samples, and anxiety and generalized anxiety were found in 32 (20%) of the samples. Negative health implications were evident in 36 (23) % of the samples.

When exploring effects on victims at high risk of adverse mental health consequences, it was noted that women were at greater risk of adverse outcomes than men, residents of

developing countries were more severely impacted than those living in developing countries. Age also played a role in the impacts of traumatic events, in that older adults were more affected than younger adults, with middle age adults being most adversely affected. Norris also noted that factors such as ethnicity, socioeconomic status and past experiences also influence the effects of exposure to traumatic events, with members of ethnic minorities, those of lower socioeconomic status, and people having pre-existing mental health symptoms being more susceptible to adverse mental health consequences.

While Norris's (2001) work is not the only attempt to identify the potentially adverse mental health consequences of exposure to a traumatic event, and authors such as Enrenreich (2002), Everely & Mitchell (2000), Herman (1997), Morgan (1997), Mitchell, Stewart, Griffin & Loba, Murphy & Dolan (2003) and Sprang (2002) have each explored this topic in great detail, Norris's work represents the findings from over a decade of such work and compiles data relating to various types of occurrences which have take place in 29 countries in various regions of the world impacting differing populations.

Treatment of CIS, ASD and PTSD

Debriefing versus Therapeutic Intervention

As previously noted, CIS, while including a number of behavioral, physiological, cognitive and psychological responses following exposure to a traumatic event, unlike ASD, is not considered to be a disorder. Consequently, interventions for CIS should not be considered treatment but rather a debriefing of the event. Bryant and Harvey (2000) articulate several key differences between debriefing and therapy, ranging from basic premises to strategies employed. Debriefing is intended to explore issues of confusion and unexpressed affect with the goal of

mitigating impacts, that is, prevent a disorder, educate, and provide opportunities for ventilation. By contrast, therapy is based on psychodynamic, cognitive, information processing or biological theories with the intention of addressing arousal, anxiety, maladaptive and avoidance behaviors. Examples include cognitive therapy and anxiety management. Other key differences are the time frame and format of the intervention. Further, where as debriefing typically entails one session with all trauma survivors within 72 hours of the traumatic event, therapy entails multiple, one-on-one sessions that are typically initiated 2 weeks or more post trauma (Bryant & Harvey, 2000, p.166).

While there is a considerable amount of literature to support the effectiveness of the Critical Incident Stress Debriefing (CISD) process (Busuttil, et al., 1995; Campfield, and Hills, 2001; Chemtob, Tomas, Law, and Cremniter, 1997; Deahl, et al., 2000), there is an emerging controversy pertaining to the effectiveness of the CISD process. Such a debate is supported by several publications which negate and/or challenge the CISD process and question the efficiency of such an intervention (Bisson, Jenkins, Alexander, and Bannister, 1997; Carlier, Voerman and Gersons, 2000; Conlon, and Conroy, 1999; Gist, 1998; Gist and Devilly, 2002; Hobbs,Harrison, and Worlock, 1996; Kenardy, et al., 1996; Stephens, 1997; Morgan, 1998; Regehr, 2001).

The following is a listing of critiques of the CISD process as reported by several of the noted authors.

1. The nature of the debriefing process may run counter to an individual's coping and impair rather then help some individuals.
2. The involuntary nature of the debriefing process. In many cases exposed individuals are mandated to attend such sessions following an occurrence. Further, the nature of the

debriefing process requires that participants respond to two questions, thus compelling reluctant individuals to actively participate in the process.

3. Debriefing sessions typically only allow individuals an opportunity to discuss their negative reactions to an occurrence and do not provide a space to discuss positive aspects which sometimes exist. For example they do not provide a space for individuals to speak of community or individual strength or resilience.
4. The prescribed time frames for debriefings sessions (typically 1-14 days post crisis) do not account for individual variances in the time frame in which different people experience and process a traumatic event.
5. The lack of standardization with regards to CISD can lead to ambiguities regarding definition, practice principles and training requirements for debriefers. This results in discrepancy in how CISD is delivered in the field.
6. The intense re-exposure of hearing other participant's accounts of the occurrence can result in individuals being re-traumatized.
7. While debriefing can give an opportunity to ventilate feelings, provide social support, expedite cognitive reframing and minimize subsequent post trauma symptoms, such variability in the goals of debriefings process makes it difficult to assess its effectiveness
8. Research in the area of CISD, both supporting and negating the CISD model, fails to use standardized methodologies in collecting their data, thus findings are often ambiguous and not reliable. More reliable and valid research methods are required.

Treatment of ASD

Treatment of ASD includes a number of possible interventions designed to manage current symptoms. The goal is to mitigate their impact and prevent the onset of PTSD. Interventions include anxiety management techniques such as muscle relaxation activities, breathing control exercises, and cognitive therapy aimed at helping the victim process negative, and sometimes irrational, thoughts and perceptions. Activities are traditionally carried out in a one-on-one working relationship with a therapist and are typically initiated two weeks following a traumatic event (Bryant & Harvey, 2000).

Treatment of PTSD

In the current literature on the treatment of PTSD, several authors (Chu, J., 1998; Figley, C., 1999; Foa, E., Keane, T. and Friedman M., 2000; Kimerling, R., Ouimette, P. and Wolfe, J., 2002; Meichenbaum, D., 1994; Young, B. & Blake, D., 1999; Young, B. H., Ford, J. D., Ruzek, J. I., Friedman, J., & Gusman, F. D., 2000) discuss common elements (regardless of theoretical approach) in the treatment of PTSD such as education, exposure to the memory of the traumatic event, exploration of feelings and beliefs, and coping-skills training. Intervention typically begins with a formal assessment that aids in the identification and review of the traumatic event, identification of symptoms and exploration of the degree of impairment upon daily living. Based upon these findings and other attributes of the victim's lived reality, treatment strategies are employed with the aim of educating the individual about PTSD, providing strategies to manage or reduce symptoms, and teaching relapse prevention strategies. In carrying out this process, treatment strategies can be employed either as stand-alone interventions or in partnership with others techniques. Commonly used strategies include cognitive-behavioral therapy, which aims to change emotions, thoughts and behaviors; pharmacotherapy, the use of medication to manage

elements of the disorder; group treatment, which provides a safe, supportive and controlled environment for survivors to meet with and share their experience with other survivors; and psychodynamic treatment, which focuses primarily upon emotional conflicts caused by the traumatic event.

Some debate has ensued about the need to employ "exposure" in the treatment of PTSD. Exposure methods "share the common feature of confrontation with frightening stimuli that continue until the anxiety is reduced" (Foa et al., 2000, p. 64). "Imaginal" exposure involves having the client think about and picture the traumatic event and then systematically describe in detail his or her thoughts and feelings as the event was occurring. "In vivo" exposure involves the client gradually allowing him or herself to be in the physical presence of some frightening stimulus that triggers stressful memories of the traumatic event. Foa et al. (2000) point out that "no other treatment modality has such strong evidence for its efficacy" (p. 321), but it is not effective with all clients and some find the treatment so emotionally difficult that they drop out of therapy.

Each of the noted interventions has inherent strengths and limitations and may have varying degrees of effectiveness in dealing with post trauma responses. Cognitive behavioural approaches have been most thoroughly evaluated and found to be effective with many clients. Consequently, they have become widely used as intervention tools when dealing with individuals who are suffering from PTSD (Foa et al., 2000, pp. 363-364).

In addition to treating symptoms directly linked to PTSD, co-morbidity is also a factor in the treatment process. As previously mentioned, conditions such as depression, alcohol/substance abuse, panic disorder, and other anxiety disorders may also be experienced by the survivor. In these cases, a therapist must also be prepared to identify and treat the co-morbid conditions.

Disaster Response and Responders

When disasters strike, depending on their nature and impact, many local, national and international organizations are ready to mobilize aid in the relief and recovery process. While each organization shares similar humanitarian values, each also possesses specific specialties and manners of operating. One of the key disaster response agencies in the world is the International Federation of Red Cross Red Crescent Societies, the focal point of my study.

International Federation of Red Cross Red Crescent Societies

The International Federation of Red Cross and Red Crescent Societies, founded in 1919, represents the world's largest humanitarian organization. With national societies in 181 countries, the International Federation strives to provide assistance without discrimination as to nationality, race, religious beliefs, class or political opinions, to improve the lives of the most vulnerable - people at greatest risk from situations that threaten their survival or their capacity to live with an acceptable level of social and economic security and human dignity.

In carrying out such a mission, the National Societies receive direction from a Secretariat in Geneva, whose role is to coordinate and mobilize relief assistance for international emergencies and promote cooperation at the international level. To aid in this role the Secretariat has established over 60 regional delegations strategically located within various geographic regions throughout the world. The role of these sub offices is to provide direct assistance and advice to their neighbouring National Societies. Support from the regional delegations typically relates to coordination of relief operations, the development of new programs, and the facilitation of regional cooperation between sister National Societies. Due to the scale of the International

Federation and its vast network of 181 national societies, the organization has an enormous capacity to access and work with vulnerable populations.

While the work of the International Red Cross often focuses on key areas such as promoting humanitarian values, emergency and disaster response, disaster preparedness, and health and community care, these are not exclusive; the Red Cross also participates in various other relief and development initiatives to aid in community capacity building globally. In total, the International Federation maintains over 97 million members and volunteers, and 300,000 employees who assist over 233 million beneficiaries each year.

In addition to the above mentioned structures of the International Red Cross, specialized units are sometimes developed by the International Federation Secretariat in an attempt to respond to a region's unique realities and to better equip the Federation in attending to its mission. This was the case in Central America, South America and the Caribbean, where the number of natural and man made disasters in recent years meant that the National Societies were unable to effectively deal with the devastation. Consequently, in 2001 the International Federation established a supplementary response unit - the Pan American Disaster Response Unit (PADRU) - to aid in supporting the humanitarian relief operations in the area. The role of PADRU is to ensure high quality Red Cross assistance to vulnerable people by reinforcing the capacity of National Societies and the Federation Secretariat to provide timely, bold and professional disaster and emergency response services - before, during and after emergencies.

The structure of the organization within each of the 181 countries has an organizational complexity similar to that of the international organization. Within each country there is one National Office and two other sub levels of Red Cross representation - regional and branch offices. Each of these offices has its own teams of volunteers and/or staff who all function under

the guidance and direction of the National Office and the International Federation. Due to the elaborate nature of the Red Cross and its complex organizational structure, workers are readily able to transcend borders, have great mobility and enhanced capacity to work within various regions. See appendix V for additional details of the structure of the IFRC.

Latin America: An Overview

> Latin America and the Caribbean are highly vulnerable to recurring disasters given at least four active tectonic plates which generate significant seismic and volcanic activity, particularly along the Pacific Coast. Furthermore, the Caribbean and Central America fall into the Atlantic and Pacific hurricane and tropical storm belts which are among the most dangerous in the world. Vast mountainous zones and complex systems of water basins result in annual mudslides and flooding and a wide variability in climate is frequently aggravated by the El Niño phenomenon. (PADRU 2004)

Due to these vulnerabilities, over the past ten years natural disasters in the region have resulted in a total of 45,000 deaths, 40 million disaster victims and direct damages that exceeds $20 billion US. The Americas, with an average of 40 major disasters per year, are second only to Asia with regard to disaster vulnerability (Pan American Disaster Response Unit, 2004). While disasters have ravaged the region and have caused gross economic and social instability, as well as loss of infrastructure and lives, one should note that disasters are not stand alone occurrences in this region and often aggravate problematic social realities and pre-existing vulnerabilities. Gross income disparities and widespread poverty, economic and political instability, widespread terrorism and warfare, HIV/AIDS and child exploitation and prostitution and are among the issues that contribute to the volatile nature of the region and vulnerability of its people.

Regional Context – Central and South America

In recent years, Central America has been the only region in the world capable of peacefully resolving long-standing civil wars through a combination of regional and national actions, avoiding the intervention of international political and military forces (International Federation of Red Cross and Red Crescent Societies, Appeal 2004, Central America). In spite of these advances, the ripple effects of years of civil war are still readily evident amongst its people. Within Central America, violence continues to be a widespread phenomenon and assumes many forms, extra-judicial killings by police, cases of social cleansing by paramilitaries, organized crime, gang warfare, regional and international drug trafficking, rape, and other forms of violence such as domestic violence and child abuse.

According to the United States Agency for International Development, Central America is home to some of the world's poorest and most densely populated nations where over half of the region's population lives in rural areas, and as many as two-thirds survive on less than $2 per day (United States Agency for International Development, Latin America and the Caribbean: Selected Economic and Social Data, n.d.). The World Food Program reports that in El Salvador 60 percent of the rural population does not have access to health services and in 1998, 23.3 percent of the population of El Salvador suffered from chronic malnutrition (World Food Program, World Hunger - El-Salvador, 2004). Similarly, in Nicaragua, the second poorest country of the Latin American and Caribbean region, the World Food Program reports that approximately 50% of the population lives below the poverty line. With almost 80% of the extremely poor population live in rural areas prone to recurrent natural disasters (World Food Program, World Hunger – Nicaragua, 2004).

Although numerous attempts have been made to counter this phenomenon by both government and local service providers, the attempts have had a limited capacity to address the phenomenon. Such factors are further compounded by the susceptibility of the region to natural disaster. Disasters in Central America are affected by a complex inter-relation of socio-economic and political factors, together with natural phenomena. The latter, including hurricanes, tropical storms, flooding, landslides, volcanoes and seismic activity have had a strong impact on the region's capacity for advancement in all spheres of human and social development (International Federation of Red Cross and Red Crescent Societies, Appeal 2004, Central America). Many parallels are evident when exploring the situation in South America

> South America's National Societies work in an environment of growing poverty. The high degree of income concentration in Latin America has not fluctuated during the last decade and inequality remains the most significant problem...South America maintains the status of a region in crisis, affected by economic problems, debt, political violence, corruption, drug issues, poverty, inequality of income distribution, unemployment, forced migration and natural disasters. (International federation of Red Cross and Red Crescent Societies, Appeal 2004, South America)

The Pan America Health Organization (2003) reports that between 30% and 75% of women in the region are victims of physical violence from their partners. According to Save the Children, (as cited in The Pan America Health Organization, 2003) South America's children face poverty, abuse, discrimination, exclusion and insecurity, do not have access to health care and education, especially in indigenous rural communities and a large portion of the population in this region are poorly nourished. For example, the World Food Program reported that more than half of Peru's population lives with below the poverty line with 6.5 million people, 25% of

the population, classified as extremely poor, and living on an income of less than US$1 per day (World Food Program, World Hunger – Peru, 2004).

HIV/AIDS is another grave concern for the region as the rate of infection continues to rise and a culture of silence parallels this increase. Fuelled by cultural beliefs, stigma and taboo, people maintain unsafe sexual practices and deny HIV status in an attempt to preserve pride and dignity and adhere to strict cultural norms and gender roles.

As with Central America, South America also has a vast history of armed conflict. The World Food Program reported that after forty years of conflict, the economy of Colombia has taken a recent economic downturn which has led to a severe deterioration in the basic conditions of Colombia's population. It was noted that poverty, food insecurity and hunger, is evident within the country with an estimated 57% of the population living in poverty. In addition, due to the presence of widespread, armed conflict, today Colombia has the third largest internally displaced population in the world. An estimated two to three million internally displaced persons (IDP) out of a total population of 43 million people have fled their homes because of threats, fear, assassinations and massacres associated with lawlessness and drug trafficking. Further, a study conducted by WFP between December 2002 and April 2003, concluded that 80% of Colombians displaced by violence live in extreme poverty and lack access to sufficient food (World Food Program, World Hunger – Colombia, 2004).

In addition to the presence of widespread social, political and economic ills, South America is also prone to both man made and natural disaster, each of which has had devastating effects upon the wellbeing of the region and contribute to the ever increasing vulnerability of the area.

Summary

This review clearly emphasizes the devastating effects of disasters and complex emergencies and illustrates the potential adverse psychological and social ramifications to which an affected population may be subjected. When probing the current situation in Latin America it can be noted that this is a region that has been affected by severe, large-scale occurrences periodically. A number of aid agencies are working in Central and South America, and attempting to attend to the needs of the people who live there. The aim of this study is to examine the capacity of the Red Cross – the world's largest humanitarian aid organization – to responsively attend to the psychological and social needs of affected populations in six Latin American countries.

Chapter 3 – Methodology

Research Goal

The goal of my research was to explore the capacity of the Red Cross National Societies in El Salvador, Nicaragua, Panama, Colombia, Peru and Argentina to address the psychological and social needs of the survivors of disasters and complex emergencies within their geographic regions. Specifically, the study intended to explore the perspectives of those working with the Red Cross regarding how vulnerable populations within these countries experience disasters from a psychological and emotional perspective. What are their needs, both immediate and long-term? What services are currently being offered? What are the strengths and limitations of these services, and what do respondents believe the Red Cross can do to enhance its capacity to effectively assist vulnerable populations to deal with the effects of disasters and complex emergencies?

Research Design

Data for my thesis were collected in El Salvador, Nicaragua, Panama, Peru, Argentina and Colombia. In carrying out my research, a multi method design was employed as it allowed for the combination of various qualitative methods within a single research design, a process commonly referred to as triangulation. The term triangulation is a concept traditionally used by surveyors and navigators to describe a process used to establish the position of a person or object by taking readings or measurements from a variety of viewpoints. By using several points of reference, a person's ability to establish a more accurate measurement is increased (Clarke, 1999, p.86). By utilizing a similar strategy and combining the use of several research methods, I aimed

to enhance confidence in the reliability and validity of my findings. Clark (1999) further states, "given that each research method has its own strengths and weaknesses, advocates of triangulation maintain that, as the strengths of one method can be expected to compensate for the weakness of another, the overall quality of the data will be improved by using more then one method. According to this view, employing multiple methods effectively reduces measurement error and helps to overcome problems of bias" (p.88).

In addition to the development of multiple research methods to aid in the collection of field data, a naturalistic paradigm was also used to in carrying out my field research. "Naturalism proposes that, as far as possible, the social world should be studied in its 'natural' state, undisturbed by the researcher… The primary aim should be to describe what happens in the setting, how people involved see their own actions and the actions of others, and the context in which these actions take place." (Hammersley & Atkinson, 1993, p.6). In addition to complementing my desire to investigate individual experiences with disasters and complex emergencies, in the natural setting of participants, this perspective also echoed my belief that "there exist multiple constructed realities" (Lincoln & Guba, 1985, p.37) that need to be explored holistically, and understood in relation to a person's natural history and lived reality. Further, the naturalistic research paradigm also fits well with my personal research values and beliefs about knowledge generation.

Naturalistic research, in addition to holistically attending to human phenomena within their natural environment, employs an inductive approach for exploration and the generation of new knowledge. In contrast to traditional deductive approaches that lead to research activities with fixed theoretical perspective and test hypotheses, inductive approaches allow for greater freedom and the examination of various surfacing themes within the data. "Theory ideally then

emerges" (Westhues, Cadell, Karabonow, Maxwell, & Sanchez, 1999). This approach supported my wish to honour the information provided by participants and the desire to give voice to their subjective experiences with disasters and complex emergencies. Further, by utilizing the premises of grounded theory, as a researcher I am also able to allow my field data and observations to inform a process of theory generation, rather then being forced to mould my observations to fit perspectives and notions of others not directly involved in this research process.

Strauss and Corbin (1998) state, within grounded theory "a researcher does not begin a project with a preconceived theory in mind...Rather the researcher begins with an area of study and allows for the theory to emerge from the data" (p.12). Not only did this approach give voice to the participants, it is also hoped that it will enhance the usability of my findings to affect positive change. "Grounded theories, because they are drawn from the data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action" (Strauss & Corbin, 1998, p.12), which is a key goal for my research project.

Special Considerations

In light of the reality that English is not the predominant language in my proposed region of study, and the fact that I am not of Latin American descent, I adopted a number of approaches to heighten my language and cross cultural competency throughout the research project. The first phase of this initiative entailed my active participation in Spanish classes at a local training centre for approximately 2 hours weekly for 4 month's prior to traveling to Latin American. I also used informal advisors from various Latin American countries to aid in the development of

my research design. Paired with the Canadian based training and consultation, I also participated in a four-week language and cultural training program when I first arrived in Panama.

Further, cultural interpreters were employed to provide both translation services and understanding of each region - the specific nature of local dialects, unique components of nonverbal communication, and a general introduction to each region, its history, customs, tradition, norms, and other unique attributes. This enhanced my ability to adapt to and function within my ever-changing environments and to work with the local populations. Each cultural interpreter was fully briefed on the nature of the research goals and objectives, ethical requirements, my personal philosophies, beliefs and approaches to working with people, and was required to sign a Confidentiality Agreement (Appendix XIII & XIV - Confidentiality Agreement). In addition to these safeguards, all documents were translated into Spanish on arrival in Panama, and each translation was reviewed by cultural interpreters to ensure that it reflected the local dialects.

In most countries, the cultural interpreter was recruited from a local training institution where translation services are offered as an academic program in which advanced level students are required to fulfil a fixed number of volunteer practice hours prior to graduation. When these volunteer arrangements could not be made, cultural interpreters were hired to aid in the process. Although every effort was made to ensure that local Red Cross personnel did not act as translators during the formal interview process, on occasion this was a necessity due to factors such as geographic isolation and an inability to secure alternate translation services. This was primarily the case in El Salvador when traveling to remote disaster affected villages and during my first meetings with members of the National Society in Lima, Peru. In such instances,

members of regional delegations who were not directly affiliated with the National Society served as a translator (in both cases members of the administrative/clerical staff were selected to fulfil the role).

Data Collection Procedure

In addition to the establishment of a clear research goal, a series of research objectives were also formulated to aid in guiding my field investigations. These were to:

1. Ascertain what the perceived needs of affected populations are following a disaster
2. Identify what psychosocial services are currently being offered to survivors of disaster and complex emergencies
3. Determine what psychosocial services worked best in promoting well-being for survivors
4. Highlight what survivors and service providers report as being essential psychosocial relief and recovery services
5. Assess the current capacity of the Red Cross national societies to provide such services, and
6. Solicit information regarding potential means for the Red Cross to improve existing, or develop new, psychosocial support programs

Based upon the identified objectives, three key data collection methods were developed and utilized to aid in attaining my research goals: 1) review of archival data (Clarke, 1999; Creswell 1994; Hill, 1993; Robson, 1993; Marshall & Rossman, 1989): 2) focus groups with emergency and disaster services personnel (Fern, 2001; Krueger, 1998; Morgan, 1993; Morrison, 1998; Stewart & Shamdasani, 1990) and 3) semi-structured interviews with those affected by,

and/or working with, disasters and/or complex emergencies relief and recovery operations (Rubin & Babbie, 2001; Robson, 1993).

Document Review

In addition to a review of the literature conducted prior to beginning the field research process, a region specific review of documents was conducted once in the field. Red Cross Annual Reports, response team situation reports, other agencies' annual reports and publications, media clippings and other documents were solicited and reviewed. Each served as a source of information that aided in formulating a holistic view of relief and recovery operations and the context in which they transpired. It also provided contextual and historical data to my research subject and to the geographic regions.

Such a review not only promoted my understanding of the local realities and the nature of ongoing and past relief and recovery operations, my new insights permitted me to make better-informed decisions about my evolving work plans and the selection of specific regions in which to conduct focus groups and/or semi-structured interviews. While this strategy served as a valuable source of insight, great care was employed to ensure that data were reviewed and used cautiously so that the findings were both contextualized and understood in relation to the circumstance in which they were compiled. Clarke (1999) cautions, "While it is important for an evaluator to make use of data derived from documents, the limitations of these data need to be recognized (p.85)."

Focus Groups (Round Table Discussions)

Focus groups were carried out in each country and provided a comprehensive view of the realities of the countries in which I carried out my research. "A focus group can be defined as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a

permissive, nonthreatening environment… The discussion is relaxed, comfortable, and often enjoyable for participants to share their ideas and perceptions." (Krueger, 1988, p.18). These are concepts that fit well with the aim of my research. Further, it has been noted that focus groups are effective when there is a power differential between participants and decision makers, as was the case with my area of research.

> The interaction that focus groups bring is useful in these situations because it allows groups of peers to express their perspectives. Having the security of being among others who share many of their feeling and experiences, the participants possess a basis for their shared views. Thus focus group interviews, when conducted in a nonthreatening and permissive environment, are especially useful when working with categories of people who have historically had limited power and influence." (Morgan, 1993, p. 15). Morgan (1993) further states "Such a tool can be a "powerful means of exposing professionals to the reality"(p.16).

By hosting focus group discussions with Red Cross Disaster Services staff and volunteers, I was able to probe the nature of the local relief efforts and attain valuable insight into the workers' perspectives on the strengths and weaknesses of their initiatives and their capacity to address the needs of the local population (See Appendix V - Focus Group Question & Key Informant Interview Questions).

It should be noted that while in the field, the expression "round table discussion" was selected and substituted for "focus group" due to insight gathered from my consultation with members of the Latin American community who served as informal advisors during the development of my research design. My dialogue with these advisors revealed that the term "focus group" often carries a negative connotation, as it is traditionally a formal process carried out by government personnel. As a result of this insight, it was decided that a more culturally acceptable and less intimidating term be used. The term "round table discussions" was selected. It was revealed that this term is associated with a strategy used by local community practitioners

and leaders to mobilize people to discuss issues and concerns in an informal manner – an understanding that fit well with the goals of my project.

Semi-structured Interviews

Although able to obtain useful information through my review of existing literature and data collected from the facilitation of round table discussions, the focal point of my project revolves around the more in-depth information solicited from the local practitioners. Semi-structured interviews were carried out with selected individuals who had experience working directly with survivors and were often personally impacted by the disasters and complex emergencies. With this strategy "the interviewer has worked out a set of questions in advance, but is free to modify their order based upon her perception of what seems most appropriate in the context of the 'conversation', can change the way they are worded, give explanations, leave out particular questions which seem inappropriate with a particular interviewee or include additional ones" (Robson, 1993, p.231). This provides a researcher with the flexibility required to capitalize on the unique opportunities each interview may offer to collect both a depth and breadth of information pertaining to a given research area.

The self-report of experience in dealing with the disaster and its aftermath was critical to my research initiative as it provided comprehensive accounts of peoples' experiences in working with and personally managing disasters and complex emergencies. Information pertaining to challenges, barriers to providing/accessing services, service omissions, effective program strategies, operation triumphs and secondary issues that affected the situation, was significant to the personal experiences of individual response workers and circumstances in which they transpired. It also provided insight into a larger pattern of relief and recovery philosophies, management strategies and protocols within a specific region and the organizational culture

within which their mandate was carried out. Holistically, this information serves as a solid body of knowledge and insight which could be paired with all other data to formulate both a comprehensive insight into the capacity of the Red Cross and to postulate program and policy recommendations geared toward effecting positive change for future relief and recovery operations (Appendix V - Focus Group Question & key Informant Interview Questions).

The initial framework for my interview scripts was developed based upon three key sources of information: literature pertaining to the nature of capacity and needs assessments (McKillip, 1987; Neuber, 1980), literature pertaining to the nature and impacts of disasters and complex emergencies as outlined in my literature review, and experiential information derived from observations made while working as a front line disaster response worker with the international Red Cross and other humanitarian aid organizations over the past ten years. Questions pertaining to the nature of disaster relief and recovery efforts in each region and key players in the delivery of humanitarian aid were designed to solicit contextual data and were informed primarily by the findings of my literature review. A large portion of interview script and questions related to topics such as perception of the needs of affected populations and the review of current practices was derived from and based upon my review of materials pertaining to capacity and needs assessments and personal experience.

Further, based upon the preliminary review of the literature, conversations with Red Cross colleagues and my own experience as a humanitarian aid worker, it was evident that the concept of psychosocial programming, although a concept currently used in relation to contemporary social work practice (Bisman, 2001; Wallace, Goldberg, & Slaby 1984; Sands, 2001; Lesser, 2000; Berzoff, Flanagan & Hertz, 1996.), it is an emergent theme in relation to Red Cross humanitarian aid initiatives. As such, not allot of formal work and/or research had been

carried out by the Red Cross in this area to date. Thus, I opted to add additional questions to my interview script about psychosocial programming.

Although a traditional needs assessments aims to explore and report the gaps in service evident within a particular organization, based upon the goals and objectives of my research project, I wanted to not only explore need but to also identify means to effect positive change. As such, a series of questions linked to respondents' perceptions of essential psychosocial programs which they felt should be carried out during humanitarian aid operations, and the means for the Red Cross to develop and deliver such programs, was also included in my script.

The devised interview script was not piloted prior to it being utilized in the field - chiefly due to time constraints and the unique nature of my sample population – but feedback was solicited from Red Cross colleagues and members of my thesis committee during its development. This a process of peer debriefing allowed for a comprehensive review of my intended research goals and review of the probability the derived questions would serve as a valuable tool in attaining data to meet these goals. The interview script and accompanying probes originally developed in June 2003 was the same basic guide used during the collection of my field data, for both semi-structured interviews and the five focus groups with each session following a consistent format - same series of questions in a similar order.

Recording of Data

Information provided by respondents was tape-recorded. Transcriptions occurred once all interviews/round table discussion had been completed in each country (to promote the accuracy of transcribed data, copies of each transcript were made available to each respondent for review and an opportunity provided for them to offer additional information or/or critiques). This

information was offered in both English and Spanish and translations, and cultural interpreters and/or translators who I worked with while in the field carried out back translations. To ensure confidentiality, each transcript and accompanying audiotape did not contain any identifying information (such as respondent's name) and they were assigned code numbers. These numbers were then paired with a corresponding master list that contained the name and affiliated Red Cross office/region. This list was maintained by the principle researcher, and not viewed by anybody else. In addition to audio recordings of the session, field notes were also drafted throughout the research process to capture additional details that would supplement the data provided via the interview process. This included knowledge of the local context and current political, economic and social situation; cultural differences of respondents; and specific features of the interview process such as a person's verbal/nonverbal communication pattern and overall tone of the session. These details now serve to enhance the richness of the formal data collected.

Interviews were conducted in both formal and informal settings ranging from sessions conducted around board room tables located within Red Cross national offices to meetings that transpired in open spaces in rural disaster affected villages – depending on the local context and the availability of 'space'. Regardless of location, sessions ranged in duration with the average interview lasting for approximately 1-1.5 hours.

Sampling

Throughout the course of my field research, I drew upon non-probability sampling strategies, and employed a process of purposive sampling to aid in identifying potential respondents. "In this form of sampling, the investigator relies on his or her expert judgment to select units that are "representative" or "typical" of the population." (Singelton, Straits, Straits, &

McAllister, 1998, p.153.). This strategy not only aided in ensuring that I was able to obtain focused information from those who had direct experience in working with disasters and complex emergencies, it allowed for greater flexibility in my sampling than probability sampling, and allowed me to capitalize on data collecting opportunities as they emerged.

When selecting potential respondents, although attention was paid to such factors as age, sex, levels of experience and expertise and social and economic backgrounds, the key criteria for inclusion was that each individual had actively participated in, or was currently involved with, a humanitarian aid initiative. In addition, due to the nature of my fieldwork whereby data was collected in various geographic regions within a given country, by design my study was inclusive of participants from both rural and urban areas. Similarly, while working in urban areas I was able to draw my sample from both paid and unpaid Red Cross personnel – actively aiming to be inclusive of both groups; in rural areas I was guaranteed representation of volunteer humanitarian aid workers because personnel in such regions typically (if not exclusively) function in a voluntary capacity. Consequently, semi-structured interviews were carried out with both Red Cross paid and volunteer humanitarian aid personnel with a near equal representation of both paid and non-paid humanitarian aid personnel. When looking at the dynamics of the focus group participants a different composition can be noted as participants in such sessions were primarily volunteers. Although a small portion of this sample did fulfil a paid role within the Red Cross, the vast majority, approximately 75%, were volunteers for the Red Cross.

During my fieldwork, an average of one focus group and 5 semi-structured interviews were carried out in each country. Exceptions to this can be noted in Panama because the affiliated Red Cross offices within this country function primarily as auxiliary supports to other sister countries. Therefore, no focus group was hosted there and five semi-structured interviews were

carried out. Further, when looking at the data collection process employed in both Colombia and Peru, due to their size and the variance in the types of occurrences with which they were dealing, additional semi-structured interviews were completed in each of these countries. For example, while working in Colombia, interviews were carried out in 3 distinct geographic regions accounting for both the occurrence of disasters within the country and the presence of active armed conflict between guerrilla and/or other armed groups and the resulting humanitarian crisis – chiefly the displacement of over 1.5 million peoples within the country who are fleeing from conflict affected areas. Consequently, an additional two interviews were carried out while there.

Recruitment for Focus Groups (Round Table Discussions)

Round table discussion participants for each country were recruited from within the selected region through an information leaflet that was distributed to the National and Regional Red Cross Offices in each country by Email or Fax (Appendix VII & VIII - Focus group recruitment leaflet). In addition to an invitation to participate and the provision of an overview of the research project, contact information was also contained within this document. Interested candidates were asked to contact me directly to obtain further information about the project and/or to express interest in participating in the sessions. Further, local and/or national Red Cross offices also provided assistance in collecting the names of potential respondents and providing additional data to those who inquired about the project. In many cases, I was unable to respond to inquiries in a timely manner due to the nature of my work plan which necessitated my being in the field for prolonged periods of time away from basic communication mediums such a phone, fax and email. While this was the case, and communication with potential participants to respond to inquiries and confirm meeting times and places was often difficult, once in a region where

communication equipment could be accessed, effort was exerted to respond to inquiries and make personal contact with potential participants. In cases where language was a barrier and/or I was unable to initiate such contact personally, cultural interpreters and/or translators aided me in this process and contacted each individual on my behalf.

Round table discussions were hosted in five countries (El Salvador, Nicaragua, Peru, Argentines and Colombia), with a total of 38 people attending the sessions. Participants in each session were primarily volunteer disaster relief workers although some of the respondents were Red Cross staff whose paid position was not linked to emergency and disaster services. In these cases, they served as volunteers when performing disaster relief work. Participants were of varied ages and sex and each had different levels of experience and expertise. The commonality for all respondents lay in the fact that each had actively participated in relief and recovery efforts in the region and each was willing to discuss the details of their experiences and their views of the Red Cross capacity to provide relief and recovery supports and assistance. Each discussion was conducted at a Red Cross facility (regional office, community centre, etc) and lasted for approximately 2-2.5 hours each, thus providing ample time for respondents to share and elaborate upon their views and opinions.

Recruitment for Semi-structured Interviews

Participants for the semi-structured interviews were recruited through a process of purposeful sampling (Singelton et al., 1998). Potential participants were identified by other disaster services personnel in the region (National Red Cross Society volunteers and staff, field delegates, etc.) following the regional focus groups and through daily encounters with disaster services personnel in the region. Once potential individuals were identified, the principal investigator contacted them. A cultural interpreter was utilized when language barriers existed.

The goal of this contact was to provide an introduction to the research project and to ascertain if the individual would like to become involved in the project. Once interest had been confirmed, an opportunity to ask questions was provided and arrangements were made to meet.

Semi-structured interviews were carried out in El Salvador, Nicaragua, Panama, Peru Argentina and Colombia with an average of five Red Cross respondents being interviewed in each country. Factors such as age and sex were not actively controlled for in the recruitment process; rather the determining criteria were active participation in past and/or ongoing relief and recovery operations and a willingness to engage in an open dialogue about their experience and personal thoughts and beliefs about disaster relief services. In total, 34 semi-structured interviews were carried out. Each semi-structured interview took approximately 1 to 1.5 hours to complete and was conducted at a mutually agreeable time and location at a Red Cross facility or in the community.

In some instances the services of a translators was not required, chiefly when dealing with members of Participating National Societies (PNS), many of whom had English as a primary, or a fluent second language. When dealing with members of the local populations – Red Cross staff and/or volunteers, the services of a cultural interpreter/translator was always utilized - even if the participant could converse in English. Such a strategy was employed for two key reasons, first, although the participant may have been able to converse in English, if they were to experience difficulties while attempting to articulate and/or express their thoughts they would be able to alternate between English and Spanish during our meetings, thus promoting the richness of their testimonies. Second, such a strategy was employed so as to ensure that key cultural elements (verbal/nonverbal communication components and contextual data) could be accounted for and explained to me both during and following each session, thus promoting my understanding of,

and ability to respond to, what was being reported. A similar strategy was employed while hosting my focus group sessions.

Ethical Issues

In June 2003, three months prior to the beginning of my field research in Latin America, the Research and Ethics Board of Wilfrid Laurier University under the direction of Bill Marr granted approval for my proposed research project - its goal, design, instruments and its accompanying documents.

Informed consent was solicited and obtained from all respondents. Potential participants, after being verbally briefed on the research process, were furnished with a translated consent statement that clearly articulated the purpose of the study and their rights as participants, thus allowing them to make informed decisions about their involvement in the research process (Please see Appendix IV-XII for copies of Consent Statements).

In addition, due to the cross cultural nature of the project and the fact that within some of the cultural contexts the concept of written informed consent was not always understood (and/or potential participants were illiterate), alternate means of attaining informed consent were derived. In consultation with cultural interpreters and/or my research supervisor, oral consent was sought six times. This entailed a full verbal briefing on the nature of the research project and a clause by clause reading and review of the informed consent statement, paired with ample time to answer questions to ensure that potential participants clearly understood the concepts covered. When appropriate, this process was audio taped but in 3 cases (in Colombia), audio recording was not utilized. This decision was made in consultation with a cultural interpreter and based upon careful consideration of factors such as geographic region, cultural norms, local context,

individual attributes of the respondent (age, educational background, current living context), and other related factors with the aim of ensuring that the research process was respectful of local realities while still being ethical. In such cases, informed consent was still obtained, witnessed by a cultural interpreter, and the standard interview script followed. In such instances, the cultural interpreter transcribed the responses of participants during the interview. In addition, a set of secondary notes were generated by the principle researcher (based upon the verbal translations provided by the cultural interpreter/translator) with both sets of data being cross-referenced after each interview so as to ensure that the information provided was comprehensively captured and documented.

Data Analysis

On completion of my field research and my return to Canada, data was analyzed using a three phase process of open, axial and selective coding (Strauss & Corbin, 1998). Microsoft Word was utilized to aid in analyzing the transcripts - both those from round table discussions and from the semi-structured interviews with individual participants. While using Microsoft word, two personal computers were utilized. One monitor was used to display the original text which I reviewed and highlighted noteworthy statements, phrases and words. A second computer was used to enter the selected open codes under very broad headings. This allowed for a comprehensive review, deconstruction, and formulation of the data.

In addition to the development of a series of broad categories to classify the open codes, during the initial phases of coding, data derived from participating national societies (PNS), national societies (NS) and countries were coded separately. PNS data was recorded in red text while all other respondent data was coded in black text. Through the process of constant

comparison it was noted that the statements of the two groups of participants bore many similarities: each spoke of the identical service providers, the same array of programs and services, similar program strengths and limitations, and made similar recommendations to affect positive change. Consequently, in my second level of coding, no distinction was made between the two groups (PNS and NS) and all text was converted to black.

Based on the open coding process and the preliminary placement of codes into purposeful groupings, subsequent categories were derived and existing categories refined, leading to the process of axial coding. During the axial coding process, the relationship between all previous codes and coding categories was explored and the connections between all data were further highlighted. An ecological perspective was used to establish a framework to order the data in relation to level of impact – individual, organizational and/or community - when looking at topics such as strengths and limitations of current humanitarian aid programs or essential psychosocial programs for affected populations that presented multiple dimensions.

Following the axial coding process, data was holistically reviewed and attempts were made to draw conclusions and generalizations regarding the meaning of the wealth of data with which I was presented. These insights were conceptualized and formulated into a series of models (Figures 1-9) that are explained in the Chapter 6 and the data presented in Chapter 5.

Techniques Used to Assess Trustworthiness

Lincoln & Guba (1985) describe "trustworthiness" as having collected data that is to be found credible. They argue that the basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audience (including him or herself) that the findings of an inquiry are worth paying attention to, worth taking account of? In establishing trustworthiness Lincoln

and Guba outline several key issues to be attended to while carrying out research: credibility, transferability, dependability and confirmability. In the execution of my research initiative, several strategies were employed to ensure that my findings were valid and reliable.

Credibility

Lincoln and Guba (1985) report that researchers are required to establish credibility to ensure that the research findings presented are representative of participants' true experiences. To establish credibility in this study six key techniques were employed.

1. Triangulation

Two forms of triangulation were utilized in this study, method triangulation – checking out the consistency of findings generated by different data collection methods (Patton, 2002) and source triangulation – checking out the consistency of different data sources within the same method (Patton, 2002). Method triangulation was based on the use of two different data collection techniques – semi-structured interviews and focus groups – in the collection of field data. In addition to the use of two data collection methods, research was carried out within six Latin American countries. The use of multiple methods of data collection and sample populations enhanced the credibility of my research and yielded a rich body of data to be compared and contrasted during the analysis process.

2. Prolonged Engagement

Lincoln and Guba (1985) state that prolonged engagement means a researcher must spend an amount of time in the research setting that is sufficient to learn about the environment that they are about to explore. Secondary to the degree of familiarity with the new environment is the element of trust that can develop between the researcher and potential participants through this process. During the collection of data, I spent 15 weeks in the field living with and learning from

members of the communities that participated in my study. This exposure enhanced my ability to establish a rapport with members of my sample population that aided in reducing communication barriers and facilitated a freer, more open dialogue between me and study participants. The establishment of trust allowed them to speak candidly in a safe space where they knew confidentiality would be respected, not fearing any repercussions. This immersion also provided invaluable insight into the cultural context and lived realties of people in each region that proved to be of utmost importance in contextualizing the voices of participants during the formulation of my research findings.

3. Persistent Observation

In addition to prolonged engagement, persistent observation (Lincoln and Guba, 1985) was also draw on to aid in enhancing the credibility of my data. Persistent observation involves focusing on the characteristics and elements of the respondent's testimony in relation to the problem or issue being explored. This provides greater clarity to the research findings and adds depth to the data being reported and/or context to the data observed while in the field. While other factors may present as being of great importance and need to be accounted for during the research process, persistent observation provides a means to contextualize the data and maintain a clear focus throughout the data collection and analysis process. Although I used this strategy to keep me focused during my data collection and analysis process, careful attention was paid to ensuring that all data/observations were accounted for and contextualized – even if the data did not directly relate to my initial goals and objective. This care can be noted when looking at the emergent nature of my findings which include a wealth of data regarding factors such as cultures, attitudes and impacts of response work upon responders, which was not directly related to my

research goals, not included in my research instruments, but provided an addition degree of depth to my overall research report.

4. Constant Comparison

Similar to persistent observation, constant comparison (Lincoln and Guba, 1985; Lofland and Lofland, 1995), involves reviewing the statement of participants in the context in which they were shared and in relation to the statements of others. Such a process allows for the development of themes, categories and sub-categories while analyzing the data and subsequently facilitated transition from open coding to axial coding and the development of theory from the information contained within the data sets. The constant comparative method helped me review and formulate my data from within each country sample and between country samples. Further, while constant comparison allowed for the identification of commonalities and patterns across my data sets, it also allowed for the identification of components of my data that did not align with the statements of others. Attempts were made to explore how such data is related to the data set as a whole and to my research goals and objectives.

5. Peer Debriefing

Peer debriefing (Drisko, 1997) proved to be a very valuable tool and occurred on two different levels – both in the field and upon my return to Canada. While in the field, my peers offered valuable insight and expertise that enhanced the credibility of my research initiative. In addition to the technical supports offered in the selection of countries and regions within each country to carry out my field research, my colleagues also proved to be great sources of insight during the initial phases of the data analysis process. Throughout the collection of my field research, either formally or informally, I relied heavily upon those in my environment to help me make sense of and conceptualize the data. Time spent with members of the Red Cross provided a

venue for me to discuss observations, solicit feedback and aided me in making sense of the data. Further, such interactions with my colleagues contributed to the thickness of my data and aided in its synthesis and on occasion illuminated major patterns and themes – patterns and themes that were later used as coding categories. In addition to the peer debriefing carried out while in the field, upon my return to Canada members of my thesis committee (chiefly my committee chair) fulfilled a valuable role in helping me during the initial phases of my data analysis process by helping me formulate my thoughts and conceptualize my raw data. These individuals also provided valuable guidance and feedback regarding the development and refinement of coding categories and sub-categories and overall presentation of findings.

Dependability and Confirmability

As a means of ensuring that my data was both dependable and confirmable, audit trails (Lincoln & Guba, 1985) were used throughout the research process. An audit trail involved the systematic recording of steps taken at each stage of the research process and provides accounts of the progression thought the data analysis process. Throughout data analysis, accounts were made of decisions made and my thinking about them. I also documented work done, and decisions made in collaboration with my research advisor. These accounts have allowed for critical reflection by both my advisor and I on the steps taken and their outcomes. Further, copies of the original data were saved (and disk backups made) at each stage of the coding process to allow tracing of the progression from open to axial and eventually selective coding.

Transferability

The final component of trustworthiness as outlined by Lincoln and Guba (1985) is transferability. Transferability speaks to the degree to which the findings revealed in this research study apply to other similar situations. Lincoln and Guba (1985) note that in order for such a

determination to be made there needs to be "thick data" to allow an individual to assess whether or not the findings can be applied to other situations. While "thick data" (Lincoln and Guba, 1985) can help an individual in deciding if findings are transferable, a larger sample size can also support this conclusion. Both thick presentation of data and a larger sample were used in this study.

Related to the notion of transferability is the concept of fittingness (Lincoln & Guba, 1985). Fittingness refers to the degree to which the situation and/or population studied matches other situations - their congruency. When reviewing my research topic (context and population) strong parallels can be drawn between my research context (six disaster/complex emergency affected Latin American countries), my research subject (members of the Red Cross), and other affected regions in the world chiefly due to the practices of the Red Cross and the nature of disasters and/or complex emergencies. Because the structure of the International Federation of Red Cross and Red Crescent Societies (IFRC) and the nature of the Red Cross relief operations are standardized globally, many generalizations can be derived. While each Red Cross National Society has adapted to accommodate local context, base programs, services and guiding principles and practices are the same throughout the world. Further, disasters and complex emergencies bear many commonalities globally in terms of type and impacts upon both infrastructure and affected populations.

Chapter 4 – Results

Chapter 4 has three parts. Part One reviews participants' views of current practice, Part Two presents participants' critiques of current humanitarian aid initiatives, and Part Three explores participants' recommendations for affecting positive change in the delivery of psychosocial programming.

Part I
Views of Current Red Cross Practices

In this first part of the chapter we review participant's views of current Red Cross practices. Although this section does not focus solely upon psychosocial programming, it does provide a comprehensive synopsis of current humanitarian aid initiatives within the regions.

Topics covered included:

1. Types of disasters and complex emergencies in the regions
2. Overview of key players in delivering humanitarian aid
3. Issues relating to coordination of humanitarian aid initiatives
4. Review of the needs of affected populations

Review of Participants

Participants for this study were of varied ages and sex, had different levels of experience and expertise, were paid and volunteer personnel, were from rural and urban areas, and represented various social and economic backgrounds. In total, 34 semi-structured interviews and 5 focus groups were carried out in 6 Latin American countries. Fifteen of the participants in the semi-structured interviews were female and 19 were male. There was nearly equal representation between paid and volunteer Red Cross personnel. Due to fact that it is culturally inappropriate to

ask a female her age in Latin America, this data was not solicited. Based on observations, however, I would estimate that participants in the interviews ranged from 18 to 65, with the typical age being approximately 30.

A review of the demographics of focus group participants shows that there were 22 females and 16 males. Approximately 75% of these participants were volunteer humanitarian aid workers. A similar age range was evident (18-65), though the typical age of respondents within the focus group sessions was lower (approximately 24 years). This estimate is based on the fact that many of the focus group participants were senior university students who were volunteering to meet the compulsory community service requirement in most Latin American universities. The information presented in this section represents the perceptions of participants in the study.

During the initial coding process, information was categorized by type of affiliation – member of Red Cross National Society and/or Participating National Society – and by country. Through this preliminary analysis staggering parallels were noted across affiliation and country. As a result, it was decided that such differentiations was not necessary and all data were grouped together for further analysis and reporting.

Definition of Psychosocial Programming

The term psychosocial programming can have a variety of meanings. When initiating my research I chose a basic definition of the term in order to allow for an integration of the thoughts and sentiments of my participants. This was "any program designed to improve psychological and/or social functioning", with these initiatives meaning different things to different members of an affected population. My initial thoughts about the concept of psychosocial programming were confirmed, but they were also expanded by this research.

Psychosocial programming can still be defined as "any program designed to improve psychological and/or social functioning", but respondents generated a long list of components of psychosocial programming. These include individual support, active listening, group interventions, psycho-educational activities, dissemination of resources, creation of safe space, possibilities for ventilation, crisis intervention, stress management, suicide intervention, assessments and referral, normalization of reactions, establishing community networks, community capacity building, identifying and addressing connection between psychological trauma and physical health, provision of social supports, peer debriefing activities, recreational and leisure activities, facilitation of opportunities for positive peer interaction, conflict resolution, mediation, income generation programs, job retraining and vocational training, disaster preparedness, and coaching about alternate means to express thoughts and feelings such as art and drama. They also said that programs should be designed for special populations such as children and the elderly. Further, participants noted the need for programs to address secondary issues related to disasters and/or complex emergencies such as the increased frequency of domestic violence, sexual assault, and child abuse. These elaborations now define my understanding of psycho-social programming.

Types of Disasters and Complex Emergencies

Participants were asked to speak about the nature of the disasters that have affected their countries. It was reported that various types of disasters and complex emergencies have occurred within the regions, some had transpired in the past, in other cases communities were still actively recovering from them. These occurrences ranged from natural disasters, such as "floods during the rainy season" in Panama and Argentina; "large mud slides" and "land slides" in Nicaragua;

"hurricane" and "tsunamis" in El Salvador and Peru; and "earthquakes" in Colombia. While identified by country, these occurrences are by no means isolated to any given region with many countries experiencing differing types of disasters each year.

Man made disasters and/or complex emergencies were also reported by respondents such as "guerilla warfare" in Colombia leading to the mass "displacement of people". Widespread acts of "terrorism" and frequent "summary executions", "massacres", and "hostage takings" were identified. Participants also spoke about associated forms of victimization such as problems with "child soldiers", and the reality that a large portion of the country is classified as "red zones" and is segregated from state programs and supports. Many participants also spoke of the impact of these occurrences on children and made statements such as "the school in the town[s] [are] often caught in the crossfire". A participant also spoke of one occasion when "50 primary school kids [were] caught [for] 5 hours in conflict", and had to "witness" the events. Similar experiences were also noted in El Salvador and Peru, regions once ravaged by civil conflict that are still struggling to manage and recover from the impact of the events.

While civil conflict and guerilla warfare were identified as the most frequent type of complex emergency within the region, in Argentina, people were in the process of recovering from a "social crisis" that resulted in a reported 57% of the population falling below the poverty line over night. In this region twenty-seven percent of the population - over 10 million people – fell into extreme poverty when the economic structure of the country rapidly disintegrated. In reference to the social crisis a participant said "regardless of cause we had vulnerable people, political corruption, no respect for law, class conflict, inflation, poverty, economic crash, banks closed, factory and farms closed, no money, no loans, grave impact on economy"

Key Players in Humanitarian Aid

Participants were asked who they believed to be the key players in the delivery of humanitarian aid on a local, national, and international level. Participants noted that several key players were involved with relief and recovery efforts within each country. For ease of presentation of the data and consistency, terminology outlined in the SPHERE project (2000) will be employed to categorize those individuals and/or groups. SPHERE defines key stakeholders as anyone affected by or affecting humanitarian assistance. This can include both service providers and recipients. When exploring who is a service provider, SPHERE has a series of sub-classifications. The term "host government" is used to identify the government in the country in which the humanitarian assistance takes place. The term "local authority" is used to identify the government or leaders who are known to be in charge of the country or area in which an incident has occurred. It is important to note that while there may be a government structure in place, they may not always be in charge of, or lead regions of the country (this is the case in Colombia where guerilla and/or paramilitary groups have acquired control of specific geographic regions). In addition, the terms "humanitarian actor" and "humanitarian agency" have been used to denote organizations that support the provision of humanitarian assistance - either local or international non-governmental organization, UN body or donor institution, whose activities support the provision of humanitarian assistance.

Host Government and/or Local Authorities

Many participants spoke to the presence of a national system for disaster response and mitigation that is comprised of representatives of various national ministries, such as the ministry of health, education, and civil defense. In addition to the presence of government bodies, each national committee is also comprised of other related professional groups, such as members of

the police force, fire departments, local medical and legal professionals and local rescue organizations. Each of these groups play a role from a national to a local level in advocating for, and effecting change in the nature and coordination of relief, recovery, and rehabilitation efforts. In addition to the presence of a national committee, in many instances, sub-level committees also exist at the departmental and/or municipal level.

Humanitarian Actor and/or Humanitarian Agency

In addition to state affiliated humanitarian actors and agencies, many other local and international organizations actively engage in the delivery of humanitarian assistance within the region. These organizations include groups such as UNICEF, OXFAM, Save the Children, World Food Program, International Organization for Migration, and many local organizations such as church groups and local psychological associations whose mandate it is to provide direct supports to affected populations. Included in this category are the International Federation of Red Cross and Red Crescent Societies and its respective national societies within each country. While each country in the region has its own national society, in many countries there are also representatives from participating national societies (PNS). A PNS can be classified as a sister national society that has set up a temporary office in a given country and works within that country - either in partnership with the host national society, or through a unilateral agreement to carry out their humanitarian work. The most frequently represented PNS' in Latin America were the Canadian Red Cross, the American Red Cross, the Holland Red Cross, the Italian Red Cross, and the Spanish Red Cross.

Who Coordinates?

During my discussions with the participants it was noted that most countries, in theory, if not in practice, have a national committee for disaster response and mitigation (COIN – Spanish acronym) that designates roles and responsibilities for affiliated key players in the field and directs operations during humanitarian aid interventions. It was noted that the "Red Cross, Ministry of Health, social security, hospitals, Ministry of Women, municipalities, police, civil defense, doctors and forensics [have] over time worked together to shape and reshape operations, set roles and guidelines, assigned [roles and guidelines] to organizations, established frameworks, [and] policies." Further, it was noted that in some countries, laws have been developed to outline who does what, and when, during relief, recovery, and rehabilitation efforts (e.g. Nicaragua's Law 337 - Attention to Disaster) and/or commissions have been established to attend to the issue of coordination in the delivery of humanitarian aid.

While these proactive strategies have been employed in an attempt to coordinate and govern humanitarian aid initiatives at a national and local level, many participants reported a vast discrepancy between theory and practice and questioned the effectiveness of COIN and other similar entities. One participant stated that "at the national level it is government, but they have little response capacity because they don't have stockpiles of supplies or a national network to actually implement something, they are more of a coordination body". In addition, it was also noted that while in theory the "national emergency committee will start all activities" and each other humanitarian agency is required to "function under [the] national committee" with each group having to "report to COIN" and "inform COIN of what they are doing", "in the affected areas there are many NGOs and IOs, each want a piece of the pie." Consequently, in the field there is often a discrepancy between theory and practice in relation to coordination and

cooperation - "you have your classic checklist of organizations", "each agency has [their] own role" and it is typically the "one who has more capacity to get to the place [that] starts the aid".

Theory versus Practice – Lack of Coordination in the Field

These statements about the discrepancy between theory and practice in relation to the coordination and cooperation between humanitarian aid organizations reflect the fact that while in many countries/regions a body of literature exists – policies, procedures and protocol - geared toward enhancing agency cooperation and service provision in the field, it was the view of respondents that these policies were not adhered to by aid agencies. One respondent noted,

> "When I look at what we were doing after the disaster, there were a lot of people doing service, but all over the place and not coordinated, not organized, disorganized, and when you look at the term psychosocial support, we did not really know what was psychosocial support, there was not even an agreement, are we doing psychosocial support, mental health, what are we doing?"

These sentiments were common among participants, many of whom spoke of the lack of coordination in the field, and the sense that the efforts are "not a collective", rather, a group of aid agencies who "act independently" with no "communication to integrate the policy". Participants indicated two key repercussions - disorganization in the field, and a disparity in the services being provided to the affected populations.

Disorganization

Participants indicated that in the field there are "many real problems in coordination" which resulted in a sense of "no real good coordination" and "no guidelines to follow". Participants noted that people were required to "modify process as they went". As such participants reported that there was "no coordinated effort" and that "each organization worked

with [their] own people and own donations." Such an approach was cited as being highly problematic as there was often "competition amongst organizations". In sum, one participant stated, "They are guided by the national plan but there is some disorganization for the response. So, the victims are the affected ones."

Disparity in services

Participants also noted that there were vast "differences in services for each community, [with] no standardization [and] no consistency" and "many agencies were responding, each have a different responses and different capacities." Further, participants indicated that "everyone was grabbing ideas from here and grabbing ideas from there" and many organizations were working "separate from each other, trying to do the best they can." Participants indicated that while a lack of coordination was problematic in all areas of humanitarian assistance, it was especially problematic when looking at the provision of psychosocial supports. One participant said, "the strategies that we were using, it could be incorrect, but if we do not have a [frame of] reference we can just do whatever the hell we want and then, who is taking care of the people afterward?" Respondents also questioned, "if you come from the outside and do whatever you want, how do you follow up with these people if you do not know the methodologies, the strategies?"

The disorganization and confusion was linked to the fact that people believed that many organizations were in a process of "trying to get their stories straight on what really is psychosocial programming and what exactly is it that we do" but that they "can not agree" as "there was no framework". A participant stated, "what we had was external NGOs , just come here to deal with the problem, then leaving, when leaving you just leave a lot of problems, which could not be taken and handled by other people because they did not know what you are doing."

Needs of Affected Populations

When asked about the needs of affected populations, participants provided a long list, and an equally comprehensive list of aspirations for programs and services that they deemed to be essential during the delivery of humanitarian aid. These needs can be organized into three broad, and sometimes overlapping, categories; physical needs, psychological needs and social needs.

Physical Needs

Participants indicated that "primary needs [are of] great importance" and that there is a "need to address basic issues before [you] can be effective and productive in other areas", noting that "in the initial phases, impact is the same [and it is] difficult to talk about psychosocial support if [there is] no food, shelter, etcetera." Participants also reported the need for shelter and "to create a safe space" as being very important, noting that the "protection that a shelter brings to a person is important." "Food, water and bathrooms" were also mentioned as being important. In addition, participants clearly articulated that while "the first need is always shelter, health, food, water, hygiene", attention to basic needs is not enough and "depending on the disaster it seems like the family structure and the community structure are the most important things [for people] in dealing with the disaster".

Psychological and Social Needs

Participants clearly stated that "psychosocial support [is] needed in natural disasters and conflicts", and that there is a need for "more psychological support, [for] people impacted by [psychological] trauma." One participant said "Without proper emotional support, [people] can not begin the life process, [to] rebuild." It was noted that "at some point when you have clothing, a house, and so on, there is something that you are going to miss." Participants spoke of the need

to provide "emotional support, [and to] give them an opportunity to be with their family - to talk, cry, fight, and scream."

In addition to the provision of supplies to meet basic needs, and attention to psychological impacts of an occurrence, participants also spoke of a "long term need to rebuild life, social networks, [and] economic rehabilitation", and that "beyond psychosocial support, [there is a] need to look at normalcy, economic, social, education [needs]." These efforts were reported as being essential to support individuals, families, and communities in regaining a sense of normalcy by aiding in the re-establishment of things such as "social structure" and "sexual relations", and creating income generating opportunities. Further, it was noted that "men, [have] many problems, complex problems, [and that it is] difficult to get economic support and jobs [which are] often overlooked."

Part II
Participants' Critiques

Part Two of this chapter will provide participants' reflections upon, and critiques of, current Red Cross humanitarian aid initiatives citing both the strengths and limitations of such initiatives.

Topics covered will include:

1. Impacts of disasters and complex emergencies upon affected populations
2. Current Red Cross Humanitarian Aid Programs and Services
3. Critiques of Existing Red Cross Initiatives
4. Strengths and Limitations of Current Initiatives

Impact of Disasters and Complex Emergencies on Affected Populations

In addition to identifying the needs of affected populations, the impact of disasters was also explored with participants. Similar to needs, impacts can be categorized into three, sometimes overlapping categories: physical, psychological and social.

Physical Impacts

A predictable list of physical impacts was identified by participants that included loss of life, destruction of houses, damage to essential infrastructure, and loss of agricultural goods and livestock. There was a general sense among those with whom I spoke that the physical impacts are "obvious", and did not require elaboration. Consequently, not a lot of time was spent on this topic.

Psychological Impacts

When asked about the psychological impacts, participants mentioned a variety of different psychological effects of disasters and/or complex emergencies including "shock", "dependency and fear", "stress and anxiety", with "many people desensitized" and "many people suicidal." In addition, "aggression [was] evident among children in schools". Many of these symptoms present themselves immediately, as was the case in Peru where a "tsunami took everything" and "people wanted to stay in the mountains, [as there was] fear of returning to the beach." It was also noted that "[psychological] trauma [is] still vivid and apparent" within affected populations and manifests in many different ways long after the occurrence. Participants reported that "kids [were] impacted, [and that] classic PTSD symptoms [such as] bed wetting, nightmares, aggression" were readily evident. "Learning disabilities and speech impediments [also] increased in children [and] two years [later these] issues [were] still evident." A participant from Nicaragua shared the story of one woman who attempted suicide:

> She was in a house during the second earth quake, and there were four people also in the house repairing the house and then the second earth quake, then the house collapsed and the four men died. She survived because she came out of the house just before it happened, just one minute before the quake.

Psychological impacts were also noted in stories pertaining to interactions with children. One volunteer reported "you could see these children beating these piñatas, and they would do it with such great strength, these people have so much anger, so much anger inside that they needed to get it out." In addition to overt psychological signs and symptoms, many participants reported psychosomatic symptoms among affected populations such as "menstrual dysfunction", "headaches", and "mental health issues, substance abuse, and violence."

In addition to the manifestation of the psychological effects of trauma in physiological and/or behavioral ways, it was also noted that few people actually attribute such symptoms (psychological or otherwise) to their traumatic experience. One participant stated:

> OK, it is very stigmatized, for example, some child may pee at night, the only thing that they know is about that child. They don't know what it is about, just a bad boy a bad girl, but the real problem, is the consequence of the disaster. And because they do not have any recognition, any, they do not know what is the problem, and they do not have the sense of the disaster and this is the consequence. Few people know, and they think, after the earthquake my family is doing this and that but few people know [why]… most people still don't.

Social Impacts

It was reported that effects of "disaster[s] [are] further aggravated by social issues" and that "disasters generally aggravate peoples' problems". Such statements speak to the fact that disasters and complex emergencies within this region were not viewed as stand alone phenomenon. People spoke of the fact that disasters are interlinked with other occurrences which they have come to consider as "every day issues" in many regions such as "bombings",

"abductions", "massacres with chainsaws", "group suicides", "gang warfare", "political corruption", and "poverty" with each having social impacts on exposed populations. Participants reported factors such as "loss of jobs", a sense that people "do not have a future [and] do not have perspective", that there are "changes in family structure [with] many female headed houses, and that women and children are more at risk of "family violence, domestic violence, and child abuse".

It was also reported that in many cases these occurrences have "taken possession of society". For example the "school year is interrupted", "parents did not want kids to return to school", "many kids [were] involved in armed activities", and that "family relations are broken because of the impact of the disaster". Further, "communication, sex, and normal activities that you have in life are very affected because of the disaster"

Current Red Cross Humanitarian Aid Programs and Services

Reactive Recovery and Rehabilitation Activities

Participants identified several humanitarian aid programs and activities that are carried out by the local Red Cross such as "evaluating and assessing damage and needs", "coordinating and distributing relief rescue people", and the use of "dogs to look for human remains". It was noted that "when [we] work with conflict related activities we [Red Cross] coordinate with the International Committee of Red Cross and Red Crescent Societies [ICRC]" and "in terrorist attacks and bombings, [the Red Cross] fulfills the same role as in natural disasters."

Proactive Recovery and Rehabilitation Activities

In addition to reactive efforts, participants also reported proactive activities pertaining to "disaster preparedness linked to floods, earthquakes, and terrorism" and various training

activities for the community. It was noted that the Red Cross does "training in community capacity building, first aid, humanitarian values, and principles [for] government, military and civilians."

Psychosocial Programs and Services

Participants talked about several Red Cross programs and services that could be classified as psychosocial initiatives aimed at attending to the adverse psychological and social impacts of disasters and complex emergencies on affected populations. These efforts ranged from psycho-educational programs to therapeutic support services; each targeting a variety of populations and having various degrees of complexity and time frames for implementation. Variation in type and duration was chiefly linked to geographic region and who used the service. It became evident that more programs and services existed in urban centers and that the programs and services offered in urban areas are typically offered by mental health professionals and could be offered over a longer duration. By contrast, programs in rural areas were typically less complex in nature and in many cases did not include the services of mental health professionals.

The degree of complexity of a program was sometimes linked to who was delivering the programs. While each country has a Red Cross national office that develops and delivers humanitarian aid programs and services, they typically do not have sufficient resources to develop complex, long-term programs. Many of their initiatives do not have a formal mental health component and are time limited. By contrast, many of the programs offered by Participating National Societies (PNS) were well funded and did offer a professional mental health component. While this is the case, many of these programs did not offer services beyond the initial phases of the humanitarian aid intervention.

When exploring the nature of the specific programs and services that were offered respondents spoke of many initiatives. These included the development of a series of psycho-educational CD's that were "broadcast over the air" aimed to disseminate information to the masses, and then have a psychologist available at the radio station during, and following, the airing to answer calls and "offer support for those who called in." Other initiatives included the establishment of "phone lines", "accompanying families during body identification process", and the establishment of "support teams inside of evacuation centers", aimed at getting people to express emotions, explore their needs, help deal with their current realities, and assess for serious mental health issues. Additional programs discussed by participants involved "outreach to families" to provide "information on what and where, how to access services, missing persons' directory, facts about what happened, what is an earthquake, to dispel "myths" and "provide information regarding normal reactions to [psychological] trauma and disaster."

These programs allowed people to "talk about earthquakes, [their] reactions, emotions, [and] gave space to cry". Additional programs were reportedly developed to work with children within schools such as "play therapy, kid's games, and the happy box" - a box containing puppets and props used by volunteers to engage children in dialogue and provide information through games and activities regarding the nature of disasters and their impacts.

Participants' Critiques of Existing Red Cross Initiatives

While numerous Red Cross humanitarian aid programs and services were named by participants, three chief critiques were noted. First, participants spoke of the primary focus of current initiatives on meeting physical needs. Second, they said that existing psychosocial programs are time limited and focus primarily upon crisis intervention, and third; they lamented

the fact that many such initiatives are not introduced or maintained by National Societies; rather, they are developed and managed by Participating National Societies, that is, societies from outside the country.

Attention to Physical Needs

Participants provided information regarding the fact that the Red Cross "provides for the basics; food, clothing and shelter", and have "first aid" programs, "give temporary shelter", "provide water", etc., with one participant stating "if you look at the National Society, they are into construction, houses, schools, buildings, but to me we are not a construction company, we are not that." This sentiment was echoed by another participant who stated "we are not really serving the community, you just go build a house, serve as a construction company then get out of there." Others said "first we look at physical needs, and then maybe someone will look at psychosocial support, and typically "crisis intervention consists of interviews linked to basic needs".

Focus on Crisis Intervention

With respect to psychosocial needs, one participant said "we try to supply for the special needs, the psychological needs following a disaster, and we have only one kind of intervention, crisis intervention". This statement was mirrored by many participants who spoke of the fact that "psychological first aid [is the] key mandate". While this is the case, participants noted that "crisis intervention has limited capacity and efforts are sporadic". The need for long-term programs with follow-up was shared by a participant who stated that "mental health is complex, and crisis intervention is not enough." Another participant reported that "following a disaster, many symptoms are evident after 6 months, and need crisis intervention, plus mid term, plus long

term [support]." Echoing this belief, another stated it is "important to have permanent programs to help people".

Participating National Society (PNS) versus National Society (NS)

Related to the preceding two concerns, the focus on physical needs and the time limited nature of many initiatives was the view that too many initiatives are introduced and managed by Participating National societies (PNS). As previously discussed the International Federation of Red Cross and Red Crescent Societies includes 181 National Societies globally. Each National Society shares the same mission and set of governing principals. Under this national network there is a great deal of sharing of skills and resources between National Societies to aid in fulfilling their mandates within a given country. Thus, a distinction needs to be made between National Societies (NS) and Participating National Societies (PNS). In the simplest terms, while there can be one National Society per country, due to the nature of the International Red Cross, there may be a presence of several sister National Societies within a given country who either work in partnership with, or unilaterally, to aid in fulfilling a mandate such as the provision of humanitarian aid following an occurrence. This presence is typically classified as temporary and function/role specific, as was the case in Latin America. Participants frequently spoke of "foreign consultants" who worked in their region. Further, participants stated that presence of the PNS is problematic because programs only exist "as long as the money lasts" and they cited a "need for donor dollars beyond the first phase of a disaster".

Strengths of Current Initiatives

With respect to program strengths, it should be noted that as a result of the data analysis process and the coding of the data, the information presented makes reference to specific components of numerous initiatives. The data reported is not linked to a specific program in a given country and the findings presented span six countries and provide a compilation of common themes. No single initiative (or regional response) is noted to be more effective then another as each country and specific humanitarian aid intervention had inherent strengths and limitations. The data presented refers to broader areas of consideration, both positive and negative, with regard to the current capacity of the Red Cross to offer psychosocial programs and services while carrying out humanitarian aid initiatives.

Organizational and Operational Strengths

Participants shared opinions pertaining to organizational and operational strengths of both current and past humanitarian aid initiatives. A key strength noted by some participants was the time frame of the intervention(s). One participant stated, "we stayed in the community… we stayed the whole time." This was a key strength due to the fact that

> You can not just walk in and expect them to tell you [about the traumatic effects], so there was actually a certain time before they established some form of trust, a relationship with the people … The volunteers were there every day visiting the same people and sooner or later these people were starting to let things out, and we kept going to the same families … We kept going to the same families, talking to the father to the mother to the children, and sooner or later these people started to come out naturally because you know these people. You start talking to them, and work on the problem.

As a result it was noted that when "working with the same people, [we] could see results." Participants also reported that such outreach strategies also gave voice to the victims. It was noted that this was the "first time that someone actually went there to listen and to talk to

these people". Based upon the information shared, volunteers were able to screen for issues "then shared information with other organizations who then acted upon Red Cross information".

In addition, one key element of this particular outreach approach was the "training of volunteers from the branches, [which] decentralized skills and knowledge, aided in community capacity building." Such a process entailed the facilitation of a series of sessions for volunteers from within each community. These sessions were carried out by qualified mental health professionals and provided the volunteers with basic skills and competencies to work with affected populations and covered such areas as introduction to psychological trauma and the nature of metal health issues, stress management techniques, basic assessment skills and knowledge of who to refer to and when. The end result of such a process was the generation of a team auxiliary paraprofessional within each community who could work within their community, both in times of crisis and during the relief and recovery process, to proactively and reactively aid in managing and mitigating the potential adverse impacts of an occurrence. Participants stated, we "trained community leaders, teachers, and the staff and people for the health units… taught these people how to recognize basic symptoms [of psychological trauma]." Thus, "none of the people had to come to town; it was all done in the community." In addition, by training the community members, it was highly beneficial "because we counsel the whole family, and later on, they will be able to help each other to get through this".

Further, as a result of the work being carried out within each community by members of that given community, respondents noted that "social networks were [also] made stronger through the process. Although not an objective of the initiative, it became a positive result of the process which "aided in establishing a community network in light of reality" further enhancing the community's capabilities to heal themselves. This notion was clearly articulated by many

respondents who spoke of the fact that by allowing community members to be involved in the relief and recovery process and employing various outreach strategies, not only were these efforts able to reach greater numbers of people, they also drew members of the community closer and aided in the establishment of both formal and informal social networks. It was reported that the networks and the sense of normalcy they promoted were of paramount importance in the healing process for affected populations following a disaster and/or complex emergency.

Strengths Associated with Communities

The Red Cross is the world's oldest humanitarian aid organization and since its inception in 1862 the organization has tirelessly strived to establish and maintain respect on a global level. Part of such an effort is reflected in the set of fundamental principles that guide its activities. While each of these principles are of great importance, two principles in particular – impartiality and neutrality - make the Red Cross a truly unique humanitarian aid organization. These two principles, in theory and in practice, have allowed the Red Cross to deliver humanitarian aid in a nonpartisan and indiscriminate manner globally. The establishment and maintenance of such a practice ethic has gained world-wide recognition and respect and has allowed Red Cross humanitarian aid workers to transcend global borders and work on both sides of conflict lines.

While this status is a key strength inherent to the Red Cross, it also serves as a key community strength. The Red Cross relies heavily upon members of a given community to work with and represent the organization in fulfilling its mandates. These individuals can draw upon the organization's global network, history and respect to aid them in working in each community. These capabilities become evident in countries like Colombia where due to internal conflict between guerilla groups and the government armed forces, many regions of the country are no longer under the control of the state and are classified as 'red zones.' A grave humanitarian crisis

exists in these areas, a crisis to which most aid organizations are unable to attend out of fear for safety of responders and/or the fact that the people in control of these areas have denied access to these aid organizations. This is not the case for the Red Cross; due to their unique history as an aid organization they are permitted access to work in all regions of the country and aid in attending to the needs of affected populations.

Participants reported several key community strengths that proved to be beneficial in the development and delivery of humanitarian aid programs. One of these strengths is the noted receptiveness of the community to the Red Cross. One participant stated, "in general the Red Cross has a good image which really helps these people get in." Another said, "in conflict and war people believe in the Red Cross". Such receptiveness was also reflective in the degree of community participation offered during aid operations. Participants spoke of the "the willingness of the community leaders" and that there were "a lot of local NGOs involved" in aid operations. Participants also noted the degree of support and enthusiasm shown by community members, especially youth, to offer their support. "Young people were a key asset, very willing to be trained and to offer support and assistance." Participants also stated that the "youth volunteers [were] very motivated" there were a "huge group of young volunteers to work with victims of disaster", and that "there are people here who are willing to help, to join the Red Cross." However, in some cases the issue was that "there were definitely more people willing to be trained and to be serving and supporting their community than could actually be trained."

Connected to the degree of support of the Red Cross and the willingness of many organizations and individuals within each community to become involved, a secondary community strength was noted by participants - a sense of community capacity building and empowerment. Participants reported that due to the nature of the work of the Red Cross that there

was a sense of community capacity and "community ownership with a view that programs would be "sustainable." A participant reported the he believed that "[there is] strengths in [the] community and one's own capacity as an individual."

Limitations of Current Initiatives

As was the case with the presentation of program strengths, when reviewing program limitations, the information presented does not makes reference to specific components of any given initiative. Rather it draws upon commonalities as they were noted in the testimonies of participants from each of the six countries and makes reference to broader areas of consideration in relation to the capacity of the Red Cross to offer psychosocial programs and services while carrying out humanitarian aid initiatives.

Organizational/Operational Limitations

"We have a lot of training, we have emergency plans, and we are prepared in disaster response, but we need psychosocial programs." This statement, made by a participant, echoes the views of the majority of those interviewed. It was noted that while the Red Cross has a capacity to carry out traditional humanitarian aid activities, in most areas there are "no psychosocial programs to date" carried out exclusively by national societies in the region. It was noted that the "willingness is there, but to do it, there is not the capacity", especially at the National Society level. Although some attempts at psychosocial programming have been initiated in the regions, many such initiatives were developed and managed by Participating National Societies (PNS). However, "it is always the outside National Societies doing it", whereby "external experts" are utilized, and local personnel serve as auxiliary supports. In such cases, these efforts are "not consolidated with the National Society". While this is the case, the area of psychosocial

programming was noted as an emerging area of intervention for the Red Cross and all parties – both PNS and NS - report several difficulties in developing and facilitating such initiatives.

1. Lack of Training to Provide Psychosocial Supports

One key challenge presented by all parties was the limited experience that the Red Cross has in the area of psychosocial programming. Many participants reported that "we never had experience [offering psychosocial support] in the field", or that it was their "first experience in working in the community", or "It was the first time the psychosocial supports were offered in a response." Many participants felt that there was a limited experience and knowledge base from which to draw.

2. Lack of Culturally Sensitive Training

Associated with this reality was the fact that very few individuals who worked in the affected areas – local and/or international aid workers - were trained to carry out psychosocial programming in the field. It was noted, "professionals [are] not trained to deal with issues", and "traditional practice does not work." Participants also indicated that while there are trained practitioners in some cases available to offer supports, there were "few professionals equipped to respond". Such a belief was rooted in the notion shared by participants that "western perspectives [are] not reflective of local reality, traditions, family structure [and] culture", and that "We impose western practice and approaches into non similar environments." These practices often "open matters that [we] can not deal with in the communities and create many problems". Such statements reflect the belief that while in many regions efforts are being exerted to train local volunteers to deliver psychosocial programs following an occurrence, it was believed that this training was not responsive to local context. Rather, participants reported that frequently the training was rooted in western clinical practice and volunteers were taught intervention strategies

that were not applicable to the context in which many would work. As such, while working in the field and attempting to offer psychosocial supports many volunteers may be practicing in a manner that is harmful, or at least not beneficial to the client population.

3. Lack of Resources to Train Volunteers

Also reflective of the emergent nature of psychosocial programming and the lack of skilled individuals to develop and manage such programs was the limited allocation of resources to psychosocial programming initiatives. Participants reported a "lack of resources" and that they "could not afford" to carry out programs in an effective manner. This idea was reflected in participants' statements regarding "access to communities" and the fact that they could only "cover [a] little area" as "geography" played a key role. Further, limited human resources were noted in relation to the fact that while in some incidences professionals were available, many such "professionals still had [their] own jobs, on top of that [they] had to be a part of the response, [and] dual roles [were] very difficult and stressful." Overall, it was stated that the "Red Cross wants to do psychosocial support but [there is] no money to carry out the work".

4. Focus on Brief Interventions

Another reported limitation of existing Red Cross psychosocial efforts is the restricted time frame for such interventions. Participants stated that "we knew we could not go and then be able to do follow up over time, especially when depending on external funding, when it is over, it is over." Others noted that in many cases there were "no long term or mid range services offered, open door but do not follow up." Such realities were often attributed to a "problem in accessing resources over the long term". Participants further stated that while in many cases the desire to carry out long term work is there, resources are the issue. One participant stated "[we] want to work in the community but [have] limited capacity." Another noted that "the problem is not

developing the programs it is accessing financial resources." A need for evaluation also became evident from the statements made by participants. One participant indicated that "most of the people at the national society want to see a quick result, but these types of programs are like rivers, they are always slow to get to the sea."

5. Lack of Evidence Based Practice

Others made statements such as we "have lots of experience but how can we measure impact", or noted that "a weakness is that there is no monitoring process". Other similar statements were noted as participants cited a "big need for indicators of psychosocial success" and "there is an ongoing struggle with best practices" – what is responsive, effective, evidence based, psychosocial programs and services. Participants also made statements such as, "[it is a] problem because [effects are] not tangible" which was cited as being problematic because "donors do not like qualitative [data, they] need numbers, tangible." There is a "need for baselines and tools for evaluation, how do we get results, from this we can get systematic, comprehensive, holistic information on project and effectiveness," and that there exist a "rich experience in the movement [IFRC], need to share, learn from [it]."

6. Lack of Appreciation of the Need for Psychosocial Programs

Another major organizational limitation was a lack of understanding of the need for psychosocial programming. While recognition of the need for such efforts was noted by many, there were individuals who cited lack of knowledge amongst members of the Red Cross regarding the topic. One participant stated "In disaster we [workers] are trained to expect psychological reactions [in ourselves], it is ironic that we do not expect the people to have reactions." Others noted "It is like we want to separate health from psychology from aid, but it is all related", or "we rebuilt buildings but did not invest in rebuilding lives". It was reported that

while not all Red Cross personnel are ignorant of the topic, there exist a great variance in perspectives within the organization. One participant stated "some Red Cross personnel see the link between disaster and [psychological] trauma, [but] many still do not see the link." As a result of this lack of consistency in views it was noted that many Red Cross staff and volunteers are "resistant to programs" and/or "not prepared to manage the psychological component of the operation." One frustrated participant stated "what we are supposed to do is serve the vulnerable people but that is not what we are doing."

Limitations Associated With the Community

In addition to organizational limitations, several limitations associated with the particular communities were also noted. Similar to the disparity in the views of members of the Red Cross to the topic of psychosocial programming, similar disparity and lack of understanding also exists within the community. One participant stated "most of the agencies do see the connection between disasters and the need for psychosocial support, so the limitation is that the people do not make the connection." Another noted that there are "many different schools of thought" on the topic. Similarly, participants spoke of the need to work on consciousness raising and noted a "need to prove to some professionals that there is a link" - between disasters and psychological trauma.

1. Lack of Social Infrastructure

Further, it was cited that at the national or state level there are several key limitations to basic response capabilities. Participants made statements such as "there are problems with the structures in the country"; "Major gap in the capacity of the Ministry of Health to respond to a normal situation, more so after a disaster"; "Mental health programs in this country are

underdeveloped", and "Poor government coordination of efforts, very problematic". As a result, in some instances, even though there may exist a desire and/or a mandate to provide psychosocial supports, there is a lack of basic capability to do so. For example, one participant noted "Under law, provision of psychosocial support for Internally Displaced People [in Colombia] is a right, but [the] state does not have capacity to deal with the depth of the issue". Such a reality was cited by participants as being problematic; one participant noted "[the] state has limited capacity, therefore, great need."

2. Duplication and Lack of Coordination

Paralleling the limitations evident at the national level, participants also reported several localized community limitations which influence the provision of psychosocial supports. It was noted that there are "many NGO's, but limited capacity, no cooperation" and that there is a "disjointed NGO approached to helping" with each organization works autonomously from the other with no sharing of information and/or resources. Thus, while there are often many people providing humanitarian aid and attempting to provide psychosocial supports, such efforts are not always effective. Participants made statements such as "many partners in the field, each competing for a piece of the pie", "there were a lot of sporadic initiatives", and "many organizations working, do same initial screening and assessment, [and] people go through the same process 5-6 times, but no real support". There is "limited interventions and investment" in psychosocial programming and that "people [are] not prepared for the disaster - hospitals, government, or Red Cross."

3. Lack of Accessibility

Accessibility was also noted as a factor. In many cases "basic and complex services are centralized and located in larger centers", as a result, a "large part of the population have no

access to services". Local realities further compound the accessibility of services. In some countries there are "few actors in the field due to the conflict." Thus, "many people can not access services due to the conflict". Further, it was noted that "rural zones are isolated, residents can not move out of region" due to conflict, thus "people are restricted and cannot travel to access medical support and assistance", which is "problematic when all sessions are offered in hospitals."

Part III
Participants' Recommendations

The final section of this chapter will focus upon recommendations for changes in the manner by which the Red Cross carries out humanitarian aid initiatives as shared by the participants. Such views note the need for a change in current ideals and practices and focus on building community capacity.

Topics covered include:

1. Participants' views of essential psychosocial services
2. Structure and composition of psychosocial programs and services
3. Program recommendations
4. A review of current attitudes towards psychosocial programming

Participants' Views of Essential Psychosocial Services

Following the exploration of current programs and services which are presently being employed, participants were asked what they felt were essential psychosocial services that should be employed during the delivery of humanitarian aid. In addition to the identification of basic programs and services, or desired elements of basic programs and services for both individuals

and communities, participants also provided a wealth of supplementary suggestions pertaining to how such programs should be developed, implemented, and maintained.

Essential Psychosocial Services for Individuals

One of the key elements identified by participants in relation to essential services to be provided for individuals during the delivery of humanitarian aid, was the creation of a safe space for people to share their experience. Participants stated "talk to them, give them information, provide counseling, but not treatment… Take people to a private place and talk to him or her. It is good for them to express their emotions, they're free to cry." Other participants stated, "Talk therapy… important component, what happened, how impacted"; "it is important when providing psychological aid to let the person know that what happened was normal, all his/her feelings are understandable, now it is time to see the future." Others noted the importance of viewing the provision of humanitarian aid in a holistic manner citing the need to "help people process past experience and life realities, then aid in rebuilding lives,"

Essential Psychosocial Services at the Community Level

Participants articulated the need for supports at the community level and identified several areas upon which psychosocial interventions should focus. The need for a supportive social network was identified by most participants. Many individuals noted that that there is a need for community based programs and services. They stated that creating "social structure at the community level [is] important", and that "a community group session is important because you share your experience with others, you have different views". Further, it was stated that it is important to "empower communities to develop own community, develop own plan, [and to use] participator approach, in partnership with Red Cross, NGOs, Government." Related to the need for group support and venues within which to share experiences, participants also spoke of the

need for psycho-educational resources to aid an individual in preparing for, and normalizing their reactions, such as a "flyer on stress and burn out for volunteers", or material to "teach normal reactions [to traumatic events]". One participant stated "The most important thing after a disaster is to provide protection for the victims in the shelter, give them first aid, food. Afterwards, provide the victims with psychosocial counseling, especially to help control his or her emotions, stress.... The idea is to make the person aware of what is going on, what's next." The importance of the family was noted by one participant who stated, "It is very important to regroup the family and have a normal life." In addition, the importance of working with parents helping them to support their children was noted, "Children basically refer to parents as a point of reference. If your father, if your mother is hysterical all the time, you basically do the same." This illustrates the importance of education at all levels in the community.

Peer support also became an emerging theme amongst participants who frequently spoke of strategies that can be used to aid community members in not only helping themselves, but also helping others. "Youth to youth services" were noted as important and that "children group sessions are good, because there are recreation activities, so they forget the situation, live a normal rhythm." This interaction serves as a positive tool for rehabilitation, as mere association with each other has a powerful healing influence. Further, outreach was reported to be important to ensure that programs and services are accessible. Participants indicated the "need to work with vulnerable groups, new Internally Displaced People (IDP), the poor" and with the "general population". It was also noted that we need programs in rural and urban areas, especially in high risk areas such as the "red zones" – guerilla controlled areas in Colombia.

Essential Psychosocial Services for Humanitarian Aid Personnel

Overwhelmingly, participants cited the need for programs that addressed not only the needs of affected populations, but also those who offered support and assistance to such people. One participant stated "it is necessary, [and] it is important to have psychosocial programs, but they should include the Red Cross volunteers and staff." Further, it was suggested that the Red Cross should "develop programs in parallel, for volunteers and for the community", and noted that "In-house attention [is] very important". Such statements made by participants spoke to the fact that the needs of humanitarian aid workers are often overlooked. In addition to the necessity to provide psychosocial supports to aid workers, participants also noted the importance of attending to the basic physical needs of these personnel. A participant noted that there is a "need to ensure attention to needs of volunteers, sleep, work rotation, proper food", with special consideration of their work realities. An example is the belief that "volunteers in red zones need more psychological support than in cities."

Desired Components and Attributes for Essential Psychosocial Programs and Services

In addition to the identification of essential psychosocial programs for selected populations, participants also noted several desired components or attributes for such programs and services. The following is a selected listing of key elements suggested by participants: 1) the need for "empathy" and "active listening" skills for aid workers; 2) the necessity to make it clear that an individuals' response is a "normal reaction to situation and [most] can deal with it", and 3) for workers to ensure that their interventions are responsive to need. One participant noted, "the attention depends on the level of emotional damage". The importance of working with families was also noted, and participants indicated that parents need to be told "to talk to their

children, support them". Further, it was suggested that the Red Cross "use community leaders, [to serve as a] bridge in communities between people and services", and should focus on "internal capacity building" with the "vision to give the people the tools to help themselves" in a "sensitive" way, which will "maximize on local structures". Finally, it was noted that such efforts need to be exerted during "three levels of response: before, during, and after" an incident; not just in the short-term relief but also the recovery phases of an occurrence.

Need for Policy

When exploring recommendations for change, participants talked of a need to "develop policy". Such policy efforts are required to "aid in coordinating", and to "put mental health issues on the agenda". In addition to the need for policies, participants shared a variety of recommendations that could be used to strengthen existing programs, and to develop new psychosocial programs.

Participants' Recommendations for Programs

Programming recommendations shared by participants can be grouped into several broad, and frequently, overlapping themes or categories, each of which speaks to a need for change in current practice and protocol.

Integrated Approach

Participants spoke of the need for an "integrated approach" to the development and delivery of psychosocial programs and services and stated that there is a "need to recognize the importance of an integrated approach." One participant said, "Psychosocial support can not be isolated, [and] needs to be incorporated into activities of every day and blended into all we do". Participants viewed psychosocial supports as "something that you can integrate" and use a

"unified approach" in carrying out humanitarian aid initiatives thus creating more "holistic approaches to help people process and deal with [their] new situation."

Participants proposed that the psychosocial programming can build on existing programs currently being offered in the community by the Red Cross and does not need to be a stand alone entity. One participant stated, "psychosocial is transversal to all professionals in the field." Another noted, "… psychosocial should be woven throughout… [and can]…work together with other programs of the Red Cross." Such views clearly relay the belief that psychosocial services can be part of existing humanitarian aid initiatives and examples were provided by the participants to illustrate how such a merger could transpire. One participant articulated that psychosocial supports can be "part of existing programs we normally separate, when we bring water after a disaster we can provide psychosocial services such as games for children, just have fun with people and offer support". Another stated "If [we] give primary health care workers basic skills and abilities, they can perform a supportive mental health role while carrying out primary health duties in an informal manner". Further, it was noted that such integration would aid in devising programs and services which are more holistic and responsive to the needs of affected populations. It was also stated that "I think that the psychosocial theme should not be set aside, it should be integrated into 'watsan' [water sanitation], health, housing, and ideally it would be combined and integrated into things."

Utilize Local Volunteers

In addition to the integration of psychosocial programming into existing humanitarian aid programs and services, it was also suggested that such initiatives could utilize local volunteers in carrying out their mandate. Several advantages of such an approach were cited by participants. One participant noted,

> because they [volunteers] know the people, speak the same language, the volunteers have lived the same experience, something that you share makes it easier to talk with these people, and people talk to you much easier because you are in the same situation, you just are on a different level, as a volunteer you have lived the earthquake, you have lost parents, family, things that you have had, a house, you can understand what they tell you.

Such a bond was cited as being beneficial because volunteers are accepted by and have familiarity with the affected population. Another participant, a member of a PNS stated, "we started working first with the Red Cross, because it was good, they had that certain good image and it was easier to go in first with volunteers, rather then just go in with a psychologist and a psychiatrist; they would have immediately shut the door and forget about it! [If we had done that]"

Standardization

The need for standardization and consistency in areas such as policies, procedures, training and service delivery was noted by virtually all participants. Many also noted the "need [for] reality based programs, ones that are proven to have an impact in communities". Participants further stated there is a "need to have minimal standard tools and guidelines for all", a need to "develop indicators to measure impact" and a "standardized means to assess need." Others stated that they "need to find tools that work", and that it is "necessary to monitor and evaluate programs". Further, it was noted based upon these findings, there is a "need to standardize interventions by PNS", and to "Standardize topics of workshops" to ensure that all key players are working in a consistent and informed manner.

Training

The need for training at multiple levels was readily noted by participants in all six countries in which I conducted my field research. One participant stated "as the Red Cross, we

are prepared for first aid, not psychological first aid. We need to receive training in psychological first aid so we can give attention to the people". Participants noted that, "it is important to receive mental health workshops", and focus upon skills building in several key areas ranging from basic "training in psychosocial programming", to "training to deal with psychosomatic illness" in an attempt to build upon existing capabilities and enhance one's capacity to effectively offer psychosocial supports while working in the field. It was further stated that "we know what is needed for basic needs but [we are] not informed on needs for psychosocial support", and that "the volunteers, when they go out, they already do it… we can just improve on that".

In addition to the need to build upon existing skills and knowledge and provide humanitarian aid workers with specialized training in the area of psychosocial support, it was proposed that a 'train the trainer' approach be employed. Participants noted a need to "train leaders to train volunteers to train community" and reported a desire to 'train volunteers in outreach". One participant proposed that there is a need to "train a core group, develop a base program, identify community needs, refine the program, continue training, [and] begin outreach". Further, it was noted that the Red Cross should "train local leaders to provide services [and] to reach isolated populations". Further, it was reported that aid workers should be provided with the skills required to evaluate program effectiveness. Participants stated that workers need "to be able to do evaluations", and cited the need for "more information sharing" within the organization and between regions. "Consciousness-raising" was also posed as being important both within the Red Cross, and in the community at large so as to "change perspectives [that] mental health equals crazy - need to break down the stigma".

While participants overwhelmingly spoke of the need to train local Red Cross staff in the area of psychosocial programming, several participants also said that such training has limitations. One participant stated, "we could actually give them basic knowledge about the symptoms of PTSD and disaster, but you can not expect these people to be professionals; you can give them professional guidance, but you can not expect these people to act like a [mental health] professional." Caution was also noted by one participant who stated "the problem for us was to not only detect the symptom but to follow up on these symptoms, not just detect but to give the people a chance to deal. It could be dangerous to have these people get out their problems and then leave them like that, it could be worse." Such statements refer to the belief that while volunteers can be trained to provide para-professional psychosocial supports during humanitarian aid initiatives, they "could never take the job of a psychologist or psychiatrist."

Community Capacity Building

Participants cited the need for "community capacity building and empowerment" stating that there is a "need to focus on psychosocial capacity building" within communities. Participants proposed several strategies to aid in achieving these goals. It was stated that members of the Red Cross "need to explore ways to network with other organizations to capitalize on resources"; it is "important to have local references", and to "develop psychosocial community approaches to channel people into local services." In addition to the utilization of local programs and services, participants also noted the importance of utilizing local community members in the development and delivery of Red Cross psychosocial programs. Participants made comments such as "In the community [you] need to find a group, the leader who is involved in the community, they can then help". That there is a need to, "hire local people, at the local level, all peoples working there", and to "use volunteers to bring people together".

Further it was noted that the Red Cross needs to exert efforts to provide communities with tools and guidance to support themselves. It was noted that "people kind of organize themselves; they do not need to be told specifically what to do". It was further stated "we can pose that this is how we see a program working out", but echoing the importance of communities taking the lead. This notion was supported by one participant who stated, "we can look to a community to use their own resources, the community just needs us to help them pull strings, someone to just help them get things going", and that the Red Cross, "needs to explore ways to make mental health not such a big problem, by giving the community the tools to deal with 95% of their own problems, reduce demand on the state system". Concern was also relayed by participants; one person stated that "if you do not have the local support in place it is actually dangerous to get these things out, and to just leave it like that because these people are not capable to deal with them." Building upon this idea, participants discussed the importance of affected populations having an active role in their own healing. While it was noted the Red Cross can take a lead and fulfill an advocacy role, it was noted that there also needs to be an effort to "provide support to allow people the opportunity to organize themselves". Participants stated that there is a "need to empower" and that "having them active in their own response, will help them deal with the disaster, and that is at a real basic level, but it is a big thing." Others made statements such as "involve people who are in shelters in their own activities", and "keeping people busy, getting them involved in their own response"; noting the importance of "look for volunteers at the community level", and "go into the community and identify who the leaders are."

Responsive

Paralleling the need for a participatory approach to the delivery of humanitarian aid and psychosocial programming within the Red Cross, these efforts need to be responsive to local context and realities. Participants cited the need for community driven initiatives and reported that the Red Cross "need[s] to have programs that are responsive to real, not perceived, community needs". Further, it was recommended that the Red Cross first look "at needs of the population, identify leaders to work with, explore what needs to be done, what will help the community" and the "need to listen to the community". Such an approach could increase "local support" and that "local connections result in less barriers and stigma".

While the Red Cross often utilizes international experts to aid in carrying out their mandate, work in the area of psychosocial programming needs to be locally driven. One participant noted, "We have international support, professional international support, but for this kind of work the people need to be local." Such responsiveness to local realities and the need for the Red Cross to use a participatory approach when devising humanitarian aid interventions was vividly relayed by one Nicaraguan participant who shared a story of the strategies employed by members of guerilla groups when dealing with the community. They said that;

> In the war, guerillas, they went to the communities and they sat with the people and listened to their needs and explained their theory as to why they were guerillas. They lived together, ate together and shared their needs. They lived the same situation, knew the reality. And in that sense they got to understand all the needs of the community. It was then easier to organize and mobilize the people, to recruit support. We can go to the field with these ideas, we need to go to the community to be with them, to understand them, and then develop a program. Get to know the people first, hear their needs. We need to respect the community.

The need to explore the lived experience of affected populations and to take into account the distinct situation of each affected region, was also noted by participants: "individual, family

and community approaches [are] needed", "need situation specific approaches, populations, type and phase of disaster", "need sensitive approaches, one does not fit all", "we need to analyze the problems of the community", "need to look at protection factors with individuals and communities' and that the Red Cross "must get close with the people", and "value the needs of the people" and devise "not just individual interventions, but community wide"

By employing the noted strategies, it was believed that the Red Cross will not only be more effective and responsive in the development and delivery of their humanitarian aid interventions, but that such interventions will also be ethical. Participants noted that members of the Red Cross "need to look at ethics [and] impacts on individuals and communities", citing the "ethics of intervention in community is important" as there is a need for "sensitive practices" while being "conscious of our own limitations"

In addition to the need for humanitarian aid programs to be responsive to local realties, participants also noted a need for such programs to be "sustainable", so as to ensure that such services would be available in the long term. "Participatory approaches" were cited as one key means to ensure that such a goal was attained. Participants stated that there is a "need to combine with existing programs and departments", a "need to use other agencies", and a "need to support local entities". It was further noted that the "formation of partnerships is important to ensure [that organizations are] on the same page". One participant reported, when referring to the development of psychosocial programs, "We are not talking some big thing that is separate, it is just mental health, and can be integrated". Further, it was stated, "I think that forming the links to the community and getting people used to helping each other and opening up to each other is a sustainable way to approach them and in the future if something were to happen there is no reason to think that the that community will not resort to their past experience". Another worker

noted that "there are other needs and they are ongoing, for that you need to link with other structures… those who will be around to help promote sustainability". In addition, it was noted that there is a need for the Red Cross to be "forming some kind of links within the community, between themselves, between families, so that there is, so that we can leave behind some kind of support structure". Such an approach and change in ideology was seen as key to sustainability, and having a long term impact by contrast to the current practice which views affected populations as being recipients of humanitarian aid, not active participants in their own healing. This notion was clearly reflected by one participant who stated, "the matter is that we are very parental and we carry the community, we need to change, we need to take by hand and lead, we need to help the community to help itself, we can then deal with more needs."

The need for proactive interventions in partnership with reactive interventions was also reflected in the data. Participants noted the need to "do prevention activities" and work on "consciousness raising", citing the "need to build on programs". One participant stated, "I think that the best thing pre-disaster is to form those links, who is in the country and who can do what? So, when there is a disaster you know how it is going to work". Further, it was noted that "prevention [is] important, train people in the community so when disaster, [happens] they can help right away and can work with teams. If a person knows what to do, what to expect, then feel better." Such views articulated the need for proactive investments by the Red Cross, so as to enhance a community's capacity to effectively deliver humanitarian aid to affected populations following an occurrence in a responsive manner. Participants stated that the communities "need structures in place, when disaster [strike] they are always busy"; another noted that it is "better to have that figured out before hand." For example, it was cited that while "disasters do bring people out so there are psychosocial people out there who are well qualified to help … knowing

who to call when there is a disaster so we can refer to them, who is available, what is their capacity, [and] how can we use them in an effective manner."

Current Attitudes Towards Psychosocial Programming

Participants noted that one of the key barriers to the development and delivery of responsive and sustainable psychosocial programs within the Red Cross was linked to attitudes and beliefs about the nature of such programs. Participants made statements such as "they feel that they will have to install a new department with a psychologist and a psychiatrist, but it is not needed". Another stated "I believe [the] National Society does not see the importance of developing a program of this type, [they] do not see the need". Further, it was stated, "psychosocial support [is] not viewed as being important to those in power, decision makers". While negative attitudes were readily evident, participants clearly cited a need to challenge such notions stating, "we cannot just sit back and think that this is not important to the country. It is. It is important". Others participants noted that members of the Red Cross "need to link disaster and mental health" and realized that the lack of psychosocial support "is a problem that will explode if you do not deal with it." While it was evident that negative attitudes did prevail, it was also evident by the statements of many participants that such views were not held by all Red Cross humanitarian aid workers. Many participants made statements such as "[we] have recognition of [that] need but no one has invested in programming." Other participants spoke of the dynamic of psychosocial programming and made statements such as "we need the support of the National Society to develop such programs", "what I like about psychosocial support is that it is not resource intensive", "need to invest a little to get there", but cautioned that "one of the biggest fears of the National Society is how can we maintain such a program after the aid is gone".

Summary

Participants openly shared ideas pertaining to the nature of existing humanitarian aid initiatives. It was noted that while there are many players working in the field, and many sporadic attempts being made to offer programs and services, there is an evident lack of coordination among aid agencies, and all too often the services provided duplicate the efforts of others and/or are not responsive to the local context and the complex needs of the affected population. Participants also spoke about the capacity of the Red Cross to provide psychosocial supports to affected populations and shared their thoughts about the strengths and limitations of existing efforts and offered their suggestions as to how the Red Cross could be more responsive in their provision of relief, recovery, and rehabilitation programs and services. While such suggestions critique the effectiveness of the traditional practices and call for a need for the development of responsive interventions, participants felt that the capacity and desire to affect such a transformation did exist within the organization and that the development and implementation of a holistic approach to the delivery of humanitarian aid was achievable.

Chapter 5 – Discussion of Key Findings

This chapter is organized into four sections: current practices, attitudes, knowledge, and shared vision. These categories were devised in collaboration with an IFRC Health Delegate while carrying out my field research in an attempt to help me conceptualize and make sense of the abundance of data with which I was being presented. What follows is an overview of key findings paired with a distillation of the many recommendations offered by the participants.

Current Practices

While the key focal point of my investigation was to explore the capacity of the Red Cross to offer psychosocial programs and services for members of affected populations following disasters and/or complex emergencies, in the field it quickly became evident that the Red Cross National Societies within the countries where I carried out my research had a limited, and sometimes non existent capacity to offer programs and services addressing psychosocial needs. Rather, what was evident, were attempts to develop collaborative working relationships between the National Societies and other entities such as Participating National Societies, Federation Delegations and/or other International organizations (IO) or local Non Governmental Organizations (NGO). In these arrangements, Red Cross National society volunteers and staff function in partnership with other professionals in the development and delivery of psychosocial services (primarily during the initial relief and recovery phases of a disaster). While in theory this seems to be an effective mode of intervention, participants highlighted several limitations to such attempts to collaborate. One key problem with this model of intervention is the noted discrepancy between theory and practice. Throughout my investigation, several key informants – from both

within the Red Cross, and other outside agencies – stated that while there were attempts at the local and national levels to formalize working relationships and devise concrete disaster management and mental health intervention strategies via the establishment of commissions and committees, such a process has had limited success. Many attempts to coordinate efforts remain in a draft format and/or have not been put into practice in the field. Thus, while attempts are being made to coordinate efforts, share information, and establish a unified national approach to the provision of psychosocial supports, much remains to be done. Paired with this problem is a second and equally problematic observation. While there are attempts at providing psychosocial programming in the communities following a disaster, there is no coordination of such efforts, nor are there benchmarks for appropriate practice. Thus, in the initial days and weeks following a disaster, numerous organizations (local and international) may be present in a community and profess to be offering psychosocial support, but the true nature of the work and its impacts is not monitored. Further, while I did receive reports of many well devised and delivered programs that had been offered in the past following disasters, most of these interventions were a form of crisis intervention, and involved the provision of psychological first aid (primarily for children), and offered little or no long term follow up supports for the survivors, limiting its effectiveness in adequately assisting the affected population. Such a limited focus can be attributed to several factors, chiefly a lack of resources beyond the initial influx of donor support following an incident and inattention to devising interventions which promote community capacity building and long term sustainability.

Attitudes

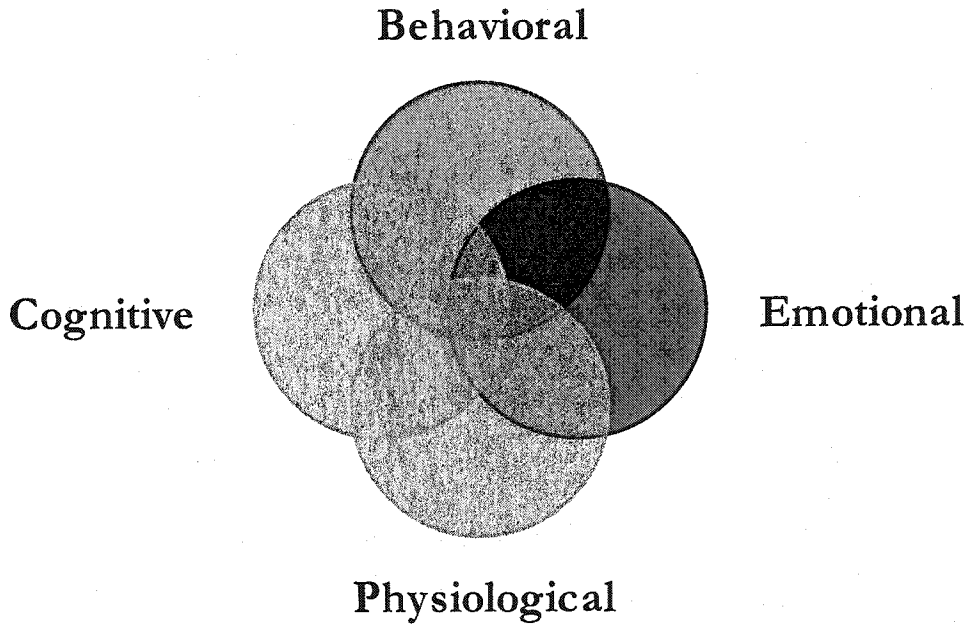
Two key themes become evident in the data and are reflective of two, frequently opposing views regarding humanitarian aid initiatives and the development and delivery of psychosocial programming. The first attitude supports the need for psychosocial programming and clearly articulates the importance of this type of intervention being integrated into post disaster relief and recovery efforts, and is supportive of its responsive development and implementation. The second attitude makes no connection between disaster and psychosocial trauma, viewing the two as unrelated concepts, thus not supporting the need for psychosocial programming to be integrated into Red Cross humanitarian aid efforts. The first attitude prevailed and was evident amongst most of the people with whom I had contact, especially among those working in the field and or those impacted by disaster and/or complex emergencies. By contrast, the attitude that negated the need for psychosocial programming to be integrated into Red Cross humanitarian aid initiatives was evident more in the conversations with participants when either talking about those who make decisions, such as heads of government departments and some Red Cross personnel, and/or when referring to some members of the affected civilian populations who for a variety of reasons (culturally or otherwise) do not make a connection between their current situation (signs and symptoms of psychological trauma) and their experience with disaster. While the presence of this attitude was viewed as being problematic, participants did not perceive it to be an insurmountable barrier to the effective and efficient development and delivery of psychosocial programming. Rather, it was seen as a factor that needs to be attended to and actively integrated into Red Cross action planning.

Knowledge: Participants Observations and Recommendations

This section conveys the participants' knowledge of the effects of traumatic events, factors that influence the impacts on communities, and the participants' recommendations about how the Red Cross could more effectively respond to the psychosocial effects.

One of the strongest points repeated by participants throughout Central America and South America is that no one who experiences a disaster is unaffected by it, be that the affected civilian population or those who respond. Therefore, when devising humanitarian aid intervention the Red Cross needs to be sure to be inclusive of the needs of all involved, not just those who manifest readily evident signs and symptoms, or those who were directly impacted by the incident. Figure I illustrates the 4 basic categories of symptoms reported; behavioral, emotional, cognitive and physiological, and the interconnectedness of each (for additional details please see appendix I -IV).

Figure 1 - Baseline Responses to Traumatic Events



While baseline responses to psychological trauma are virtually universal, variance becomes evident when exploring how the responses are shaped by an individual's unique disposition and external environment. While experiencing a disaster or complex emergency can serve as a traumatic event for an individual, these occurrences are often not a stand-alone source of psychological trauma. Disasters or complex emergencies can occur in areas that have already been subjected to long term acute stressors. It was reported that in many regions the stress of daily living, such as civil conflict, political instability and poverty is extreme. In such cases, experiencing a disaster and/or complex emergency frequently serves to aggravate the already dire situation. Thus, when devising intervention strategies, the Red Cross needs to take into account the fact that while a given disaster or complex emergency may be the immediate source of psychological trauma, the manifestations of trauma within the affected population may be broad scoped in nature. Consequently, careful attention needs to be paid to the local circumstances, cultural context, and the lived realities of members of the affected population. Such an individualized approach to the development and delivery of psychosocial programs is imperative so as to ensure that the programs and services offered are context specific and responsive to the needs of the local population.

Figure 2 illustrates the interconnectedness between a traumatic experience and factors inherent to each individual. These include gender, age, personal values, and factors related to one's relationship with his/her external environment such as social status, degree of social supports and past experiences. Each of these factors plays a role in compounding and or mitigating an individual's experience of an occurrence. Such factors need to be taken into consideration by the Red Cross when developing and delivering humanitarian aid initiatives.

These concepts are further reflected in Figure 3, which illustrates an ecological systems model on the interplay between a traumatic event, one's cultural context, and a person's lived reality. This model speaks to the unique nature of each individual's experience and indicates how individual distinctiveness - such as past experience, access to social supports, and social status - can influence how people experience a disaster and/or a complex emergency.

Figure 2 - Traumatic Experience: Factors that Mitigate and/or Compound

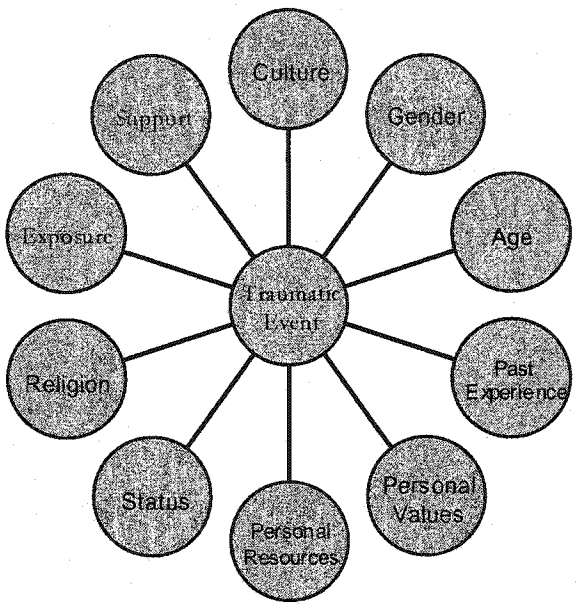
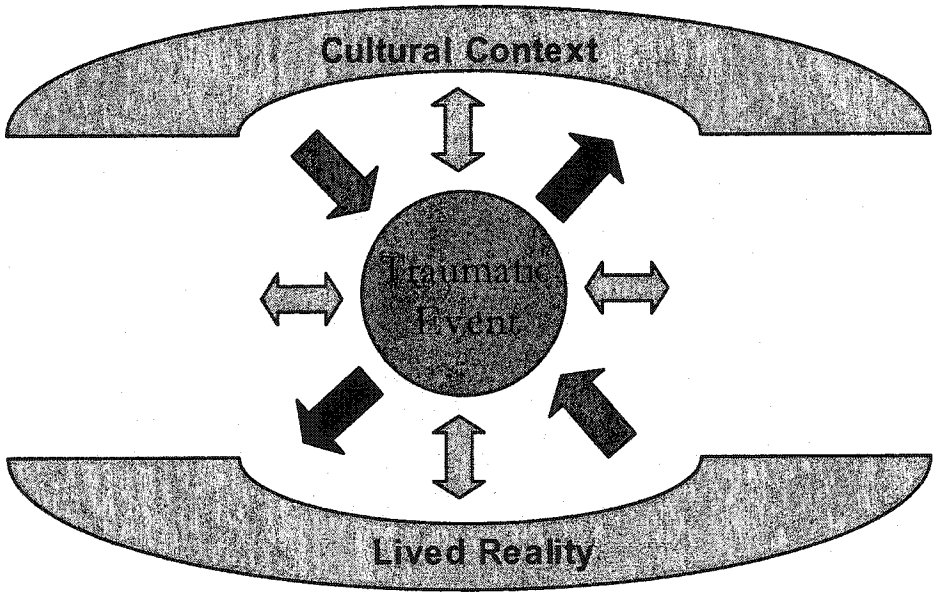


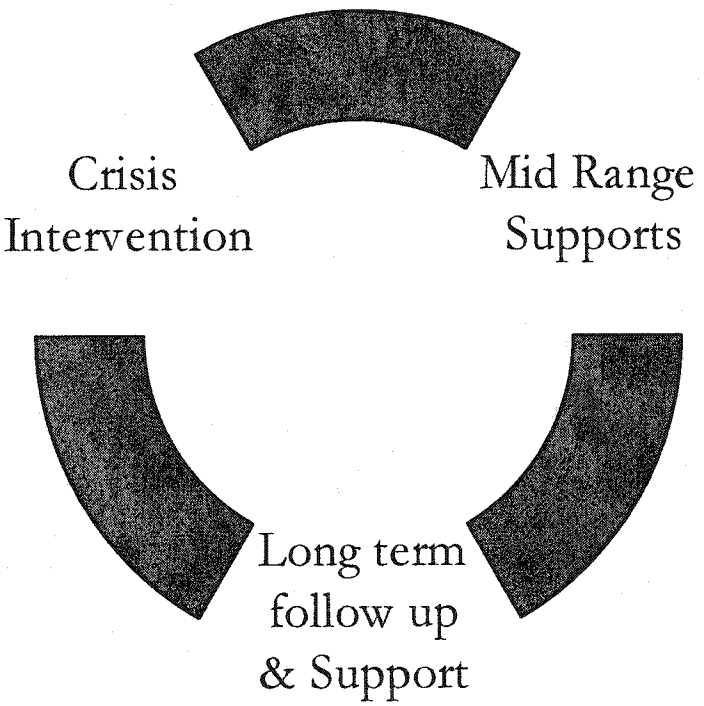
Figure 3 - Ecological Systems Model for the of impacts of a traumatic event



Building upon the recognized need for the Red Cross to pay careful attention to both cultural context and a person's lived reality when devising psychosocial programs and working with affected populations during humanitarian aid initiatives, participants were also keen to identify the need for psychosocial support that extends beyond the initial crisis phase of a disaster and/or complex emergency. While it is crucial to have early interventions directly after an incident to mitigate the long-term impact of the experience, it was reported that people process psychological trauma in diverse ways and symptoms do not always surface immediately following a traumatic experience. Consequently, in addition to immediate crisis intervention efforts, mid-range and long-term interventions and supports are required.

Figure 4 illustrates the view that the delivery of humanitarian aid and provision of psychosocial supports need to be offered over an extended period of time in order to ensure that both immediate and long term needs of affected populations are attended to in a responsive and effective manner. In addition to the crisis intervention initiatives designed to attend to the immediate, and sometimes readily evident impact of an occurrence, mid range programs and services paired with long term follow up and supports for affected populations are essential. Such efforts will ensure that programs are available to deal with less evident and sometimes delayed manifestations of the traumatic experience and facilitate long-term recovery and rehabilitation.

Figure 4 - Cycle of Intervention



When reviewing the notion of 'key players' and discussing who is involved in the delivery of humanitarian aid following disasters and complex emergencies, participants reported a need to re-evaluate current practices. While it was reported that outside intervention is required during time of disasters, it was noted that strategies developed by external experts and employed by humanitarian aid workers in the field are not the key to rebuilding communities and lives. Rather, it became very evident that communities have an immense internal capacity; they just need the tools and guidance to aid in healing themselves. It was reported that affected communities need to be empowered and provided with resources (human and material), informed guidance, and support to allow them to be active participants in their own relief, recovery, and rehabilitation initiatives. Such assistance will not only ensure a timely, comprehensive, and culturally sensitive response during the rescue and recovery phases of the disaster, it will also provide a community with the skills and resources required to devise sustainable programming that can be carried out over the long term when donor support dissipates. Further, it was noted that such strategies can also be employed by the community in the future, if and when a subsequent disaster or complex emergency should occur, thus enhancing their internal response and healing capabilities, reducing the need for external interventions and donor support.

Figure 5 summarizes the argument that members of the affected population need to be viewed as active participants in their own healing process rather then recipients of humanitarian aid. This notion was articulated clearly by participants from all countries throughout Latin America.

First and foremost, participants noted the necessity of giving voice to a community and allowing them the opportunity to assess and identify their own needs, a process often neglected in the past as external experts have carried out assessments and identified needs without

consultation with, and input from, the community that they intend to serve. Building upon the notion of giving voice to a community to aid in identifying their needs, participants also noted the need for interventions to be developed by, or in partnership with, the affected community, ensuring that such efforts are reflective of real needs and responsive to local circumstances. Further, the need for internal training and capacity building within the affected community was noted, thus providing the community with the skills and tools to be active agents in the delivery of psychosocial and other humanitarian aid interventions. In addition to a participatory approach to the development and delivery of humanitarian aid initiatives, the need for ongoing support and evaluation within the community was also cited as being important. It was recommended that a formal monitoring and evaluation process be inherent to the delivery of psychosocial programs and services. Such an addition would aid in ensuring the developed initiatives are responsive to the ongoing and evolving needs of members of the community over the long term.

Based upon this premise of participatory approaches to the development and delivery of humanitarian aid and psychosocial supports, several key principles were suggested by participants. Figure 6 provides a brief synopsis of the core principles of community capacity building as identified by participants. Such principles challenge the current expert oriented approach to the identification of need and the development and delivery of humanitarian aid efforts by giving voice, empowering communities, and ensuring that members of the affected population are active participants in their own healing.

Figure 5 - Model of Community Empowerment and Capacity Building

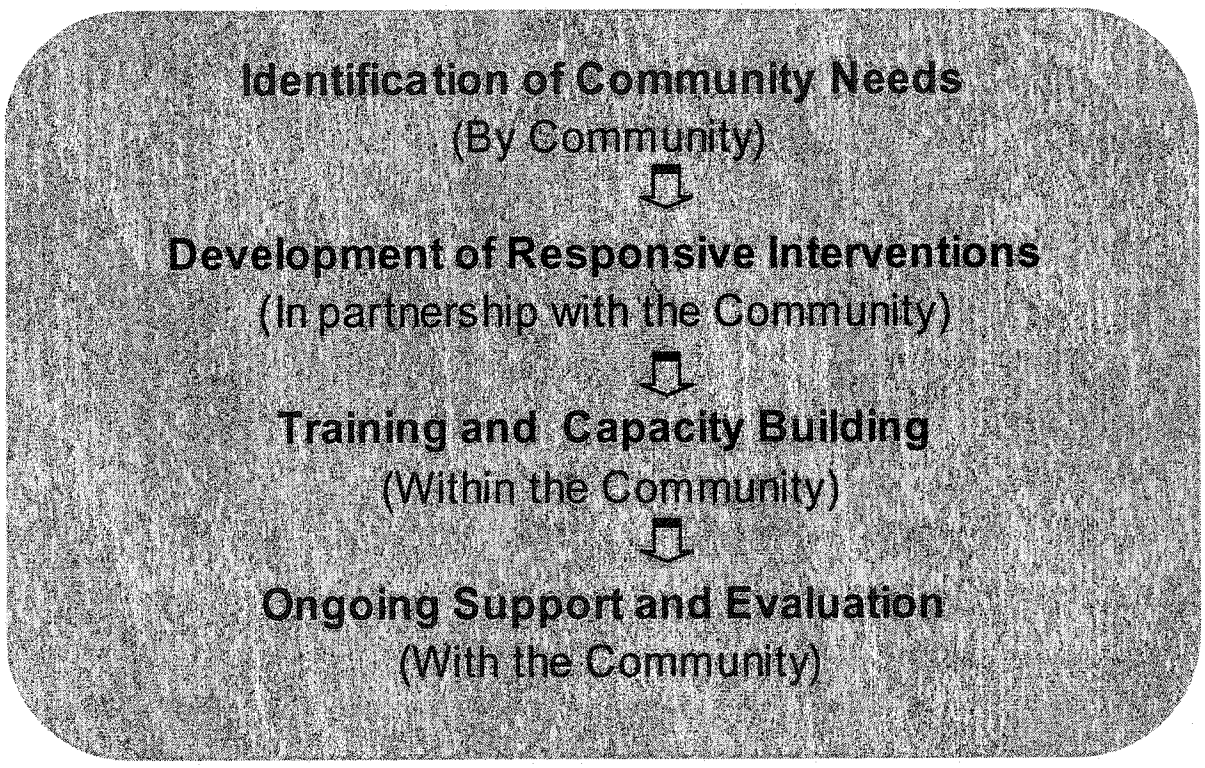


Figure 6 - Principles of Responsive Capacity Building: Empower vs. Impose

In addition to the challenge to current strategies that are employed to identify needs and the manner in which humanitarian aid programs are developed and delivered, participants also cited a need for members of the Red Cross to confront their current views and beliefs regarding psychosocial programming. It was felt that members of the Red Cross need to examine the view that psychosocial programming should be developed by a separate department as participants were of the belief that the Red Cross could integrate psychosocial programming into current humanitarian aid initiatives.

Participants frequently spoke of the commonly held view that psychosocial programs and services need to be isolated efforts carried out by professionals, a view reportedly held by many Red Cross directors and administrators. While it was noted that professional supports are of great importance in the delivery of psychosocial programs, participants felt that not all psychosocial support needs to be carried out by mental health professionals and that such programming could include host of differing activities all intended to promote well-being within affected populations. Such efforts, although having many distinctive features and deviating from the traditional provision of humanitarian aid to meet basic needs, does not need to be a stand alone program. Rather, it was proposed that such efforts could be integrated into existing Red Cross humanitarian aid initiatives and be carried out by trained volunteers and staff members.

Figure 7 summarizes the notion that psychosocial programs span a continuum of interventions ranging from simple activities geared towards aiding affected populations to regain a sense of normalcy in their lives such as recreational and leisure activities to conventional clinical interventions. Building upon this model, Figure 8 illustrates the view that while skilled professional support is essential to aid in dealing with various manifestations of psychological

trauma amongst affected populations, not all psychosocial interventions need to be carried out by such experts. Rather, trained volunteers and staff can fulfill the role of paraprofessionals in the delivery of psychosocial support during humanitarian aid operations. Figure 8 also illustrates the belief that while professionals are required to aid in the provision of psychosocial services, such professional intervention is only required in severe cases; all other supports can be provided by trained staff and volunteers. It was also noted that the approach of attending to the psychosocial needs of an affected population by a paraprofessional could mitigate long term impact, thus reducing the need for professional mental health support in the future. Such an approach reflects the previously noted need for community capacity building, whereby local volunteers, staff, and other community members are provided with the skills, resources, and guidance to be active participants in their own healing, and not solely recipients of aid.

Participants recognized that such a transformation in ideology and practice would require an upfront investment of time and resources by the Red Cross, in order to equip a core group of personnel with the needed skills and abilities. However, long-term maintenance of such efforts would require fewer resources as the program could be integrated into current programs and services, and include a "train the trainer" component. Participants noted that once a core group of volunteers are trained in basic understanding of traumatic stress, mental health, and psychosocial programming, these individuals could be utilized to train other community members. This would form a coalition of skilled paraprofessionals who are equipped to offer psychosocial supports. This coalition can then work in partnership with and under the guidance of mental health professionals during the delivery of humanitarian aid. The approach to community capacity building and empowerment has several key advantages in addition to the integration of psychosocial services into Red Cross humanitarian aid initiatives. By training local volunteers,

the Red Cross would be able to decentralize service provision and employ outreach strategies that reduce service barriers often presented due to the lack of skilled individuals able to respond in affected regions. By training volunteers within each community the Red Cross would be able to enhance its capacity to offer support to all affected populations. These supports would be provided by people who are aware of the local context and are attuned to the needs of the people. Further, these individuals would be able to aid in providing programs beyond the initial phases of the response, and help members of their community in rebuilding their lives over the long term. While this is the case, it should be noted that the goal of such efforts is not to train volunteers to replace professionals, rather, such training and service delivery is intended to be carried out in partnership with, and/or, under the guidance of mental health professionals. Thus the formation of partnerships within the community is imperative to the success of such an initiative.

Figure 7 - Continuum of Psychosocial Programming: Humanitarian Aid Activities

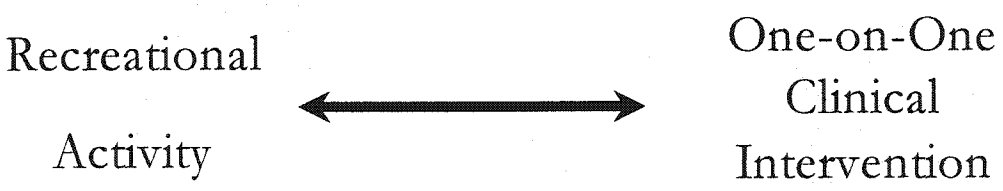
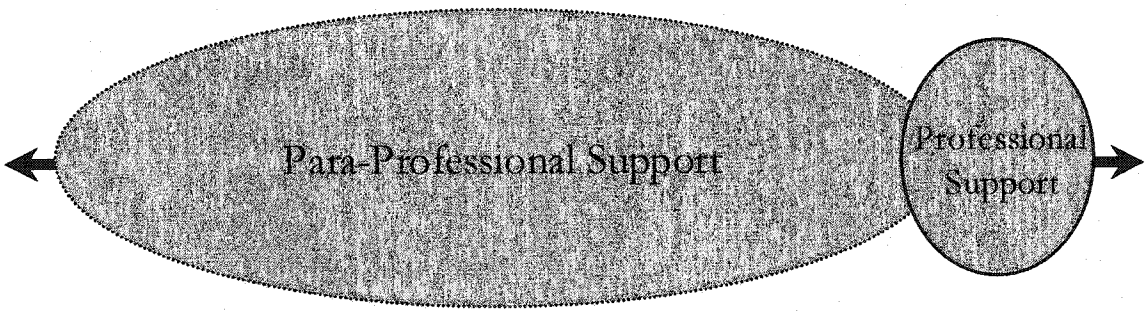


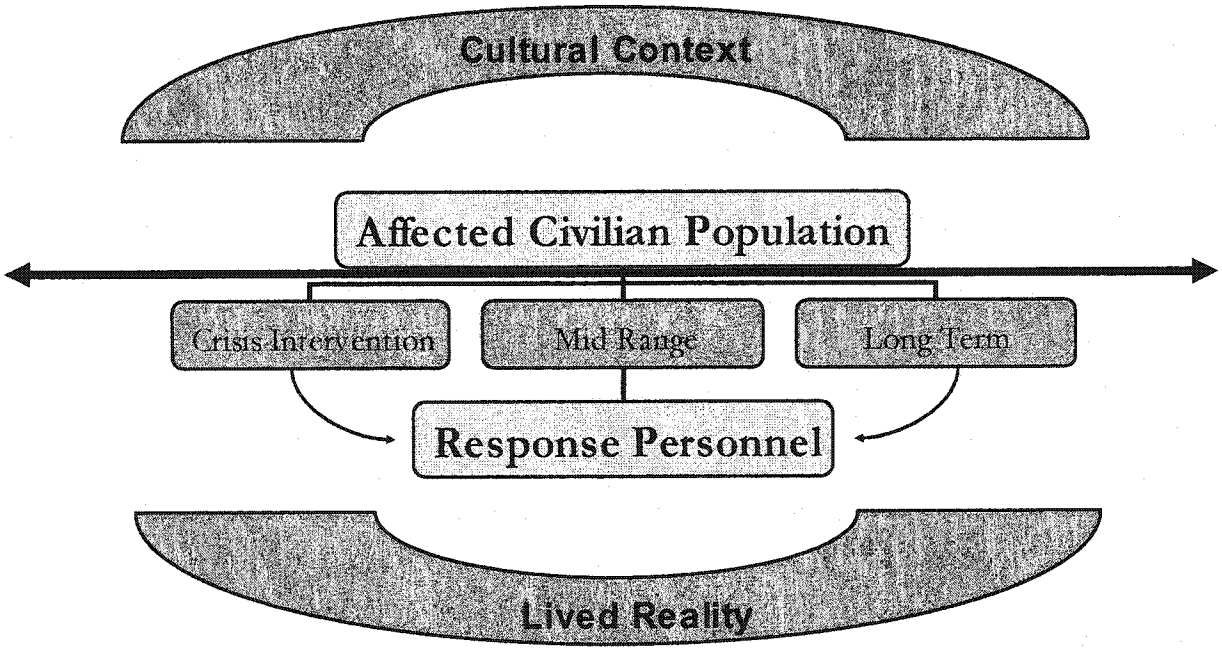
Figure 8 - Continuum of Psychosocial Programming: Humanitarian Aid Actors



Shared Vision

While at no point in my research did I encounter a participant who reported that their organization has sufficient capacity to meet the psychological and emotional needs of survivors of disaster, each participant did provide me with considerable insight into how such capacity could be attained. Regardless of the country in which I was or the group with which I was meeting, there was a shared vision for future capacity building, and an aspiration to strengthen their ability to assist vulnerable populations, especially within the Red Cross National Societies. A shared vision can be summarized in several key points: 1) a holistic approach that focuses on community capacity building and ownership; 2) utilization of local resources and the establishment of partnerships in the community to encourage resource sharing (both human and material); 3) the promotion of long term sustainability; 4) attention to psychological and emotional health directly following a disaster; 5) in the long term, the provision of supports and services within the community in a manner that is culturally sensitive and respectful of local realities and; 6) careful attention to the psychological and emotional needs of care providers who are working with, and for, the victims in the field. Figure 9 summarizes this view and provides a graphic representation of the reported need for the development and delivery of holistic humanitarian aid initiatives.

Figure 9 - Psychosocial Support: An Integrated Approach



While the data discussed and the accompanying models are not reflective of all the thoughts, values and beliefs shared by participants, this summary does capture the recurrent and insightful views that were shared by those with whom I had the privilege to interact and learn from.

Reflections on the Literature

Both parallels and differences between the insights offered by participants and the literature reviewed for this study can be identified. These parallels and differences fall into two broad themes: cultural views of psychological trauma, and clinical versus community perspectives on healing.

Cultural Views of Psychological Trauma

1. Impacts of Disasters and Complex Emergencies

When exploring the impacts of disasters and complex emergencies on affected populations, my findings did echo the literature in many areas. It was reported that members of the affected population exhibited an array of cognitive (irrational thoughts and beliefs, distorted perceptions), behavioral (bed wetting, aggression, avoidance) emotional (depression, crying) and physiological symptoms (muscle pain, stomach aches, menstrual problems). These symptoms are characteristically associated with critical incident stress (Mitchell & Everly, 1997), acute stress disorder and/or posttraumatic stress disorder (American Psychiatric Association, 1994). Further, Taylor's (1989) framework for classifying members of the affected population following a disaster and/or complex emergency was useful when exploring the impacts of an occurrence. It was reported that disasters and complex emergencies have an array of impacts on a range of

individuals, not just those directly exposed to an occurrence - the primary victims. Participants reported that this awareness is important when developing and delivering holistic humanitarian aid initiatives so as to ensure that service providers identify and support all victims.

2. Onset of Symptoms and Related Factors

Also reflective of the literature (American Psychiatric Association, 1994; Bryant & Harvey, 2002; Herman, 1997; Foa, Keane, & Friedman, 2000) were the accounts of participants related to the delayed onset of post trauma symptoms within the affected populations. Participants reported an array of immediate reactions but also noted that in many cases symptoms did not surface until months, even years, after an incident. Further, participants spoke of the role an individual's personal disposition and/or elements of their external world (such as access to resources, social supports, personal perceptions of mental health and past experience) played in buffering and/or compounding the effects of being exposed to a traumatic event, a topic sometimes noted within current literature but not comprehensively explored in relation to disasters, complex emergencies and/or different cultural contexts (Freedman, et al., 2002, Herman, 1997, Mitchell & Everly, 1997, Murphy & Dolan, 2003; Nader, Dubrow & Hudnall Stamm, 1999).

3. Classification and Labeling

While Western terminology could be used to label and categorize the information shared by participants, these classifications – CIS (Mitchell & Everly, 1997), ASR & PTSD (American Psychiatric Association, 1994) - were rarely used by local people. Neither were Western perspectives on mental health and psychological trauma readily evident among study participants. When speaking with individuals regarding their views of mental health, many participants did not acknowledge a need to label post trauma responses. Further, it was felt that

these labels often pathologize an individual's experience with an occurrence and infers an individualistic view of what was deemed to be a collective experience/issue. In addition, it was reported that such a view leads to an expert oriented approach to helping and healing (healing can only be facilitated by mental health professionals), which negates, and often weakens, a community's capacity to heal itself.

4. Attention to Culture When Working With Affected Populations

Nader, Dubrow & Stamm (1999) noted the importance of being aware of cultural variances in views of psychological trauma when working with diverse client populations. The authors state, "We have found that simply understanding the cultural context is not sufficient. It is essential to incorporate this knowledge into program design and implementation (p.2)." Although awareness of the need to be culturally competent does exist, it appeared to not be formally integrated into practice in the field. Participants indicated that current humanitarian aid initiatives are often developed and directed by external (international) experts. While attempting to be culturally sensitive and competent, merely fine-tuning an approach imported from another cultural context prior to implementation was not deemed to be appropriate by participants. Rather, participants spoke of the need to develop interventions in partnership with local communities, thus ensuring that they are responsive to the needs of the affective population and respectful of local context.

5. Stigma

While the current literature does sometimes mention the stigma associated with mental health issues (Saleebey, 2002; Nader, Dubrow & Hudnall Stamm, 1999) these accounts are not widespread. With participants in this study, the significance of stigma was readily evident with many individuals talking about apprehension among people in their communities when dealing

with mental health professionals. These feelings about seeking professional help often prevent help seeking out of fear of being labelled as having a mental health problem. Attention to such a reality, and exploration of means to counter such a barrier, was identified as a program need by participants.

Clinical versus Community Perspectives on Healing

1. Individualistic versus Community Perspective on Sources of Trauma

Participants noted that a clinical view of psychological trauma as an individual problem is often contradictory to the thoughts and perspectives in their communities. Building upon this perspective, it was also noted that the majority of current literature on the topic views psychological trauma as being the result of an isolated traumatic event (Bisson, Jenkins, Alexander, & Bannister, 1997; Everly, & Mitchell, 2000; Hobbs, Mayou, Harrison, & Worlock, 1996; Suar, Mandal & Khuntia, 2002). While this may be the case in many instances, participants noted that realities of daily living in many regions are also sources of ongoing psychological trauma. Thus, while practitioners may aim to address the impacts of a given disaster and/or complex emergency upon an individual, practitioners need to be aware of the fact that the recent occurrence may not be a stand alone source of trauma. As such, attention needs to be paid to a person's unique cultural context, social location, past experience and currently lived reality.

2. Clinical Assumptions

Traditional mental health interventions are based on Western ideology and have inherent assumptions regarding access to resources - chiefly mental health practitioners - and presume the ability to establish a therapeutic alliance between the practitioner and a client (Chu, J., 1998; Figley, C., 1999; Foa, E., Keane, T. & Friedman M., 2000; Kimerling, R., Ouimette, P. & Wolfe,

J., 2002; Meichenbaum, D., 1994; Young, B. & Blake, D., 1999; Young, B. H., Ford, J. D., Ruzek, J. I., Friedman, J., & Gusman, F. D., 2000). While in a Western context such an approach serves as the dominant model of intervention - as reflected in literature and practice - when looking at a non-Western context, this approach was viewed as problematic. For example, in addition to the previously mentioned cultural disparity in views of mental health, there is often a disparity in access to resources, human and otherwise, that would make wide scale provision of clinical services impossible. Thus, even if it were deemed to be culturally appropriate, participants reported that there might be limited access to mental health professionals. In Colombia, there are over 3 million internally displaced people, for instance, of whom 80% live in extreme poverty, without access to basic resources of daily living. In situations like this, participants questioned how clinically based interventions could be employed for most people. While we can learn from the current literature pertaining to treatment models and programs (e.g. cognitive behavioral therapy and the critical incident stress management program), these approaches would need to be significantly modified if they were to be responsive to the local realities and needs of the affected population.

3. Importance of Knowledge

Herman (1997) stresses the importance of the psycho-educational component of the healing process stating:

> With patients who have suffered a recent acute trauma, the diagnosis is fairly straightforward. In these situations clear, detailed information regarding post-traumatic reactions is often invaluable to the patient and her family and friends. If the patient is prepared for the symptoms of hyperarousal, intrusion, and numbing, she will be less frightened when they occur. If she and those closest to her are prepared for the disruptions in relationship that follow upon a traumatic experience, they will be far more able to tolerate them and take them in stride. Furthermore, if the patient is offered advice on adaptive coping strategies and warned

> against common mistakes, her sense of competence and efficacy will be immediately enhanced (p. 157).

This sentiment was echoed by participants who spoke of the clear need for affected populations to be educated on matters related to psychological trauma such as the nature of, potential impacts, and self help strategies. It was suggested that this insight be integrated into humanitarian interventions in a culturally responsive manner.

4. Integrated and Participatory Approaches to Helping

Participants also spoke of the need for holistic interventions that are offered beyond the initial crisis phase of a humanitarian response. Some of the current literature (Mitchell & Everly, 1997) focuses primarily on crisis intervention strategies and most stresses the importance of stabilizing an individual before the healing process can begin (Herman, 1997).

Participants noted that while providing for basic needs is of great importance, the healing process can begin immediately. An integrated approach to the delivery of humanitarian aid was proposed whereby trained paraprofessionals could work as a part of a collaborative response team and provide various psychosocial supports paralleling the delivery of conventional relief and recovery programs and supports.

The concept of participatory approaches to healing is an area in which the literature is lacking in knowledge and insight. When reviewing the current literature, in addition to it being clinically focused and based upon many Western assumptions, it also uses an expert oriented approach to healing that views affected individuals as recipients of help rather then active participants in their own healing. While skilled mental health professional were deemed to be necessary to aid in the healing process, participants noted the importance of each individual taking ownership of, and playing an active role in, their own healing. This strengths oriented

philosophy can be noted in the works of such people as Saleebey (2002) and Kahn (1994) who discuss the need to encourage the helping profession to avoid pathologizing people.

Further, these authors stress the importance of working with people at their level, to empower them to mobilize their own strengths, both internally and within their environment, and to make each person an active agent in the healing process. According to Saleebey (2002):

> ...empowerment indicates the intent to, and the process of, assisting individuals, groups, families, and communities to discover and expend the resources and tools within and around them... To discover the power within people and communities, we must subvert and abjure pejorative labels; provide opportunities for connection to family, institutional, and community resources; assail the victim mind-set; foreswear paternalism; trust people's intuitions, accounts, perspectives and energies; and believe in peoples dreams. (p.9)

While these insights do exist among some practitioners, few attempts have been made to integrate these ideas into a practice addressing the effects of traumatic events.

5. Deprofessionalize Mental Health Supports

Discussion of a participatory and integrated approach to healing led to the notion of deprofessionalizing mental health supports. While the vast majority of the participants noted the importance of mental health practitioners in the healing process, and viewed them as a valued component of any humanitarian aid initiative, participants did not see healing as being rooted in clinical practice. Rather, participants reported that although professionals are necessary, especially when dealing with severe mental health cases, it was their view that the majority of the healing process following a disaster and/or complex emergency could be facilitated by trained paraprofessionals. Paraprofessionals could be recruited from the local communities and provided with skills and competencies related to psychological trauma and the provision of basic psychosocial services that

could then be employed within their own communities - a notion rarely discussed within current literature other then in relation to the facilitation of self help groups.

General Lack of Literature

In addition to the aforementioned parallels and disparities in views and perspectives between current literature and data collected in the field, my search of the literature showed that there is a general lack of culturally sensitive literature pertaining to working with peoples in non Western contexts - especially in relation to attending to psychological trauma. Authors such as Chung, Farmer, Werrett, Esasthope, & Chung (2001) and Raphale (1986) echo this sentiment and encourage more research attention in this area.

Research Limitations

In reviewing my research project, four key limitations became evident. One of the primary, and readily evident, limitations pertains to my ability to effectively communicate with my respondents. As Spanish was not my native language and the fact that I only have a basic capability to converse in Spanish, translators and/or cultural interpreters were required to help me in carrying out the field research. As a result, information shared by respondents would be translated and then relayed to me. Although having the utmost confidence in the competency of my translation personnel, there is a risk that subtleties may have been lost during the translation process. In addition, although translators and/or cultural interpreters were solicited to sensitize me to my new surroundings (cultural norms, communication patterns – both verbal and non verbal, etc), regardless of their efforts, due to time constraints I was unable to fully comprehend the complexity of one cultural group before being required to travel to a new geographic region

and become immersed in a new environment. Thus, valuable cultural cues may have been overlooked during my interactions with participants, cues that may have proven valuable to heightening my understanding of the information being shared with me.

Similarly, geography posed a challenge to my research. Data was collected in several countries, the study sample is large, and every effort was made to work with the local Red Cross in selecting specific regions to ensure that the data collected was representative of realities of the region. Nonetheless, my data can in no way be deemed to be representative of the whole of each country's reality. Rather, it provides a preliminary review of the current context and the nature of humanitarian aid initiatives in the region. As a result, one must be cautious when considering the transferability of findings and their applicability to other parts of these countries, or to other countries.

Another potential limitation of this study is the fact that a portion of the recorded data is retrospective in nature as respondents spoke both of historical and current initiatives. As a result, the accuracy of the data reported might be compromised, as respondents were required to recall details of activities that have transpired in the past. Although this was the case, examples provided by respondents were taken from current Red Cross humanitarian response initiatives of varying scales as well as incidents that occurred in recent years but from which the affected communities are still recovering.

An additional noteworthy limitation of my research relates to the novelty of the topic. This means that limited data was available to help assess the capacity of the Red Cross to attend to the psychological and social needs of affected populations – my research goal. Rather, the bulk of data collected pertains to the lack of psychosocial programs and services within the Red Cross

and the shared vision and aspirations of respondents in relation to what they believe to be essential psychosocial programs for affected populations.

Implications for Future Research

In reviewing findings of this study many new questions emerged that could be addressed in future research studies. Two broad topic areas warrant further attention: 1) the specific needs of humanitarian aid workers while carrying out their humanitarian duty and the impact of their work on their personal well-being, and 2) the role culture plays in shaping how an individual experiences a traumatic event.

When looking at the needs of humanitarian aid workers and the impact of their work on their well-being the following are potential questions to guide such an exploration;

1. What are the potential impacts of response work upon responders – positive and negative?
2. What programs and services are currently being offered?
3. What are the strengths and limitations of such initiatives?
4. How could humanitarian aid organizations be more responsive to the needs of aid workers?
5. How can aid workers become more equipped to help themselves and their peers?
6. What role should response workers play in the field - limits (e.g. what role should paid versus volunteer personnel fulfill?)?

When looking at the role culture plays in shaping how an individual experiences a traumatic event, the following are some potential areas for further exploration on this topic;

1. Cultural views on mental health and healing

2. Exploration of means to integrate culturally specific characteristics (traditions, customs, etc) into humanitarian aid initiatives – integrated/blended approaches
3. How do you manage cultural variances when dealing with large scale occurrences that have numerous affected 'populations'?
4. How can Western practitioners work with and learn from other non-western practitioners so as to be more responsive in the delivery of humanitarian aid?
5. What role do negative stereotypes and perceptions play in reducing help seeking behaviors amongst affected populations?
6. Exploration of psychosomatic manifestations of psychological trauma and the manner in which people accommodate/explain such symptoms (e.g. do people make a connection between disaster, psychological trauma and symptoms).

Although these topics were not the focus of the current study, they have great relevance to the overall subject matter, and require special consideration when developing and delivering psychosocial support programs and services.

Chapter 6 – Conclusion

The goal of this qualitative evaluation was to explore from the perspective of paid and volunteer responders, the capacity of the Red Cross National societies in El Salvador, Nicaragua, Panama, Colombia, Peru and Argentina to address the psychological and social needs of the survivors of disasters and complex emergencies within their geographic regions. Specifically, the study intended to explore how vulnerable populations within these countries experience disasters from a psychological and social perspective. What are their perceived needs, both immediate and long-term? What services are currently being offered? What are their strengths and limitations? And what do participants believe the Red Cross can do to enhance its capacity to effectively assist vulnerable populations dealing with the psychological effects of disasters and complex emergencies?

Field research was carried out in six strategically selected Latin American countries and captured the voices of over seventy Red Cross humanitarian aid workers through thirty-four semi-structured interviews and five round table discussion sessions. Participants for this study were a mix with respect to gender, socioeconomic status and education level, and represented rural and urban populations. The commonality for each of these individuals was their commitment to the Red Cross in either a paid or voluntary capacity as a humanitarian aid worker - each having been an active participant in a recent and/or historic Red Cross humanitarian aid initiative.

During the course of my field research, participants shared information pertaining to the nature of humanitarian aid initiatives, their views on the capacity of the Red Cross to provide psychosocial supports to affected populations, and each offered their suggestions as to how the

Red Cross could be more responsive in their provision of relief, recovery, and rehabilitation support and assistance.

When reviewing current practice of the Red Cross it became evident that many regions have limited or a nonexistent capacity to offer psychosocial supports following a disaster and/or complex emergency. It was noted that while attempts have been made in the past to coordinate efforts and formalize a working agreement relating to who should provide what services and when, these efforts to date have not been successful in coordinating and enhancing service provision. Participants reported that during response efforts there is a considerable amount of disorganization with many entities working in isolation. As a result, respondents commented that current efforts are not being coordinated and focus primarily upon crisis intervention – neglecting the mid range and long term needs of affected populations.

Contributing to an already problematic approach to the provision of psychosocial programming, respondents also noted that current attitudes regarding psychosocial initiatives also contribute to their ineffectiveness. While respondents spoke of a positive view of such programming amongst front line responders, they said that this attitude is not universal and there is a negative view of efforts to address psychological issues among the general population in their communities. Some participants in the study shared the belief that psychosocial services were not necessary, though the view was held by a only a small group of individuals who either negated the need for psychosocial programming as an element of any Red Cross intervention (failed to acknowledge the link between psychological trauma and disasters and/or complex emergencies) and/or believed that the organization does not have the capacity to offer such services.

In light of this sometimes negative assumption of current psychosocial programming, the majority of participants was keen to suggest means to effect positive change and proposed numerous strategies for the Red Cross to enhance its service provision to affected populations. Participants spoke of the profound impacts of disasters and complex emergencies and noted their potentially adverse psychological repercussions. Participants also noted the need to view such impacts in a holistic manner accounting for the fact that in many cases an occurrence merely serves to aggravate existing issues linked to the realities of daily living within each region. Noting that careful attention needs to be paid to context specific factors that serve to mitigate and/or compound the impacts of an occurrence, when devising an intervention strategy it was proposed that interventions need to be developed in collaboration with members of the affected population and integrated into existing Red Cross efforts. This would ensure that members of affected communities are active participants in their own healing rather then passive victims.

A participatory approach would not only ensure that the interventions developed and employed were responsive to local needs. It was believed that they would also ensure that the community would develop the skills and resources to offer programs and services beyond the initial phases of a humanitarian aid initiative and become stronger, more empowered and self sustaining in the process. This process of empowerment would promote healing, strengthen the capacity of communities to respond to subsequent disasters or complex emergencies, and reduce their reliance on outside aid.

Based upon the testimonies of the participants key recommendations in relation to how participating national societies, regional delegations and the Pan American Disaster Response Unit work with national societies can be formulated. It was noted that such entities need to

function in a manner which strengthens national society's capacity to effectively and efficiently develop and deliver responsive humanitarian aid initiatives.

Participants' reported that participating national societies, regional delegations and/or the Pan American Disaster Response unit should: 1) aid national societies carry our research initiatives so as to ensure that devised interventions are responsive to local needs and realities; 2) work in partnership with national societies in the areas of project development & training so as to advance local capabilities and knowledge in a context sensitive manner; 3) work with national societies to facilitate partnerships with local agencies who share similar mandates and/or who can offer technical supports and assistance to the national society at all stages of the relief and recovery process, thus promoting the sustainability of such intervention once donor dollars have dissipated; 4) work with national societies to evaluate humanitarian aid initiatives so as to derive benchmarks for best practice and guidelines for the implementation of evidence based interventions when working with members of the affected population; 5) work with all national societies within the regions to share lessons learned and promote a spirit of mutual learning and information sharing. Further, it was noted that the supportive role of participating national societies, regional delegations and the Pan American Disaster Response Unit can be an active and ongoing one where by such entities serve as auxiliary supports during time of crisis and function as mentors and consultants on an ongoing/regular basis.

Although frequently overwhelmed by the nature of the information I obtained and the depth of the issues that were presented to me, I am comforted by the resilient nature of the people who I have been privileged to meet and their degree of commitment and determination in attempting to deal with psychosocial and social impacts of disasters and/or complex emergencies. It is my desire that this document not only honors the voices of these individuals, but also ensures

that their voices be heard. Such people possess an immense body of knowledge and insight and have the capacity to become active participants in the healing process. The question new becomes how the Red Cross will respond to such new knowledge and insight.

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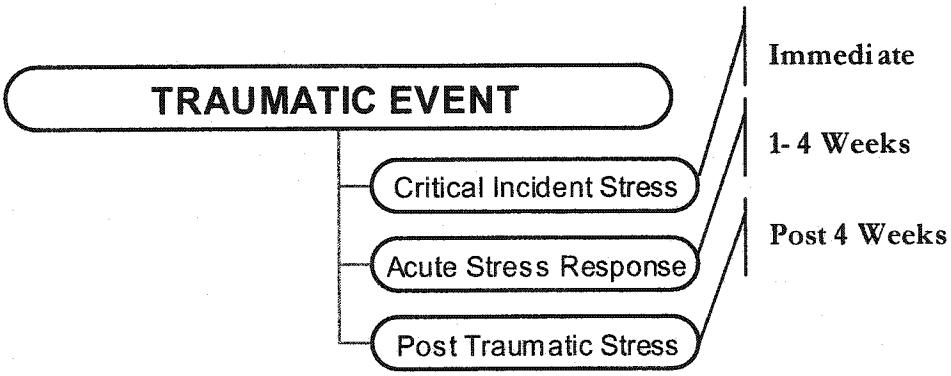
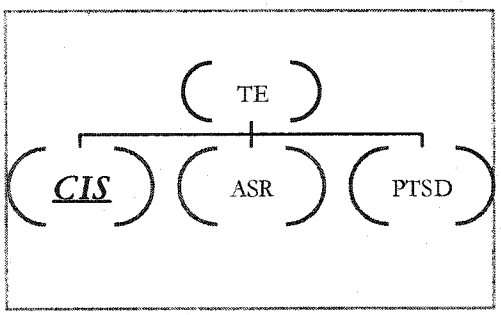
Appendix I – Trauma Continuum

TRAUMA CONTINUUM



Appendix II – Critical Incident Stress

Critical Incident Stress (CIS)



Definition

The stress response that a person or group has to a critical incident (CI/TE) which overwhelms a person usual coping mechanism.

Selected Indicators

Cognitive:
- Confusion
- Disorientation
- Difficulty making decisions

Physiological:
- Excessive sweating
- Dizzy spells
- Increase heart rate/respiration

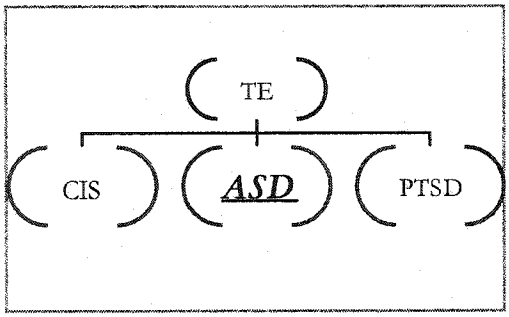
Emotional:
- Shock/anger/grief
- Hopeless/helpless
- Depression

Behavioral:
- Changes in eating/sleeping
- Decreased personal hygiene
- Withdrawal from other

Everly & Mitchell, 1999

Appendix III – Acute Stress Disorder

Acute Stress Disorder (ASD)



Definition

An anxiety disorder, triggered by a TE, which includes anxiety symptoms, reexperiencing of the event, and avoidance of stimuli related to the event, which last for a minimum of 2 day and persist no longer then 4 weeks.

Note: ASD was added to the DSM in 1994

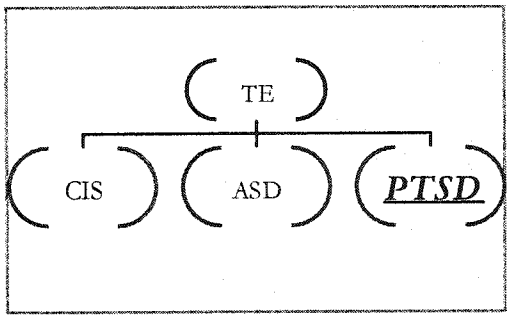
Selected Indicators

- Subjective sense of numbing, detachment, dissociation, amnesia
- Recurrent images of TE - thoughts, flashbacks, dreams
- Sense of reliving the experience
- Avoidance of stimuli that arouse recollection of TE
- Distress on exposure to reminders of TE
- Increased anxiety and arousal - hypervigilance, difficulty sleeping, poor concentration, irritability

APA (DSM IV-TR)

Appendix IV – Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD)



Definition

An anxiety disorder, triggered by a TE, which includes anxiety symptoms, reexperiencing of the event, and avoidance of stimuli related to the event, which last for more the 4 weeks

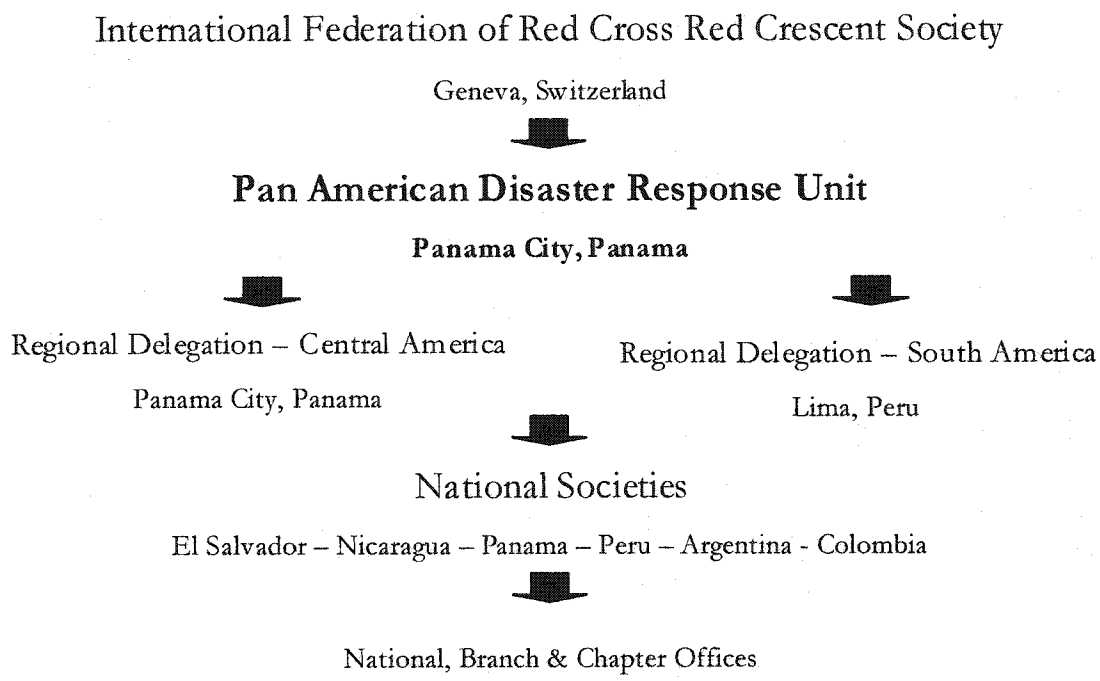
Selected Indicators

- Recurrent and distressing recollections of the event – images, thoughts and perceptions
- Recurrent distressing dreams
- Acting and feeling as if the traumatic event recurring
- Intense psychological distress and/or Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the TE
- Inclusive of ASD symptoms

APA (DSM IV-TR)

Appendix V – IFRC Organizational Chart

ORGANIZATIONAL CHART



Appendix VI - Focus group question & key informant interview questions

1. What is the nature of disaster relief and recovery efforts in this region?
    a. Specific disasters and relief operations
2. Who are the key players?
    a. Locally
    b. Nationally
    c. Internationally
3. What is their role
    a. Are such efforts centrally coordinated?
    b. By who ?
4. What is your perception of the needs of affected populations following a disaster?
    a. Rural & Urban
5. What psycho/social services are currently being offered to survivors of natural disaster?
    a. Rural & Urban
6. What psycho/social services work best in promoting well-being for survivors?
    a. Rural and Urban
7. What are the strength's and limitations of existing programs and services?
    a. Rural & Urban
    b. Accessibility?
8. In your opinion, what are the essential psycho/social services that are required for a post disaster relief and recovery effort?
    a. What services?
    b. Why?
9. How should one go about developing and implementing post disaster psycho/social programs for survivors in this region?
    a. Who should be involved?
    b. How do you access resources?
    c. How do you ensure that programs are responsive to need and sustainable?
10. Any additional comments?
11. Are there any other Disaster Services personnel in the region that you suggest that I should meet with?

Appendix VII - Focus group question & key informant interview questions - Spanish translation

1. ¿Qué es la naturaleza de alivio a desastre y los esfuerzos para la recuperación en esta región?
    a. Operaciones específicas de desastres y de la ayuda.

2. ¿Quienes son el personal clave?
    a. Local.
    b. Nacional.
    c. Internacional.

3. ¿Cuál es su papel?
    a. Están sus esfuerzos centralmente coordinados?
    b. Por quién?

4. ¿Cuál es su percepción sobre las necesidades de las poblaciones afectadas por un desastre?
    a. Rural y urbana.

5. ¿Qué servicios sicológico/social se le ofrecen actualmente a los sobrevivientes de un desastre natural?
    a. Rural y urbana.

6. ¿Qué servicios sicológico / social trabajan mejor en promover el bienestar personal de los sobrevivientes?
    a. Rural y urbana.

7. ¿Qué limitaciones y fortalezas tienen los programas y servicios existentes?
    a. Rural y urbana.
    b. Accesibilidad.

8. En su opinión, ¿Qué servicios sico / social son esencialmente requeridos para la ayuda en un desastre y para los esfuerzos de recuperación?
    a. ¿Qué servicios?
    b. ¿Porque?

9. ¿Cómo debe uno desarrollar y poner los programas de desastres sico / social en ejecución para sobrevivientes en esta región?
    a. ¿Quién debe estar implicado?
    b. ¿Como usted tiene acceso a los recursos?
    c. ¿Como usted se asegura de que los programas dan respuesta a las necesidades y al sostenimiento?

10. Algún comentario adicional.

11. Hay algún otro personal de servicios de desastres en la región que usted me sugiere que yo me reuna.

Appendix VIII - Focus group recruitment leaflet

Seeking Round Table Discussion Participants

ASSESSING THE CAPACITY OF THE RED CROSS NATIONAL SOCIETIES (AND THE PAN AMERICAN DISASTER RESPONSE UNIT) TO ADDRESS THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF SURVIVORS OF DISASTER AND COMPLES EMERGENCIES IN CENTRLA AND SOUTH AMERICA

Are you a member of a Red Cross disaster relief and recovery team working in Central and/or South America? If so, you are invited to participate in a focus group session to be hosted by the National Red Cross office within your region.

This session will he facilitated by Bill Walters a Masters of Social Work Student at Wilfrid Laurier University, in Waterloo Ontario, Canada, as a part of his graduate thesis which is being carried out under the supervision of Dr. Anne Westhues of the Faculty of Social Work, Wilfrid Laurier University, Waterloo, Ontario, Canada.

As a respondent in this study you will be asked to participate in a focus group session with approximately 10-12 other disaster services personnel from you region. During this session you will be asked questions pertaining to, and given an opportunity to discuss, your experience in working with post disaster relief and recovery efforts. This session will be hosted at the National Red Cross Office (*date to be added*).
Please note: Participation in this meeting is voluntary and will take approximately 2 hours.

If interested please contact Bill Walters at
bill.walters@redcross.ca or 654-5432

Appendix IX - Focus group leaflet - Spanish translation

Buscando Participantes para el Grupo de Foco

DETERMINACION DE LA CAPACIDAD DE LAS SOCIEDADES NACIONALES DE LA CRUZ ROJA (Y DE LA UNIDAD PANAMERICA DE RESPUESTAS A DESASTRES) DE TRATAR LAS NECESIDADES PSICOLOGICAS Y EMOCIONALES DE LOS SOBREVIVIENTES A UN DESASTRE NATURAL EN CENTRO Y SUR AMERICA.

Es usted miembro de algún equipo de ayuda y recuperación de desastres de la Cruz Roja que trabaje en Centro y Sur America? Si es así, esta invitado a participar en un grupo de sesiones que se realizará por la Cruz Roja de su región.

Esta sesión sera facilitada por Bill Walters – Estudiante de Maestría en Trabajo Social de la Universidad Wilfrid Laurier, en Waterloo Ontario, Cánada, como parte de su tesis de graduación que se está realizando bajo supervisión de la Dra. Anne Westhues de la Facultad de Trabajo Social, en la Universidad Wilfrid Laurier, Waterloo, Ontario, Cánada.

Si quieres pertenecer a esta investigación te invitamos a participar en la sesión del grupo de foco con aproximadamente de 10 a 12 personal de servicios a desastres de su región. Durante esta sesión usted podrá hacer preguntas concernientes al tema y le damos la oportunidad de discutir, su experiencia en trabajos de alivio de desastres y los esfuerzos de recobro. Estas sesiones se darán en la Oficina de la Cruz Roja Nacional (la fecha será dada. Post data: La participación en esta reunión es voluntaria y tomará aproximadamente 2 horas.

Si esta interesado por favor contacte a Bill Walters a la siguiente dirección bill.walters@redcross.ca o al teléfono (507) 654-5432.

Appendix X - Consent statement for interview respondent

CONSENT FORM FOR PARTICIPATING IN A STUDY ASSESSING THE CAPACITY OF THE RED CROSS NATIONAL SOCIETIES (AND THE PAN AMERICAN DISASTER RESPONSE UNIT) TO ADDRESS THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF SURVIVORS OF NATURAL DISASTER IN CENTRLA AND SOUTH AMERICA

I understand that I am being asked to participate in a research study that is being conducted by Bill Walters, a Masters of Social Work Student at Wilfrid Laurier University (Ontario, Canada). The purpose of the study is to assess the capacity of the Red Cross National Societies (and the Pan American Disaster Response Unit) to address the psychological and emotional needs of victims of natural disaster in Central and South America. I understand that this project will be conducted under the guidance of Dr. Anne Westhues, Professor of Social Work at Wilfrid Laurier University (and thesis committee chair). I also understand that a cultural interpreter will be present during the interview process and will be involved in the data analysis component of this research project to aid the researcher if such support is required.

Voluntary participation:

I understand that my participation in this study is voluntary in nature.

I understand that I can discontinue my involvement in this study at any point during the research process.

I understand that while participating in an interview I can choose to not provide an answer to any question(s) that the interviewer asks me.

Involvement Required:

I understand that I will be asked to participate in a guided interview consisting of 8 questions related to my experience with post disaster relief and recovery efforts (with regards to services offered by the Red Cross).

I understand that this interview takes approximately 1 to 1½ hours to complete – depending on the amount of details I choose to disclose.

I understand that the researcher will be conducted interviews with a total of 8 to 10 individuals in my country, I also understand that the researcher will be carrying out similar interviews in other countries in this region (a total of 32 to 40 respondents from both Central and South America).

I understand that I have a right to access and review copies of the transcripts from my interview, although this is not required. I understand that such materials, if requested, will be sent to me via a medium of my choosing.

No, I do not require that the interviewer forward me a copy of my interview transcript for my review.

Yes, I would like to request that a copy of my interview transcript be sent to me for my review.

I understand that I have a right to request that a copy of a summary final report be forwarded to me at the end of the research project if requested. I understand that such materials will be sent to me via a medium of my choosing.

No, I do not require that the interviewer forward me a copy of a summary final report.

Yes, I would like to request that a copy of a summary final report be sent to me at the end of the research project.

I understand that all correspondence with me from the interviewer (if requested) will occur via Email , Fax or Express Post (please check one box) using my contact information as listed below.

My contact information:

_____

_____

_____

_____

Risk:

I understand that it is possible that I may have an adverse emotional reaction and/or experience emotional discomfort when talking about my experiences.

I understand that if do have an adverse emotional reaction I may request to discontinue the interview.

I understand that the interviewer can provide a listing of free and confidential counselling and support services that I can access if I deem such services are necessary both during and following my participation in this study.

Confidentiality:

I understand my research records will be kept confidential and that I will not be identified in any publication or discussion. The researcher will assign me a code number at the beginning of the research process; he will keep my identifying information in a locked filing cabinet in order to contact me and share the research materials (my interview transcripts and a subsequent copy of the final research report for my review if so requested).

I understand that only the principal researcher, a cultural interpreter and thesis committee chair professor Dr. Anne Westhues will have access to this identifying information (if technical assistance is required during the process of data analysis).

I understand that at the end of the research project all my identifying information will be destroyed.

I understand that the overall results from this study will be shared with the faculty and staff of Wilfrid Laurier University and will be compiled into a graduate thesis. Further, I understand that such findings may also be submitted in journal article format for publication and/or may be distributed to other interested individuals and organizations.

I understand that non-identifying quotations may be used in published reports, and that any quotation that may reveal my identity will not be used without my written permission.

I understand that I have a right to have all questions about the research study, the goals, the procedures employed, how the information will be used, my rights, and any other related concern answered by the researcher.

The Research Ethics Board at Wilfrid Laurier University has reviewed and approved this research project. Please direct any concerns to Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-1970 ext 2468, or via Email at bmarr@wlu.ca.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Subject's signature_____ Date _____

Investigator's signature_____ Date _____

Appendix XI - Consent statement for interview respondent - Spanish translation

FORMA DE CONSENTIMIENTO PARA PARTICIPAR EN UNA INVESTIGACION QUE DETERMINA LA CAPACIDAD DE LAS SOCIEDADES NACIONALES DE LA CRUZ ROJA (Y DE LA UNIDAD PANAMERICANA DE RESPUESTA A DESASTRES) DE TRATAR LAS NECESIDADES PSICOLOGICAS Y EMOCIONALES DE LOS SOBREVIVIENTES A UN DESASTRE NATURAL EN CENTRO Y SUR AMERICA.

Entiendo que se me está solicitando participar en un estudio de la investigación que está siendo conducido por Bill Walters – Estudiante de Maestría en Trabajo Social de la Universidad de Wilfrid Laurier en (Ontario, Cánada). El propósito de este investigación es el de determinar la capacidad de las Sociedades Nacionales de la Cruz Roja (y de la Unidad Panamericana de Respuesta a Desastre) de tratar las necesidades psicológicas y emocionales de las víctimas de un desastre natural en Centro y Sur América. Entiendo que este proyecto será conducido bajo dirección de la Dra. Anne Westhues, Profesora de Trabajo Social en la Universidad de Wilfrid Laurier (y el cómite de tesis). También entiendo que un intérprete cultural estará presente durante el proceso de entrevista y estará implicado en el componente del análisis de datos de este proyecto de investigación para ayudar a los investigadores si se requiere tal ayuda.

Participación Voluntaria:

Entiendo que mi participación en este investigación es voluntaria en naturaleza.
Entiendo que puedo continuar mi implicación en esta investigación en cualquier punto durante el proceso de investigación.
Entiendo que mientras participe en una entrevista puedo elegir no proporcionar una respuesta a cualquier pregunta(s) que el entrevistador me haga.

Implicación Requerida:

Entiendo que me pedirán participar en una entrevista dirigida que consiste en 8 preguntas relacionadas con mi experiencia en manejo de alivio de desastres y los esfuerzos de recuperación (en lo que respecta a los servicios ofrecidos por la Cruz Roja).

Entiendo que está entrevista tomará aproximadamente de 1 hora a una 1:30 para terminar dependiendo de la cantidad de temas que eliga divulgar.

Entiendo que el investigador conducirá las entrevistas con un total de 8 a 10 personas de mi país, también entiendo que el entrevistador llevará entrevistas similares a otros países de esta región (un total de 32 a 40 respondedores de Centro y Sur América).

Entiendo que tengo derecho a accesar y repasar las copias de las transcripciones de mi entrevista, aunque esto no se requiere. Entiendo que tales materiales, si están solicitados, me serán enviados por la vía que yo eliga.

- ☐ **No**, no requiero que el entrevistador me envíe una copia de la transcripción de mi entrevista para revisión.
- ☐ **Si**, quisiera solicitar que una copia de mi transcripción de la entrevista me sea enviada para mi revisión.

Entiendo que tengo derecho a solicitar una copia del informe final del sumario me remitida al final del proyecto de investigación sí es solicitada. Entiendo que tales materiales me serán enviados por la vía o medio que yo eliga.

- ☐ **No**, no requiero que el entrevistador me envíe una copia del informe fianl del sumario.
- ☐ **Si**, quisiera solicitar que una copia del informe final del sumario me sea enviada al final del proyecto de investigación.

Entiendo que toda mi correspondencia con el entrevistador (sí esta solicitado) ocurrirá vía Email , Fax ☐, o Código Postal ☐ (por favor marque con un gancho) usando mi información de contacto según lo enumerado abajo.

Información de contacto:

_____
_____
_____
_____

Riesgo:

Entiendo que es posible que puedo tener una reacción emocional adversa y / o experimentar malestar emocional al hablar de mis experiencias.

Entiendo que si tengo una reacción emocional adversa puedo solicitar descontinuar mi participación en la entrevista.

Entiendo que el entrevistador puede proporcionarme una lista libre y confidencial de los servicios de asesoramiento y de la ayuda a la que puedo tener acceso si sugiero que ambos servicios son necesarios durante y después de mi participación en la investigación.

Confidencialidad:

Entiendo que mis expedientes de la investigación serán mantenidos confidencialmente y no se me identificará en ninguna publicación o discusión. El investigador me asignará un número de código al principio del proceso de investigación; él mantendrá mi información en un gabinete

cerrado en orden para poder contactarme y compartir los materiales de la investigación (mis transcripciones de la entrevista y una copia subsecuente de la investigación final para mi revisión si es solicitada).

Entiendo que solamente el investigador principal, el intérprete cultural y la profesora del cómite de tesis la Dra. Anne Westhues tendrán acceso a está información (si la asistencia técnica se requiere durante el procesos de análisis de datos).

Entiendo que al final del proyecto de investigación toda la información que me identifica será destruida.

Entiendo que los resultados totales de este estudio serán compartidos con la Facultad y el personal de la Universidad de Wilfrid Laurier y compilados en una tesis de graduación. Además entiendo que tales resultados se pueden someter a la publicación del algún artículo en el diario o se pueden distribuir a otros individuos y organizaciones interesadas.

Entiendo que eso de no identifar las citas se puede utilizar en informes publicados y que ninguna cita que pueda revelar mi identidad no será utilizada sin mi permiso escrito.

Entiendo que tengo derecho de tener todas las preguntas sobre el estudio de la investigación, las metas, los procedimientos empleados, como la información será utilizada y cualquier otra preocupación relacionada contestada por el entrevistador.

El tablero de investigación de ética de la Universidad de Wilfrid Laurier ha repasado y ha aprobado este proyecto de investigación. Si tiene alguna duda por favor dirijase a Bill Marr, Catedrático, Tablero de Investigación de Etica, Universidad de Wilfrid Laurier, 519-884-1970 ext. 2468, o vía Email bmarr@wlu.ca.

He leído y entendido la información antedicha. He recibido una copia de este formulario. Estoy de acuerdo en participar en esta investigación.

Firma _____ Fecha_____

Firma del Investigador_____ Fecha_____

Appendix XII – Consent statement for focus group participants

CONSENT FORM FOR PARTICIPATING IN A STUDY ASSESSING THE CAPACITY OF THE RED CROSS NATIONAL SOCIETIES (AND THE PAN AMERICAN DISASTER RESPONSE UNIT) TO ADDRESS THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF SURVIVORS OF NATURAL DISASTER IN CENTRLA AND SOUTH AMERICA

I understand that I am being asked to participate in a research study that is being conducted by Bill Walters, a Masters of Social Work Student at Wilfrid Laurier University (Ontario, Canada). The purpose of the study is to assess the capacity of the Red Cross National Societies (and the Pan American Disaster Response Unit) to address the psychological and emotional needs of victims of natural disaster in Central and South America. I understand that this project will be conducted under the guidance of Dr. Anne Westhues, Professor of Social Work at Wilfrid Laurier University (and thesis committee chair). I also understand that a cultural interpreter will be present during the focus group sessions and will be involved in the data analysis component of this research project to aid the facilitators if such support is required.

Voluntary participation:

I understand that my participation in this study is voluntary in nature.

I understand that I can discontinue my involvement in this study at any point during the research process.

I understand that while participating in a focus group I can choose to not provide an answer to any question(s) that the interviewer asks me.

Involvement Required:

I understand that I will be participating in a focus group whereby I will be provided with an opportunity to share my experiences, and may be asked questions regarding my experience, with post disaster relief and recovery efforts (with regards to services offered by the Red Cross).

I understand that focus group will take approximately two hours to complete – depending on the amount of details participants choose to disclose.

I understand that the focus group will have approximately 10 to 11 other participants, I also understand that the researcher will be conducted similar focus groups in 4 other countries in this region (a total of 50 to 55 respondents from both Central and South America).

I understand that I have a right to access and review copies of the transcripts from the focus group, although this is not required. I understand that such materials, if requested, will be sent to me via a medium of my choosing.

No, I do not require that the interviewer forward me a copy of my interview transcript for my review.

Yes, I would like to request that a copy of my interview transcript be sent to me for my review.

I understand that I have a right to request that a copy of a summary final report be forwarded to me at the end of the research project if requested. I understand that such materials will be sent to me via a medium of my choosing.

No, I do not require that the interviewer forward me a copy of a summary final report.

Yes, I would like to request that a copy of a summary final report be sent to me at the end of the research project.

I understand that all correspondence with me from the focus group (if requested) will occur via Email , Fax or Express Post (please check one box) using my contact information as listed below.

My contact information:

_____

_____

_____

_____

Risk:

I understand that it is possible that I may have an adverse emotional reaction and/or experience emotional discomfort when talking about my experiences.

I understand that if do have an adverse emotional reaction I may request to discontinue my participation in the focus group.

I understand that the facilitator can provide a listing of free and confidential counselling and support services that I can access if I deem such services are necessary both during and following my participation in this study.

Confidentiality:

I understand that due to the nature of a focus group (meeting with more then one individual) information that I share during the session will be heard by others attending the meeting, thus, confidential of that information can not be guaranteed.

I understand that the focus group records (focus group transcripts and audio recordings) will be kept confidential and that I will not be identified in any publication or discussion. The researcher will assign me a code number at the beginning of the research process; he will keep my identifying information in a locked filing cabinet in order to contact me and share the research materials (my interview transcripts and a subsequent copy of the final research report for my review if so requested).

I understand that only the principal researcher, a cultural interpreter and thesis committee chair professor Dr. Anne Westhues will have access to this identifying information (if technical assistance is required during the process of data analysis).

I understand that at the end of the research project all my identifying information will be destroyed.

I understand that the overall results from this study will be shared with the faculty and staff of Wilfrid Laurier University and will be compiled into a graduate thesis. Further, I understand that such findings may also be submitted in journal article format for publication and/or may be distributed to other interested individuals and organizations.

I understand that non-identifying quotations may be used in published reports, and that any quotation that may reveal my identity will not be used without my written permission.

I understand that I have a right to have all questions about the research study, the goals, the procedures employed, how the information will be used, my rights, and any other related concern answered by the researcher.

The Research Ethics Board at Wilfrid Laurier University has reviewed and approved this research project. Please direct any concerns to Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-1970 ext 2468, or via Email at bmarr@wlu.ca.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Subject's signature_____ Date _____

Investigator's signature_____ Date _____

Appendix XIII – Consent statement for focus group participants - Spanish translation

FORMA DE CONSENTIMIENTO PARA PARTICIPAR EN UNA INVESTIGACION QUE DETERMINA LA CAPACIDAD DE LAS SOCIEDADES NACIONALES DE LA CRUZ ROJA (Y DE LA UNIDAD PANAMERICANA DE RESPUESTA A DESASTRES) DE TRATAR LAS NECESIDADES PSICOLOGICAS Y EMOCIONALES DE LOS SOBREVIVIENTES A UN DESASTRE NATURAL EN CENTRO Y SUR AMERICA.

Entiendo que se me está solicitando participar en un estudio de la investigación que está siendo conducido por Bill Walters – Estudiante de Maestría en Trabajo Social de la Universidad de Wilfrid Laurier en (Ontario, Cánada). El propósito de este investigación es el de determinar la capacidad de las Sociedades Nacionales de la Cruz Roja (y de la Unidad Panamericana de Respuesta a Desastre) de tratar las necesidades psicológicas y emocionales de las víctimas de un desastre natural en Centro y Sur América. Entiendo que este proyecto será conducido bajo dirección de la Dra. Anne Westhues, Profesora de Trabajo Social en la Universidad de Wilfrid Laurier (y el cómite de tesis). También entiendo que un intérprete cultural estará presente durante las sesiones del grupo de foco y estará implicado en el componente del análisis de datos de este proyecto de investigación para ayudar a los facilitadores si se requiere tal ayuda.

Participación Voluntaria:

Entiendo que mi participación en este investigación es voluntaria en naturaleza.
Entiendo que puedo continuar mi implicación en esta investigación en cualquier punto durante el proceso de investigación.
Entiendo que mientras participe en el grupo de foco puedo elegir no proporcionar una respuesta a cualquier pregunta(s) que el entrevistador me haga.

Implicación Requerida:

Entiendo que participaré en un grupo de foco en el cual me proporcionan la oportunidad de compartir mis experiencias, y pueden hacerme preguntas con respecto a mi experiencia, en alivio de desastres y los esfuerzos de recuperación (en lo que respecta a los servicios ofrecidos por la Cruz Roja).

Entiendo que el grupo de foco tomará aproximadamente 2 horas para terminar dependiendo de la cantidad de temas que los participantes eligan divulgar.

Entiendo que el grupo de foco tendrá de 10 a 11 participantes, yo también entiendo que el investigador conducirá otros grupos de focos similares en otros 4 países de la región (haciendo un total de 50 a 55 respuestas de Centro y Sur América.

Entiendo que tengo derecho a accesar y repasar las copias de las transcripciones del grupo de foco aunque esto no se requiere. Entiendo que tales materiales, si están solicitados, me serán enviados por la vía que yo eliga.

☐ **No**, no requiero que el entrevistador me envíe una copia de la transcripción de mi entrevista para revisión.

☐ **Si**, quisiera solicitar que una copia de mi transcripción de la entrevista me sea enviada para mi revisión.

Entiendo que tengo derecho a solicitar una copia del informe final del sumario me remitida al final del proyecto de investigación sí es solicitada. Entiendo que tales materiales me serán enviados por la vía o medio que yo eliga.

☐ **No**, no requiero que el entrevistador me envíe una copia del informe fianl del sumario.

☐ **Si**, quisiera solicitar que una copia del informe final del sumario me sea enviada al final del proyecto de investigación.

Entiendo que toda mi correspondencia con el grupo de foco (sí esta solicitado) ocurrirá vía Email ☐ , Fax ☐ o Código Postal☐ (por favor marque con un gancho) usando mi información de contacto según lo enumerado abajo.

Información de contacto:

_____

_____

_____

_____

Riesgo:

Entiendo que es posible que puedo tener una reacción emocional adversa y / o experimentar malestar emocional al hablar de mis experiencias.

Entiendo que si tengo una reacción emocional adversa puedo solicitar descontinuar mi participación en el grupo de foco.

Entiendo que el facilitador puede proporcionarme una lista libre y confidencial de los servicios de asesoramiento y de la ayuda a la que puedo tener acceso si sugiero que ambos servicios son necesarios durante y después de mi participación en la investigación.

Confidencialidad:

Entiendo que debido a la naturaleza del grupo de foco (reuniones con más de un individuo) la información que se comparte durante la sesión será oída por otros que asisten a la reunión, la confidencialidad de esta información no podrá ser garantizada.

Entiendo que los expedientes del grupo de foco (transcripciones y grabaciones de audio del grupo de foco) serán mantenidos confidencialmente y que no se identificarán en ninguna publicación o

discusión. El investigador me asignará un número de código al principio del proceso de investigación; él mantendrá mi información en un gabinete cerrado para estar en contacto y poder compartir los materiales de la investigación (mis transcripciones de la entrevista y una copia subsecuente de la investigación final para la revisión si es solicitada).
Entiendo que solamente el investigador principal, el intérprete cultural y la profesora del cómite de tesis la Dra. Anne Westhues tendrán acceso a está información (si la asistencia técnica se requiere durante el procesos de análisis de datos).

Entiendo que al final del proyecto de investigación toda la información que me identifica será destruida.

Entiendo que los resultados totales de este estudio serán compartidos con la Facultad y el personal de la Universidad de Wilfrid Laurier y compilados en una tesis de graduación. Además entiendo que tales resultados se pueden someter a la publicación del algún artículo en el diario o se pueden distribuir a otros individuos y organizaciones interesadas.

Entiendo que eso de no identifar las citas se puede utilizar en informes publicados y que ninguna cita que pueda revelar mi identidad no será utilizada sin mi permiso escrito.

Entiendo que tengo derecho de tener todas las preguntas sobre el estudio de la investigación, las metas, los procedimientos empleados, como la información será utilizada y cualquier otra preocupación relacionada contestada por el entrevistador.

El tablero de investigación de ética de la Universidad de Wilfrid Laurier ha repasado y ha aprobado este proyecto de investigación. Si tiene alguna duda por favor dirijase a Bill Marr, Catedrático, Tablero de Investigación de Etica, Universidad de Wilfrid Laurier, 519-884-1970 ext. 2468, o vía Email bmarr@wlu.ca.

He leído y entendido la información antedicha. He recibido una copia de este formulario. Estoy de acuerdo en participar en esta investigación.

Firma _____ Fecha_____

Firma del Investigador_____ Fecha_____

Appendix XIV – Confidentiality agreement

CONFIDENTIALITY AGREEMENT

It is mandatory for all Cultural Interpreters to read and sign this confidentiality agreement form prior to becoming involved with the research project titled:

CONSENT FORM FOR PARTICIPATING IN A STUDY ASSESSING THE CAPACITY OF THE RED CROSS NATIONAL SOCIETIES (AND THE PAN AMERICAN DISASTER RESPONSE UNIT) TO ADDRESS THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF SURVIVORS OF NATURAL DISASTER IN CENTRLA AND SOUTH AMERICA

I, the undersigned, as a cultural interpreter involved with the study: ASSESSING THE CAPACITY OF THE RED CROSS NATIONAL SOCIETIES (AND THE PAN AMERICAN DISASTER RESPONSE UNIT) TO ADDRESS THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF SURVIVORS OF NATURAL DISASTER IN CENTRLA AND SOUTH AMERICA, being conducted by Bill Walters, a Masters of Social Work Student at Wilfrid Laurier University (Ontario, Canada). I acknowledge that all information of a confidential or private nature which may come to my knowledge or attention in the course of my work will be kept in the strictest confidence. This includes information about the respondents in the study, as well as the other volunteers and staff I may work with. I understand that the disclosure of any information is in violation of research ethics and will be cause for review and/or termination of my position as a cultural interpreter.

Cultural Interpreter Signature: _____

Date: _____

Principle Researcher Signature: _____

Date: _____

Appendix XV – Confidentiality agreement – Spanish translation

ACUERDO DE CONFIDENCIALIDAD

Es obligatorio que todos los intérpretes culturales lean y firme esta forma del acuerdo de confidencialidad antes de participar el proyecto de investigación titulado:

UNA INVESTIGACION QUE DETERMINA LA CAPACIDAD DE LAS SOCIEDADES NACIONALES DE LA CRUZ ROJA (Y DE LA UNIDAD PANAMERICANA DE RESPUESTA A DESASTRES) DE TRATAR LAS NECESIDADES PSICOLOGICAS Y EMOCIONALES DE LOS SOBREVIVIENTES A UN DESASTRE NATURAL EN CENTRO Y SUR AMERICA.

Yo, el infrainscrito, como intérprete cultural implicado en la investigación: **QUE DETERMINA LA CAPACIDAD DE LAS SOCIEDADES NACIONALES DE LA CRUZ ROJA (Y DE LA UNIDAD PANAMERICANA DE RESPUESTA A DESASTRES) DE TRATAR LAS NECESIDADES PSICOLOGICAS Y EMOCIONALES DE LOS SOBREVIVIENTES A UN DESASTRE NATURAL EN CENTRO Y SUR AMERICA**, siendo conducido por Bill Walters, Estudiante de Maestría en Trabajo Social de la Universidad de Wilfrid Laurier (Ontario, Cánada). Reconozco que toda la información de naturaleza confidencial o privada que puede venir de mi conocimiento o atención en el curso de mi trabajo será mantenida en estricta confidencialidad. Esto incluye la información sobre los respondedores en el estudio, también la de otros voluntarios y del personal que trabajo en la misma. Entiendo que el acceso de cualquier información es una violación a los códigos de ética y puede ser una causa para la revisión o terminación de mi posición como intérprete cultural.

Firma del Intérprete Cultural:_____

Fecha:_____

Firma del Investigador Principal:_____

Fecha:_____