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IMMEDIATE PSYCHO-SOCIAL SUPPORT FOR DISASTER SURVIVORS.

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The article describes how psychosocial support, in the immediate and mid-term disaster response for Haitian earthquake survivors in hospitals in the Dominican Republic, ameliorated some of the suffering and prevent the crisis from becoming crystallised into symptoms and complex grief. The support was centred on (1) providing information; (2) facilitating social regulation of emotions; (3) supporting a social support network for the patient; (4) focusing coping efforts; and (5) normalisation of reactions. Finally it is described how the crisis made values of caring, compassion and responsibility expressed and shown by the survivors.

Youn zetwal file tonbe
Fann fonten tet-mwen
Pakanpak
Youn loray gwonde tonbe
Nan mitan zantray-mwen
Tidife boule kale nan ke-m tou wouj

Ou met koupe-m
Rache-m jete-m
Ou met boule-m
Fe chabon ak mwen
Zwazo p'ap sispann
Fe nich nan rasin-mwen[1]

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[1] Star sharpens and falls / splits my forehead / temple to temple / Lightning burns / within my gut / Flames hatch in / my pounding heart / You can cut me off / uproot me, toss me away / You can burn me / into charcoal / Birds won't quit / nesting in my roots. Part of a poem by the Haitian poet Emanyel Ejen (Emmanuel Eugene) – pseudonym Manno Ejen – which deals with political oppression, but clearly shows resilience in the face of adversity.

1. Introduction

There is recognition and acknowledgement that complex emergencies such as major disasters, especially those involving severe injuries, bereavement and loss, will indeed have mental health consequences for many survivors (Staub et al, 2005; Silove, 2004; Joseph et al, 1997). This would be specially so where the social infrastructure has been compromised and the mental health systems existed prior to the emergency may be insufficient to meet the multifaceted needs of communities affected.

A framework of understanding of psychosocial support to people exposed to critical and potentially traumatising incidents has been developed over the last decades. In many parts of the world, extended families and social networks with many deep and lasting relationships between the members are weakened by the current structure of families and work. That means that the traditional ways of supporting each other no longer suffice in the case of disasters and fatal accidents (Jensen & Baron, 2003). In some areas, the traditional ways of support may still exist, but they may be weakened by economic challenges as a result of globalisation or the general changing of life styles. Thus, they may be vulnerable and fragile. In Haiti, the extended family and kin support system is strong, but when disaster separates individuals from the system, the impact may be severe, and in that particular situation dependency on the support system may turn into a risk factor (Nicolas, Schwartz, & Pierre, 2009; Nicolas, Desilva, Subrebost, Breland-Noble, Gonzalez-Eastep, Prater, & Manning, 2007).

Being exposed to a disaster may induce feelings of fear and anxiety, physical pain, loss of energy and motivation, change in temperament and identity, estrangement from friends and family, disturbed sleep or nightmares, inability to make decisions, concentrate or remember, loss of faith and spirituality, inability to work, and a loss of interest in care of family and self.

Furthermore, the social environment of the individual may change profoundly during and after the disaster. These changes may include (1) family separation, (2) increased violence in the community or in refugee camps, including rape and humiliation, (3) fear and uncertainty about the future, (4) loss of livelihood, and (5) changing of roles within the family.

The community and even the larger society may be severely impacted by the disaster as there may be an increased level of mistrust, fear, insecurity, pain, guilt, grief, religious and moral confusion, violent behaviour (rape, robbery, and domestic violence), absence of acceptable leadership, and alcoholism/drug abuse. The community and the society may be characterised by loss of trust and hope, apathy and abusive behaviour (including corruption), and lack of good governance. These factors make the recovery of individuals, families and communities very challenging if the process does not include the local community and levels of governance in the society.

However, still there are also protective factors. All experience points to that already in the very moment of the disaster at least a huge part of the impacted people start to mobilise social support. They share limited resources and provide protection of the most vulnerable. They take part in the immediate and long-term rebuilding of the community and they participate in the traditional mourning ceremonies as soon as these are organised. They will share feelings and narratives about what happened and share ideas of how to cope with the present situation (Berliner, Anasarias & de Casas Soberón, 2010; Berliner & Mikkelsen, 2006)

In this article we describe and analyse the need of psycho-social support as seen in survivors of the 2010 earthquake in Haiti. We focus on the reactions – and interventions – in the immediate and mid-term phase of the emergency.

2. Background

On Tuesday the 12th of January 2010, Haiti was hit by an earthquake that measured 7.1 on the Richter scale. The earthquake struck less than ten miles from the capital, Port-au-Prince. The initial quake was later followed by twelve aftershocks, greater than a magnitude of 5.0 on the Richter scale. The destructive nature of the earthquake affected the population, leaving hundreds of thousands dead, massive destruction of private and public property, an untold numbers of the population injured and countless numbers as refugees and affecting the whole population with this traumatic experience.

The Dominican Republic facilitated treatment of injured survivors. The survivors were transported in helicopters, ambulances and other vehicles from Haiti to the Dominican Republic in the first hours and days after the earthquake. A large group of medical doctors, nurses and other staff volunteered in this endeavour to save as many people as possible.

The hospitals in the Dominican frontier, as well as in the cities of Santo Domingo, and Santiago and Barahona, mobilised all their resources to treat thousands of patients coming from Haiti. Many of the injured survivors had to undergo amputation in order to save their lives.

The University Iberoamericana UNIBE, in cooperation with the Plaza of Health Hospital, created a Crisis Intervention Unit with physicians and psychologists from both institutions, with the aim of providing service to affected communities in Haiti and in the hospitals in the Dominican Republic. Staff and students from the Master Degree Program in Crisis and Trauma joined the Crisis Intervention Unit and provided psychological support to the survivors and their families in hospitals in the Dominican Republic and in camps for survivors in Haiti under the supervision and guidelines provided by the UNIBE University. As the Master Program is conducted in cooperation with the University of Salamanca in Spain, technical inputs and additional funding for the Crisis Intervention Unit were provided by this university and the University of Aarhus, Denmark provided technical input.

The Crisis Intervention Unit provided support to survivors and their families in hospitals at the Dominican border to Haiti, in Santo Domingo, and in camps and cities in Haiti, as well as psychosocial support in shelters in Santo Domingo (for patients' families and for patients after being discharged from hospitals), and in Jimani and Fond Parisien in Haiti. All activities were coordinated with the General Direction of Mental Health in the Ministry of Public Health in the Dominican Republic. All the work at the Crisis Intervention Unit was performed by staff volunteering in the efforts.

In the first days following the earthquake, the team provided psycho-social support to survivors, of whom most were in a state of numbness, without energy, in grief, without hope, bewildered, recognising their personal losses, and disoriented. In the camps, their living conditions were without means for hygiene or privacy, and without options for generating an income. Most of them had a huge need for information about their family and belongings, but in the first days it was very difficult for us or for other aid organisations to provide that kind of information. In this phase we were mainly focusing on identifying the survivors and patients most in need of psycho-social support or even psychiatric treatment – and to provide this service to the ones most in need. We were guided by the understanding that we should organise social support for the survivors in grief and refer those with pathological reactions for treatment.

The aim of our service was to provide emotional, informational and practical support through listening to their pain and their needs. Psycho-educational interventions were also used to explain the various psychological reactions and possible ways of coping with challenges such as intrusive images, fear, pain, and nightmares.

The Crisis Intervention Unit went to the hospitals El Melenciano Hospital and El Buen Samaritano Hospital in Jimani, at the border between Haiti and The Dominican Republic, and provided support for patients and their families. A special focus was on supporting children and families with children.

Haitian-born medical students from UNIBE volunteered as translators and helped the survivors, and us, to overcome the language barrier between Creole and Spanish/English. Because of the heavy work load and the language barrier a number of the patients did not know about their treatment or prognosis as they were not able to talk with the physicians and nurses. A major part of the psychological support in the first days after the earthquake was to provide translations that made it possible for the staff to inform the patients and their relatives about the treatment.

Besides from facilitating the communication, the psycho-social support was mainly to listen to the expressions of grief and pain and to accompany the survivors in that very difficult moment of their life. Furthermore, we supported patients in re-establishing contact with their relatives in Haiti. The separation of family members was a huge problem as the means of tracing and of communication were not established in the first days after the earthquake, but in the following weeks the hospitals organised free telephone lines for the patients to help them communicate with relatives in Haiti.

The patients were full of anguish as they did not understand what had happened to them, how they came to the hospital, and the progress of their treatment. For instance, a young woman cried and shouted in agony when her wounds were being washed once a day as she did not understand the reason for the washing. She had one leg amputated and the doctors tried to save the other leg. When she received information about the treatment, she felt more secure and was able to better resist the pain. Many of the patients feared for the future and expressed lack of hope for the future. The family members, who had come with the survivors from Haiti, suffered from just waiting and not knowing how they could support the patient in the best way and because they were also impacted by the earthquake and losses of family members and property, even though they were not injured. The psycho-social support for the family members was mainly to facilitate ways of being useful to the patients, the staff and other family members in the hospital.

At the Good Samaritan Hospital, the Crisis Intervention Unit and the hospital mental staff gathered a group for children with the aim of supporting the surviving children in their grief process through play sessions. Most of the children were severely injured and had amputations of a leg or an arm and a lot of them were in the hospital without their family. The family members with children did a remarkable effort to support other children as well as their own child. In the sessions we used arts and plays. When we asked the children to make a drawing of their feelings now, they all made a drawing of where they were when the earthquake struck. Then we invited each child to tell us what happened, where they were and who helped them. After the round, the children expressed some relief and we used this experience in the following session, where we invited the adult family members and the children to participate in activities, where the children could sing and paint what they felt and wanted.

In the weeks following the earthquake we went twice to Fond Parisien on the Haitian side of the border. We offered psychological support to survivors in grief and pain and to their families, and psychosocial support to groups of children. As seasoned psychologists, we also had the pleasure of answering a number of questions from excellent, but inexperienced, younger psychologist and staff sent in by aid organisations. When a refugee camp for 600 survivors was established in Fond Parisien, we continued the psycho-social support with survivors and their families and psycho-social support to facilitate a sense of community in the camp.

In the history of the Haiti – Dominican Republic relationship, there have been fights and prejudices and some Haitian earthquake survivors expressed to us that before the earthquake, they were convinced that at least some of the Dominican people would reject them. They feared that they would receive inappropriate treatment in the hands of the Dominicans, but the experience of the help they received changed their understanding. One of the first religious services made at the survivors' camp at Fond Parisien was dedicated to the Dominican Republic as an expression of appreciation of the way the Dominicans responded to the Haitian tragedy.

As Haitian patients were discharged from the hospitals they were in urgent need for housing, while they continued treatment as outpatients. The Catholic Church and the NGO "Children without Borders", and individuals helped establishing shelters for the patients and their families. After the termination of the treatment they would go back to Haiti. The maintenance of the shelters was provided by the Church, as well as the provision of food, clothes and school materials for the children. The staff and volunteers in the centres had very little time for the preparation. Given the situation in Haiti, it was envisaged that the patients and their families would stay in the shelters for several months.

The Ministry of Public Health supported the shelters by deploying psychologists, nurses, physicians, and specialists in public health to help the affected survivors through psychosocial support. We continued to visit 5 shelters after the initial assessment of needs was made and sent to the Department of Mental Health. The survivors expressed that they were concerned about their future in Haiti and that in some centres they suffered from boredom as there were limited activities to participate in. In other centres a number of activities were already established for children and parents.

The objectives of the psycho-social support by the Crisis Intervention Team were to provide information on the recovering process and to help create a sense of community and mutual support in the shelter. Individual and group support was provided to facilitate the grieving process of the survivors. Particular support was given to parents to help them facilitate the recovery process of their children. In two shelters support groups of children were organised and sustained through weekly sessions.

The lack of knowledge on how to organise the shelters in the most supportive way created a high level of stress for the directors of the shelters and for the volunteers working there. The Crisis Intervention Unit responded to this by offering psycho-social support for the following levels within the shelters: (1) the Directors of the Centres (with a focus on setting clear and realistic goals with respect to the present state of the shelter and to engage volunteers and survivors into the activities needed to reach the goals); (2) the interpreters (training in intervention in crisis); (3) the volunteers (facilitating supportive teams); and (4) the survivors (individual psychological support and supportive groups). Furthermore, the Unit organised conferences, workshops and panels open to the public, with the aim of informing potential future volunteers and donors of the needs of the survivors. Finally, the Unit provided free training for mental health professionals, who wanted to engage themselves in the psycho-social support activities.

The support was organised from the needs of the target population and encompassed the following focal points: (1) Calming – which included follow-up of medical examinations, assessment of traumatic stress, sessions of mourning and grief, information, and activities for children and adults; (2) Promotion of resources – which included information about how to live with a prosthesis and other aspects of medical recovery, education of children, inviting the survivors into participating in the tasks of the shelters, and classes of basic Spanish; (3) Building and supporting social relations – which included group sessions with families and relatives in the shelters, tracing, provision of means of communication, visits to other shelters and contact with volunteers from the local community; and (4) Creating and sustaining hope – which included talks about the future and especially about how to plan the return to Haiti.

As the survivors had to leave the shelter, when they were ready, most shelters provided support in planning the return to Haiti. In the shelters we promoted a bulletin board in which the news from Haiti was presented, as well as other means of access to the media. When available, a survival kit bag was given to them, when they left the shelter – containing some food, some items for personal hygiene, some clothes and a limited amount of money. Finally, a farewell ritual was held.

On the basis of the first assessments of the needs in the shelters, we made a list of indicators for the shelters to be inspired by in their efforts to provide psycho-social support for the survivors. The list comprises the following points:

1. The shelter develops the ability to help the victims and their family to cope with the present.
    - 1.1 The shelter has established hours of activities for each weekday, as well as for the weekends.
    - 1.2 It promotes collective memorials to help the survivors cope with the loss of their loved ones.
    - 1.3 The shelters promote the reunification of the families through the networks provided by Mental Health, the Red Cross, CONANI, the United Nations, and the media.
    - 1.4 The refugee shelter functions as a small society or community, where each of the adults in accordance to their abilities participates in the development of the activities of the shelter.
        - 1.4.1 Those who are teachers educate the children.
        - 1.4.2 Other professionals help their fellow refugees with their knowledge.
        - 1.4.3 They create a network of support through support sessions for the group of survivors in the shelter.

    1.5 The refugees help in the activities related to the maintenance of the shelter, i.e. they are in charge of preparing the food and they are in charge of keeping the camps clean
2. The shelters have a recovery program for the patients, of whom many are amputees, with a need for support in regaining a sense of bodily control to avoid depression related to being disabled.
3. Psychological support is provided through psycho-social sessions with a variety of activities, including reflection, art, play and sport.
4. Personnel from the Mental Health System supervise the implementation of the psycho-social support programs within the shelters.
5. The volunteers are provided with relevant training and continuous support in their work.

This approach includes a stabilisation of the daily life of the outpatients. It also provides options for participation in the activities in the shelter and it opens for mutual social support and through that for social regulation of emotions and thoughts. Furthermore, the shelters make information on the situation in Haiti available and offer sessions for psycho-social support for children. Thus, the shelters aimed to offer the required crisis recovery support – which we will discuss below. First we will give examples of the expressed needs of the patients in the hospitals.

3. Learning from Cases

In this section we will present cases, which we see as rather typical for the sufferings of many of the earthquake survivors, whom we met in the hospitals in Santo Domingo. As we did not ask all the patients for permission to use their stories for research, we have changed the cases slightly, so no patient can be identified. We find it ethically acceptable to use the cases in that way and even more so as no known harm or inconvenience was or will be inflicted on the patient through this use of their story. In the encounter with the patients, the objective was solely to offer crisis intervention, i.e. psychological first aid. The cases were written from field notes made immediately after each session with a patient. In cases where we together saw patients, the written account is compiled from versions conducted individually by each of the researchers. The method applied is empirical and inspired by Deleuze's (2001) argument that we cannot study the phenomenological worldview of the person as a state or a force that lies behind (or is created through) the words and behaviour of the person – but that the story and behaviour is a process of doing, of becoming and conceptualisation, which reflects a material context and life as part of that context. We did not have the opportunity of going back to the patients to hear their reflection on our understanding and thus the credibility of the research is based in the pragmatic value of the support as we were guided by the assessment of the patients need for particular types of support and by our practical endeavour for responding to the needed support to the highest possible extent.

The first case describes a meeting with a patient 14 days after the earthquake.

> *A middle aged lady from Haiti lies in her hospital bed in a room with four other patients. She was sent here when she was rescued from the rubble of her house in Port au Prince, because she had severe internal contusions. The medical staff wants us to talk with her as she seems paralysed and sighs and cries almost incessantly. She has refused to talk with anyone until now, even though the other patients had tried to speak with her. When we address her, she looks bewildered for a short while. Then she started to speak about her losses. She tells us that she lost a child and that she did not have any communication with the family back home. She speaks in a quiet, tired voice, and tells us that she is really happy to talk with somebody that speaks Creole, that is the interpreter, a young student of medicine. She tells that she could not recall anything from the earthquake and that she suffers from a continuous fear of being in the hospital building as she fears that another earthquake will destroy the building. We talk with her about how her memory will come back little by little and that it is understandable to fear that the earthquake will strike again, but that there is no likelihood that it will happen here and now. She says that it is useful to know and asks about the interpreter's family and if all the members of his family survived the earthquake.*

In this case example, the lady is in need of social support in a very basic, but crucial sense, as she simply needs somebody to talk with. She shares her grief of the losses she suffered. She expressed her fear of a new earthquake and is calmed when we tell her that it is not likely that an earthquake will strike here. The lady is in need of talking with us about what happened to her and as she speaks, she is gradually able to put the bits she remembers into a more coherent narrative about the incident. During the interview of a little less than 20 minutes, she becomes less confused and by the end of the interview, she shows empathy for the young interpreter's family, which showed her empathy as a dignified and caring mother with a huge capacity for compassion.

The next case shows the reactions and needs of a young survivor.

> *The patient is a young social science student, who was buried in the earthquake under tons of rubble as the big office building she was in*

> *at that moment collapsed in the earthquake. She was in that building for a minor administrative enquiry when the earthquake struck. She was buried under the debris for two days, before she was helped out. Immediately after she was taken in a helicopter to Santo Domingo and her right leg was amputated as soon as she arrived at the hospital. Her right arm is severely injured and the doctor tells us that it is still doubtful whether it can be saved or if it must be amputated. She tells us that she has a lot of pain and that she is very concerned about the future as she used to work to get money to finance her studies at the university. She cries during the interview because of the pain and because of continuous speculations about the future as she sees it without any hope. We talk about the necessity of resting now and giving her body time to recover, instead of wanting to solve all the problems at once. The recovery will have to be the first step in trying to cope with the new life condition. She accepts this and wants us to tell the doctors that the nursing assistant, who washes her wounds daily, should be gentler as it is very painful. The interpreter – a final year student of medicine – talks with the nursing assistant and explains to the patients why the cleaning of the wounds is painful and why it must be done thoroughly daily.*

In this case we see that the patient is caught between the need for planning how to cope with the future and a need for resting. Through the session, of around 15 minutes, she became calmer and stopped crying. Even though the speculations about the future showed a rational effort of coping with the situation, they turned into ruminations as she was unable to regain mastery of her situation before she had physically recovered more than at the present. Her speculations were counterproductive to her recovery as they did not allow her to rest.

The next case shows how children and parents may be supported psychosocially.

> *An 8 years old girl, with a severely injured leg, lies in her hospital bed and the mother sits beside her. We talked with them in their hospital room with 7 beds occupied by injured children and their mothers and relatives sitting around the beds. The mother had asked the medical staff for advice as the child was very afraid that another earthquake would strike. She told us that the child was paralysed and was very quiet in comparison to how she used to be. The daughter looked at us and responded when we started to play with her with her doll and asked her if the doll was one she brought with her or a new one which she got here in the hospital. The mother told us that the daughter brought the doll with her from Haiti. Then the mother told us how she had managed to get herself and the daughter to Santo Domingo on one of the*

> *helicopters that flew injured people from Port au Prince to hospitals in Santo Domingo. If she had not succeeded in that, the child would have died, she said. Furthermore, she told us that she had had contact with the family back home and that she knew that her husband and their other child had survived the earthquake. We responded to the mother that her story for us was about caring and compassion and keeping the daughter alive through taking on-the-spot action. The daughter listened observantly to our conversation with the mother. Then we talked with the mother about that the daughter's fear of a reoccurrence of the earthquake will fade away gradually as they talk about what happened in a way that emphasises that it was possible to do something to prevent the worst consequences of it – as in when the mother managed to get the daughter to the hospital and in that way coped very actively with the incident. Then the mother explained to the child that the fear would disappear gradually and we asked the child about what she thought about that – and she said "yes" in a very low voice, while she smiled at us and at the mother. The mother said that she was relieved by knowing that it was a common reaction in children and that she had felt that it was best not to talk with the daughter about what happened during the earthquake, but that she would talk with the daughter about it from now on. We talked about that the fear was rational and that it would continue to come back even though one tried to avoid it, so that it was better to confront it by building up a shared recollection of what happened. The daughter started to play with her doll again and the interpreter joined her, playing hide-and-boo, i.e. that the doll disappeared and suddenly jumped out of its hiding place. The little girl was laughing quietly and when she got the doll back she replicated the play now being the one in charge of hiding and showing the doll to the interpreter.*

In this case, a very clearly stated need of the mother is met by the information given about the normality, i.e. that it is often seen in children (and in adults) and that in most cases it will lessen gradually. As she gets a means for supporting the child – by in a soothing way sharing the experience of what happened during the earthquake and that it is not likely that it will happen again here – she becomes able to provide a helping social regulation of the child's fear. This will not take away the fear at once, but it will open for moments without it, even though it may reoccur from time to time.

An important aspect of the support provided in the cases was that the patients were given a means of communication through a shared language. As the patients spoke Creole and the staff spoke Spanish, the communication between them was very limited. The first step of the psycho-social support was to provide interpreters and young Haitian students of medicine and other people volunteered as interpreters. These students spoke Creole, Spanish and English fluently. The level of proficiency of the student volunteers was very high as they knew about psycho-social support from their studies and were able to support the dialogue between the provider of the support and the patient in a highly supportive way. Even though they were impacted by the earthquake themselves as they have families in Haiti, they understood the importance of neutrality and empathy in the way that own experiences can be used as far as they are brought about to comfort and support the patient. They were respectful to the stories and the needs of the patients and to the gentle introduction of a gradual and balanced confrontation with the memory of what happen and the challenges of the present and future life situation. They were good in conveying questions and answers between patients (and relatives) and staff in a non-judgmental and focused manner.

A number of relatives came with the patients from Haiti as well as some patients had family members living in Santo Domingo. These relatives were also confused about the situation and as they did not know how to be of best use, they became rather passive and awaited instructions from the staff. When we asked the patients about their needs, many relatives approached us and asked us to come to see particular patients. In that way they facilitated the contact between us and patients in need for support.

> *The patient was a young woman with a university degree. She lived in another country, but was back in Haiti at the time of the earthquake. She was buried in debris and had a severe injury to one of her legs. Two weeks after the earthquake it was still pending whether the leg could be saved or if it had to be amputated. The staff wanted us to talk with this patient as she was very silent and did not want to share her feelings with anyone, although she was crying most of the time. When we addressed her, she said that she did not have any need for talking with us. Her fiancée sat next to her bed and when we left, he followed us and asked for advice on how he could support her. She did not respond to his questions, but said that she appreciated that he was there next to her. We responded that he was doing what she needed and that was what he could do at the present. Presumably, she would start to talk to him after a while, but even though she would not, he was supporting her in the best way by just being there with her. If he felt like doing that, he could from time to time tell her about his caring and love for her and that he would still love and care for her – whatever happened. He looked calmer after this 10 minutes conversation and said that it was good to know as he was beginning to feel useless and thought that he was not capable of supporting her in the best way.*

The case shows that psychological first aid may be needed by the relatives and that supporting them is meaningful in itself as a way of sustaining and strengthening the support they provide for the patient.

The last example shows how the needs of the patients are complex, but in the first stages of the crisis they are often still quite straightforward and openly expressed.

> *The patient is an elderly gentleman, who suffers from amnesia and confusion. He had severe head injuries during the earthquake. He talks fragmentarily about his mother, while he cries and clings to one of the providers of the psycho-social support and calls him mother. He keeps saying that he just wants to go back to his mother, but in the conversation it is not possible to find out whether the mother is still alive or where she lives, as he cannot give us a telephone number or an address. He shares a room with another elderly gentleman, who explains to us that he does not know how to help the other one. During the conversation, the second gentleman hides his head in a towel, while the first one talks about the mother. He tells us that he feels sorry for the other man and that he wants to be able to comfort him, but as the days have passed, he found himself incapable of helping him. He himself suffers from head injuries and has difficulties concentrating, and he feels that he should be supporting his family in Haiti instead of being here in the hospital. He explains to us that it is his task as a father to be there and to support the family. On top of this, he is concerned about paying for the hospital, as he is quiet wealthy and he wants to pay the hospital. We talk with him about the hospital's free telephone line to Haiti and he tells us that he will use it. Furthermore, we talk about that the most supportive act to the family may be to concentrate on the recovery process right now as soon as he has established the communication line with his family. He agrees upon that it is a good idea to recover, so that he will have the strength to support his family and that he may need to rest now to be able to do that. During the conversation, which lasted for about 20 minutes, the other gentleman in the room becomes less agitated and starts to follow the conversation for a while.*

In this case example we meet a very confused patient with a high need of emotional support. His longing for his mother is reflected actively in the present situation and is to the highest possible extent met by one of the providers of psycho-social support, as he gives the emotional comfort after an attempt of making the patient realise that he is not his mother. The patient becomes calmer through this process – maybe even supported by the light amusement, which was expressed by the psycho-social team as one of its male members suddenly was addressed as mother. The other patient in the room had a need for knowing that what he had done to support his roommate was acceptable. Furthermore, he had a need for contact with his family and for allowing himself to concentrate on his recovery, so that he would be able to help his family better, when he could return home.

In other cases, the family support became a challenge as the family members did not know how to support the patient in the best way and the patient on her/his side felt that she/he had to support the family members as well.

> *In a hospital room we meet a mother with a daughter with an injured leg, which caused her a lot of pain. The daughter is a student and was in a classroom when the earthquake struck and she was dug out of the debris as one of the few survivors from that building. She was also one of the few survivors of her class and she suffers severely from intrusive memories of the incident and from the loss of her sister, who died in the earthquake. The first time we saw her and the mother, she was very quiet. The mother was very sad and asked us in a low voice how she could support the daughter. We asked the daughter about that and she responded that she felt the same, i.e. that she did not know how to support the mother. They were both silent as they felt that the other one should be protected against remembering the incident and the loss of the sister/daughter. We asked them to tell this to the other and as they did that, they began to look at each other. Instead of sitting with their back against the other one, they turned around and spoke more directly together.*

In this case the mother and the daughter build a mutual avoidance as they want to protect and support the other, but both are left with their own grief and the silence and a feeling of being unable to help the other one. Through the support they found a way of talking together and to support each other in the deep grief they both felt. We saw them again the next day and they wanted help to continue the sharing of emotions. They explained that it was easier to talk together with external help than without. So the support was done in the same way again, and they began to talk with each other again.

> *We met a survivor, a young woman, with a large scar on her face after the injuries, she suffered in the earthquake. She was afraid that her boyfriend would leave her because of the scar. She told us that she saw herself as very unattractive and even hideous with the scar. She said that this perception was reinforced by the response she got from her family and from other patients. As part of the support, we helped her to talk with a surgeon – with the support of an interpreter. During this talk of less than five minutes, the doctor explained to the young lady that the hospital was going to offer her plastic surgery, which would make the scar less visible. The surgery could not completely recover the face, he said, but it would make it far better than it was now. This information had a considerably positive effect on the mood of the patient.*

In this case, the patient got a new perspective on her situation as the intervention added a positive experience of care and an attempt of repairing the damage to her previous bleak perception of it. The patient said that it was calming to know that it was possible to actively do something to improve the situation.

The last case, which we will present here, shows the reaction of a young man of 15 years of age.

> *The young man had flashbacks of what happened to him and his family during the earthquake. These flashbacks came while he was in his hospital bed, speculating about the earthquake. When he fell asleep he had nightmares about the earthquake. His father was in the hospital with him – and he was very compassionate and concerned about the suffering of his son. When we asked, the son said that the flashbacks and nightmares were less vivid now, but they were still very unpleasant. He wanted to know if the flashbacks and the nightmares would disappear over time. We explained that they would diminish if he stopped trying to avoid them and instead saw them as a temporarily reaction to the earthquake and a way of processing it gradually. He said that this information supported his own experience through the 2 weeks, which had passed since the earthquake. The father told us that the information made him much calmer now as he was afraid that the son would never recover from the flashbacks and nightmares, which had alarmed him a lot.*

In this case the son and the father become calmer about the flashbacks and the nightmares. Because of that they are able to regulate their emotional response and see the flashbacks and the nightmares as passing states and not as a permanent dysfunction or a threat of something that will gradually destroy the mental sanity of the son.

In all the cases, the patients and relatives are in a crisis as they (1) feel a threat to life, body, ability, family members, or to their future; (2) did not foresee or expect the disaster to happen; (3) are in a challenging situation which exceeds their present capacity for coping with all its aspects at the same time; (4) are exposed to an incident, which they do not have experience in coping with. They all suffer extensive losses – of love ones, of property, of life expectations and plans for the future. On top of this they were separated from their social support network. In the psycho-social support for coping with the crisis a clear focus was on (1) providing information through facilitating access to medical information and to information about their family in Haiti; (2) sustaining and promoting a sense of safety through social regulation of emotions; (3) supporting the social support system around the patient; (4) focusing the coping efforts of the patient; (5) focusing on that one can deal with the suffering in various ways, which is closely related to the process of normalisation of the expressions of the suffering.

The challenge was to provide this in a context with a lot of insecurities about how the situation in Haiti would develop – which we will address below. However, in this situation we still found that all the patients and relatives, we met, benefitted from a brief support based in their needs and focused on solutions to the challenges, they saw in their present situation.

Finally, we found that the adversity made the values of the patients and the relatives clearly expressed. These values are first of all caring for other people and love for the family members. In all the cases, we saw how people expressed a value of helping the ones in need and of doing it in the best way. Another clearly expressed value is to be responsible for one's future and for making a living.

4. Discussion

Caplan stated as early as in 1961 that the immediate intervention (which was named emergency psychology) in a crisis prevents grief and fear from growing into permanent mental and social symptoms. This type of prevention is known as secondary prevention. Secondary prevention is also called early intervention as immediate action is taken to support people in an emergency and in need of support. In the face of immediate response, the aim is to support the impacted people, so that processes of grief and suffering do not become permanent and start to create symptoms and behaviour, which may challenge the recovery of individuals, families and communities.

The social psychological study of grieving and trauma was to begin with, closely related to emergency psychology. Works by Lindemann (1944) and Kardiner & Spiegel (1947) showed that interventions (support) to the victims should be based on four principles: the immediacy of interventions, the proximity to the critical incident, brevity, and that it should be build on the assumption that the survivor will be able to recover and return to a satisfactory level of functioning. This is what Caplan (1964,1961) conceptualised as secondary prevention, which is an acute psychological support guided by the above mentioned principles of immediacy, proximity, expectancy, and brevity. The intervention aims at supporting the survivor in: (1) stabilisation through stopping the escalation of distress; (2) mitigation of acute symptoms of distress; and, (3) restoration of adaptive independent functioning, if possible or if it is not, reference to further professional help (Flannery & Everly, 2000).

Today, classic concepts such as the initial shock, the unexpected, tunnel vision, loss of previous identity, distorted attention, dissociation, cognitive impairment, and the need for relationships, should be remembered, as they describe the immediate reaction to disaster – and as such they can be understood as normal responses, but still also as extremely painful. Today, we have a deeper understanding of the neuro-physiological activation at the time of the impact (van der Kolk, 1994, 1996). Furthermore, we know that the crisis is experienced as a breakdown of trust, of values, and of certain aspects of life in general. The crisis may change the worldview and the values of the impacted individuals, families and communities – as a way of trying to provide meaning to the often meaningless and non-symbolic incident. The meaning is often provided in groups as a collective symptom, which in many cases increases the risk for sustained symptoms, such as aggression, complex grief, and substance abuse – which over time may lead to a decrease in capacities for cooperation and in economic outcome for the individual, the family or the community.

The secondary prevention may often be quite straightforward.

The value of talking about the traumatic event has been widely discussed. A review of research on trauma (MacIntosh and Whiffen, 2005) concluded that the recalling of traumatic experience is activated through the limbic and paralimbic system, the amygdala (which provides emotions to the experience) and the visual cortex, while the hippocampus (memory storage) reduces its volume. Furthermore, the Broca's area (control of language) is disabled, which is why it is difficult to put the experience into words. Other researchers found some evidence that it can be harmful to the survivor to talk about the incident (Richards, 2001; Wessely & Deahl, 2003). But still, done in an empathic way the verbalising of the experience has been recommended by therapists both in psychoanalysis and in behavioural cognitive therapy (Follette & Ruzek, 2006, Foa et al., 2009). In emergencies we find that some survivors talk extensively about what happened to them, while others are more or less blocked (Hart, Steele, Boon & Brown, 1993; van der Kolk, 1994). In our meeting with the survivors of the earthquake, we found some, who refused to talk about what happened to them. In these cases we did not encourage the survivor to talk about the incident but instead to talk about their present needs and concerns. Through this approach, we could open a feeling of hope and options for active change, which made it possible for the survivor to start communicating with others again.

We noticed that most survivors then became more able to speak about their experience during the critical incident. Then, we asked the survivor to give a detailed account of the incident, so that it became possible to distinguish between facts, thoughts and feelings. In this process we related the account of the critical incident to the life circumstances of the victim at the time of the earthquake and at the present.

The research on support in the immediate and mid-term disaster response implies that the intervention actually neither has to be complex nor prolonged. Surprisingly, very often sufficient help as secondary prevention can be offered in session of no more than 15 minutes. The content contains information (often given as psycho-education), listening empathically to the survivors' needs and concerns, and providing ways of coping.

Hobfoll et al. (2007) provides an overview of selected empirical research on the outcome of interventions aiming at restoring social and behavioural functioning after disasters with mass casualties. They conclude that interventions that enhance and preserve the five essential elements, *sense of safety*, *calming*, *self- and communal efficacy*, *connectedness*, and *hope*, are the most supportive to the impacted population at the individual, family and community level.

The reason for this is that the immediate and mid-term response holds the possibility of preventing a crystallisation of the grief and the fear into individual or socially shared symptoms of complex grief, distrust, and aggression, abuse and violence.

The knowledge we gained from supporting the survivors was that the immediate response through needs based interventions may prevent suffering from developing into permanent symptoms, but that there is a need for sustained social support and occupational options for the survivors. The crisis will gradually develop into a reorientation phase as the survivors try to make new ways of living with the losses suffered. However, if the community is severely damaged by the disaster it may be difficult to secure social support and occupational options.

Terr (1991) identifies three types of crises: a single episode (type I), several episodes (type II) and a single episode in a situation of high stress (type I and II combined). On a basis of solid research he stated that the last two (type II and I and II combined) have the largest impact on the individual in terms of mental and social suffering.

Even before the earthquake, a majority of Haiti's population lived in a situation with a high level of stress due to civil conflict fuelled by poverty and corruption. Because of the particular context the earthquake had a context specific outcome, which may be understood as a chain of subsequent critical events. One of the outcomes is that still, one and a half year after the earthquake, more than half a million people still live in refugee camps. Furthermore, since the earthquake there have been several hurricanes causing the death of people and destroying parts of the fragile infrastructure of the refugee camps. Finally, a cholera epidemic has affected over 250,000 people and caused nearly three thousand deaths.

There are also particular strengths in the context. Even though Haiti has many of the challenges of *failing states*, it has managed to attract a notable amount of foreign aid, it is not placed in a region with armed conflicts and is not under attack from other nations or guerrilla groups. The huge emigrant communities, especially in the United States and Canada, provide the country with remittances, and it has duty-free and quota-free access to the U.S. market, guaranteed in an agreement. However, poverty increased after the earthquake and the enormous gap between poor and rich became even wider. Many poor people live in a state of continuous high stress as their lives are endangered by hunger, illnesses, and violence.

Later in the recovery process it became clear that the development of symptoms of traumatic stress is clearly related to the communication and behaviour of families and in the community. This calls for a community psychology approach. In Haiti, after a few months, we saw how violence and depression were clearly related to the worsened living conditions for many survivors, mainly related to the severe poverty faced by many families. The women in the families urged their husbands to bring food for their children, but lack of job options and education made it impossible for many of the men to provide the needed supply of food. This process led to increased tension in the couple and triggered violence and subsequently depression in women. This, in its turn, increased child neglect. Thus, the best way of treating and supporting the individual is through supporting the community in finding the most effective ways of providing food and jobs. This process is in line with the description we find in the Sphere (2004) and the IASC (2007) that disaster can severely disrupt social and economic structures and thus, hold the capacity to exacerbate existing inequalities and put people, who are already vulnerable, at a higher risk of experiencing physical and emotional suffering and neglect. In the acute emergency phase there is, in almost all cases, an increase in the crude mortality rate, because of lack of food, shelter, physical security, water and sanitation. In the following post-emergency phase the level of service provision may still be at a minimum, the basic health care services may have collapsed and there may be scarcity of food. Often disaster-inflicted poverty is an ongoing source of distress, because the people affected by the emergency have lost their livelihood and are not able to engage in income-generating activities as they were before the emergency (Anckermann et al., 2005; Van Ommeren et al., 2005). The aim of recovery supporting intervention is directed towards the restoration of social support networks in the community.

Psycho-social interventions aim at promoting social cohesion within groups, which have suffered traumatic experiences together, so that the group can provide social support in a broad and action promoting way, i.e. that the group does not limit the support to emotional support (Orford, 1998; Speck & Attneuve, 1974; Navarro Góngora, 1991, Anasarias & Berliner, 2009; Berliner, Larsen & de Casas Soberón, 2011, 2012).

In a following article we will describe the means and challenges in the recovery process of the survivors in Haiti in the above described situation. In the present article, our focus is on the psycho-social support as part of the immediate and mid-term disaster response.

5. Conclusion

The psycho-social support in the immediate and mid-term disaster response for Haitian earthquake survivors in hospitals in the Dominican Republic could ameliorate the suffering and prevent the crises reactions from becoming crystallised into symptoms and complex grief. Because of the openness in the immediate crises the survivors could benefit from brief sessions of support. The support was centred on (1) providing information; (2) facilitating social regulation of emotions; (3) supporting a social support network for the patient; (4) focusing coping efforts; and (5) normalisation of reactions. Finally, our cases made it clear that the crisis conveyed that values of caring, compassion and responsibility were expressed and shown. This particular finding should be studied more in future research on crisis and emergency responses in disasters.

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