



The Psychosocial section aims to pursue didactic, research, policy, and operational excellence in international disaster preparedness, response, and recovery, including the prevention and mitigation of psychosocial stress, and the promotion of resilience.

A quarterly newsletter of the Psychosocial section of the World Association of Disaster and Emergency medicine

Introduction

This is the first newsletter issued by WADEM’s Psychosocial Section. There will be three issues per year (April, August, December).

It is being distributed, free of charge, to all WADEM members and to others known to us as having an interest or involvement in international psychosocial research and field work.

Please feel free to forward it to people who may be interested.

The Psychosocial Section Newsletter has been developed as a medium to provide WADEM members and other interested academics, professionals, students, and organizations with useful information relevant to international psychosocial work. Each issue will have a theme, this first issue’s theme being that of **Community Resilience**, a research project abstract, a review article, a “from the field” section, and one or more journal references addressing that issue’s theme will appear in each newsletter. In addition, each issue will briefly identify a different graduate school program or institute having a disaster mental health track, an organization providing a variety of psychosocial resource information, a journal with psychosocial emphasis articles, and an upcoming event of likely interest.

Issue 1, April 2017

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RAND Corporation

“Community resilience is a measure of the sustained ability of a community to utilize available resources to respond to, withstand, and recover from adverse situations.”

Editorial note

Dear friends,

Two years ago I took upon myself the responsibility of co-chairing the psychosocial section with Gordy Dodge. Among our goals were the mitigation of psychosocial stress, and the promotion of resilience. Resilience has been at the core of my research in the past decade, thus I was thus happy and honored when Gordy (as editor of the newsletter) suggested that the first newsletter core theme will be Community Resilience. In this issue you will find essays written by a group in Japan, reflections on a lifetime career in community resilience from an expert that has been dealing with it for over 35 years, a review of assessment methods, and more.

I hope you have an enjoyable and interesting read. We welcome your comments and thoughts.

I wish my successors joy and satisfaction as I leave the leadership of the section, and I wish us all, health peace and happiness.

Prof. Limor Aharonson-Daniel



Dr. Gordon R Dodge

Prof. Limor Aharonson-Daniel

Graduate Training Programs

This issue's feature: The Disaster Mental Health Institute (DMHI)

University of South Dakota

The Disaster Mental Health Institute (DMHI) at the University of South Dakota (USD) has offered two graduate programs in disaster mental health since 1997. The primary program is the Doctoral Specialization in Clinical and Disaster Psychology. The doctoral specialization is only available to students enrolled in the USD doctoral Clinical Psychology Training Program (CTP). Students must complete all the requirements of the CTP in addition to the Doctoral Specialization requirements. The central course in the doctoral specialization is Disaster Mental Health. It incorporates the Red Cross' Fundamentals of Disaster Mental Health course, which is currently 4 hours in length. However, there are an additional 41 hours of instruction in theory, research, and practice in disaster mental health.

The core requirements also include Traumatic Stress, because DMH providers need to understand what are ordinary human reactions to traumatic stress and what responses might indicate the need for professional intervention. Crisis Intervention is another required core skill. The USD CTP emphasizes the importance of cultural responsiveness for clinicians. In keeping with that emphasis, another required course in the Doctoral Specialization is Serving the Diverse Community in Disaster.

The doctoral specialty track also requires students to complete Introduction to Behavior Therapy (which includes cognitive-behavioral theory) and Rural Community Mental Health. Both of these courses provide valuable theory and tools for working in both preparedness for and response to disasters. Students also need to complete one of five electives.

In addition to the coursework, students are required to complete either their thesis or dissertation (or both) on a topic in the area of traumatic stress or DMH. They must also have a DMHI faculty member on their committee, but any of the CTP faculty can serve as a student's committee chair and major advisor. After completing all coursework, students are required to complete a capstone exercise consisting of a tabletop disaster exercise.

The DMHI also offers the Graduate Certificate in Disaster Mental Health. The graduate certificate is for existing mental health professionals and graduate students in mental health from programs other than the USD CTP, but it is also available to other college graduates. It requires three of the same courses as the Specialization in Clinical and Disaster Psychology: Disaster Mental Health, Crisis Intervention, and Serving the Diverse Community in Disaster. An elective course is also required; students can choose between Traumatic Stress and Management in Disaster Mental Health. A number of students choose to complete both electives. The certificate requires the participants to complete the same capstone exercise as for the doctoral specialization.

The DMHI website is [HTTP://.usd.edu/dmhi](http://.usd.edu/dmhi). E-mail is <dmhi@usd.edu>, Contact person is Dr. Randy Quevillon, 605-677-5351.



REVIEW: Community-resilience assessment tools

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Community resilience is the capacity of the community to respond effectively to disturbance and crisis (Wyche, Pfefferbaum, Pfefferbaum, Norris, Wisniewski & Younger, 2011), a significant component in emergency preparedness and response (Molin Valdes, Rego, Scott & Aguayo, 2012). To reveal the internal resources of the community, resilience is assessed prior to, during, and after the emergency situation, in an attempt to maximize the ability of the community to withstand extreme situations, thus reducing the impact of crises and disasters. Because community members often serve as first responders in mass events (Cohen et al., 2016), it is important to strengthen the community as a functional system.

While community resilience is considered one of the core elements in facing emergency situations (Norris et al., 2008), a thorough search of the literature found that standard accepted tools for assessing community resiliency are lacking (Chandra et al., 2010, Kimhi & Eshel, 2015), as is the translation of published research into a standard accepted measurement tool (Castleden, McKee, Murray, & Leonardi, 2011; Bonanno, Romero & Klein 2015).

The beginning of the twenty-first century marked an increasing in development tools for assessing community resilience, with the focus in the literature shifting from theoretical articles to developing measuring community resilience, using theoretical knowledge (For example: Magis, 2010). Many of the assessment tools were developed by experts or end users, and most of them related to a multi-dimensional paradigm, reflecting the complexity of the resilience term. One form of classification is related to the event or the process that the community might face, and most of these tools are directed to measure community-resilience in the context of emergency and changes preparedness. However, several tools, especially those related to health context, are linked to a community's resilience during routine periods (Poortinga 2012) as well as risks or poverty situations (Castleden 2011, Davis 2008; Sanders 2008).

Cutter (2016) indicated the element of methodological approach for community-resilience assessment as a function of the purpose and goal of the resilience assessment, and described two approaches: a bottom-up assessment using highly localized data, local knowledge and information and a top-down assessments using state, national, or international sources of data and quantitative methods in the construction of the index. Cutter (2016), proposed that using the top-down approach enables us to compare across units of analysis using standardized data. In contrast, other researchers (e.g. Magis, 2010) emphasized the added value of a bottom up measurement, hearing the voice of community members when dealing with emergency preparedness and response. The residents' perceptions yield an understanding of behavioral norms and expectations that express the existence or nonexistence of communal values. For example, the statement: "I can rely on people in my town to come to my assistance in a crisis" reflects the individual's social trust and faith in the community

(Cohen et al., 2013). It is important to mention that there is third approach that bases its results on both “bottom up” and “top down” assessment (Sherrieb, 2012; Perz et al., 2012), integrating the information besides correlate the findings from the different databases.

Cutter (2016) and Sharifi and Yamagata (2016) explored assessment tools of community resilience, the former examining 27 tools, the latter – 36. In a systematic review conducted by Ostadtaghizadeh et al. (2015), 17 models and tools were reviewed. These explorations express the absence of a “gold standard” in measuring community resilience, a problematic situation is especially reflected in existence (or non-existence) of longitudinal researches, or among different cross-sectional studies that use the same assessment tool, enabling comparison between situations and communities. A broad systematic review conducted by the European DARWIN project (<http://www.h2020darwin.eu/>) (Adini et al 2017), revealed mentions of some 65 methods for the assessment of resilience, of which 12 publications (18%) dealt with organization resilience; 5 publications (7.6%) used only qualitative methods, and 3 publications (4.6%) dealt with methods of economic resilience. Three tools were used in more than one publication: Communities Advancing Resilience Toolkit CART (Pfefferbaum et al., 2013); Conjoint Community Resilience Assessment Measurement (CCRAM – Leykin et al., 2013), and Climate Disaster Resilience Index (CDRI- Yoon et al., 2016). Similar findings, found in Cutter’s, selected “bottom up” tools that assessed the capacities of a community to be resilient in the face of emergencies. Overall, the CART and the CCRAM – both questionnaires developed and validated by a team of experts – were the most frequently cited. Each tool has five factors (although not the same five) and a similar number of items in the questionnaire. Regarding the differences, studies conducted using the CART tool used adapted versions of the tool, with both quantitative (Pfefferbaum, 2013) and a qualitative approach (Sherrieb, 2012) in different research populations. Nonetheless, the CCRAM tool has a short, 10-item version, enabling to integrate this tool with other questionnaires, or to assess community resilience swiftly during an emergency situation (Leykin et al., 2013). The studies conducted by the CCRAM tool analyzed the data using sensitive analysis such as quantile and spline regressions, in order to understand the weaknesses and strengths of sub-populations within the general study population (Cohen et al., 2016).

Conclusion

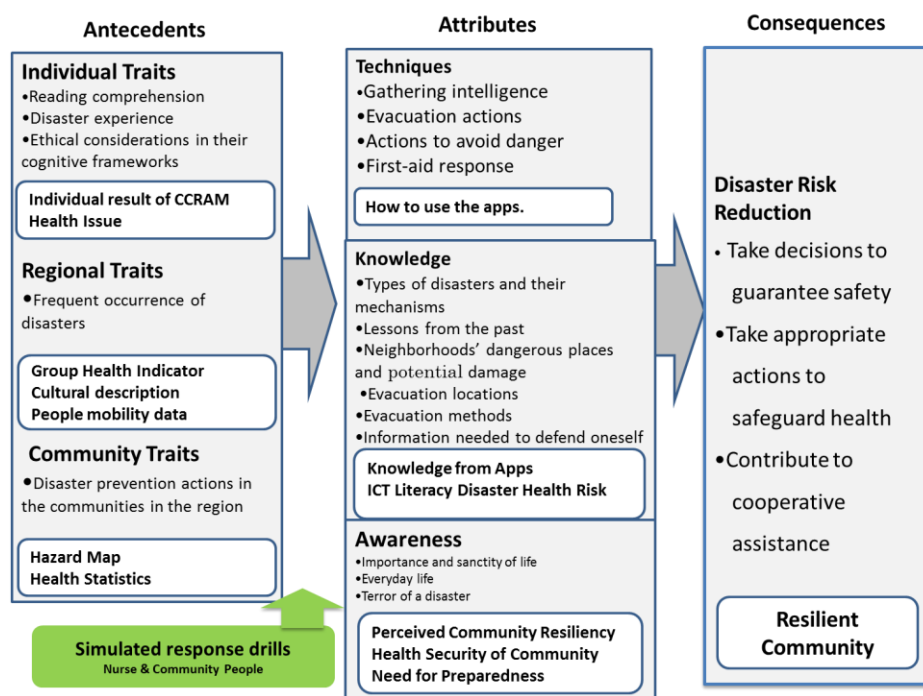
Despite the growing number of assessment tools, evidence based theories regarding community resilience are still young. In order to develop solid research in the field, we need to wait for the accumulation of longitudinal studies as well as cross-sectional studies conducted repeatedly with the same tool. Publishing research results may standardize the community resilience assessment, creating a gold standard for this significance issue.

PROJECT: Exploring the participatory ICT method for community resilience
Sakiko Kanbara, University of Kochi, Hiroyuki Miyazaki, University of Tokyo, JAPAN

The International Strategy for Disaster Reduction adopted Sendai Framework for Disaster Risk Reduction 2015-2030 (UNISDR, 2015) which reflects a major shift from the traditional emphasis on disaster response to disaster reduction, and seeks to promote a "culture of prevention" with overlapped Sustainable Development Goal (SDGs) places significant focus on the "human centered" approach.

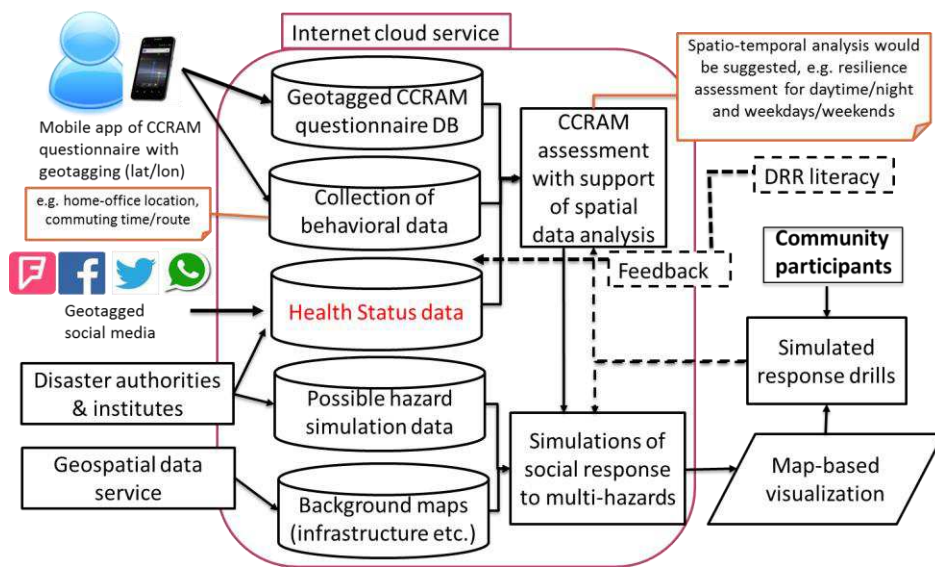
This project paper aims to suggest the framework to enhance the community resilience, as an example of human dimension, in innovation of public health surveillance systems for disaster management to respond to the global agenda above. The building of community resilience has a positive effect on DRR at the local level. The association between community resilience and public health during emergency situations is well established (Castleden 2011; Poortinga 2012; Chandra et al. 2010), yet it revealed a lack of empirical studies dealing with community resilience (Castleden 2011). This gap is especially evident regarding the use of community resilience results as a basis for designing intervention plans. There are descriptions of some tools that provide a calculation of community resilience scores (eg. Pfefferbaum et al. 2015) but the scientific basis for the development of these tools are often key informants or a small sampling of volunteers. It was considered that goal should be achieved through innovative ongoing surveillance that will incorporate geospatial assessment as well as behavioral, and self-reported information. As one solution, we proposed to apply geospatial technology for people’s behavior modelling in disaster situation presented in Figure 1.

The Conjoint Community Resilience Assessment Measure (CCRAM) is an internationally accepted tool for assessing community resilience (Cohen et al.,2013; Cutter, 2015). The CCRAM was developed by a multi-disciplinary group of Israeli experts in order to offer a standard tool that will provide reliable information (Leykin et al., 2013; Cohen et al.,2013). The CCRAM portrays five factors representing: leadership, collective efficacy, preparedness, place attachment and social trust, with quick assessment of repeated measures.. (Aharonson-Daniel, 2015) For more frequent and broadly distributed data



collection, the CCRAM on cellular devices could be utilized for establishing and continuously supporting a society, such as smartphones and internet cloud services for data collection and management. The questionnaire application with geo-tagging function enables to retrieve various conditional data, such as distance to community center or neighbors, ethnicity, and cultural backgrounds. The cloud service will connect with other services, such as OpenStreetMaps, a volunteer-based geospatial data service, hazard data services, such as EM-DAT, and social media data, such as Facebook and Twitter. And an internet-based system that can be an easy support tool for health providers together with household sampling of a community (study population) to decision making. It will be in delivering up-to-date information relevant and actionable to stakeholders so that there is a significant shift in preparedness paradigms and consequently preparedness behavior as well. The analyzed data shall be visualized in user-friendly map forms using WebGIS that are compatible with smartphones so that the participants of the system can browse the data in disaster cases too. (Figure 2)

Disaster risk reduction literacy includes the ability to “be aware of dangers related to disasters, habitually obtain information related to disasters, and guarantee one’s own safety by making accurate judgments during a disaster.” It relates not only to the information needed during a disaster but also to the knowledge that creates awareness and response techniques and actions (Kanbara et al 2016). This trajectory of



system would be expected to later result in a mode of transferring guidance to first responders and civilian populations regarding DRR and behavior and also as a way to reach large populations and increase DRR literacy. When adopting community resilience to human response in disaster risk reduction, this model should be a suite of daily behavior patterns, (such as home-office places and commuting pattern), and emergency response patterns, such as evacuation.

Further complementary global communication beyond national and discipline would carry future innovative system and data but sustainable community resilience itself.

Organizational and Informational Resources –

This issue's feature: MHPSS

Mental Health and Psychosocial Support Network “is a growing global platform for connecting people, networks, and organizations, for sharing resources and for building knowledge related to mental health and psychosocial support both in emergency settings and in situations of chronic hardship.” (www.MHPSS.net). For more information please visit their website.

Primary Relevant Journals –

This issue's feature: Intervention

INTERVENTION, Journal of Mental Health and Psychosocial Support in Conflicted Areas, “is a multi-disciplinary fully reviewed journal.” “The purpose of this journal is to make existing knowledge on mental health and psychosocial support in areas of conflict explicit and accessible to all interested parties, both in areas of conflict and elsewhere.” INTERVENTION, 2016, 14,3). For more information please visit their website at www.interventionjnl.com.



FROM THE FIELD: A historic overview of how the resilience concept developed

Prof. Mooli Lahad, The Community Stress prevention Center (CSPC)

Background

The town of Kiryat Shmona, situated 4 km. from the border between Israel and Lebanon, was continuously a target for shelling in the early 1980s. Usually the damage was to structure and property but occasionally there were injuries and fatalities. However, the most significant impact was the psycho-social damage done. Over the past 35 years, the town's population has fluctuated between 16,000 - 20,000, but according to estimates, some 250,000 have lived in Kiryat Shmona at one time or another. This massive turnover is one of the psychosocial outcomes of the situation.

As hard as it is to believe today, in 1979, when I arrived to this region, there were less than 10 articles and not even a single book on how civilians can cope when facing life threatening incidents such as ongoing shelling. The only guidebook was a collection of activities edited by Ayalon (1976) called "Rescue". Schools, teachers and pupils were trained to run to the shelters, but little more than that. Sitting for what was sometimes hours, they had to find ways of calming and entertaining themselves and keeping themselves occupied in an overcrowded space, worrying all the time about parents, siblings and spouses "somewhere out there".

Back then, the major difficulty was getting the principals and teachers to address the subject in their classes. Training the children to run to shelters was fine, broaching the subject was considered by the superstitious to be "opening one's mouth to the Evil Eye" or to the more rational, "opening a Pandora's box". It took more time and more shelling to convince the first principal that there was a need for a psycho- educational program to inoculate staff and pupils.

The integrative model of coping and resiliency - BASIC Ph.

One of the major phenomena observed time and again was that despite the constant threat and disruption of routine, the damage and the casualties, the overall picture for both children and adults was one of coping, surviving and managing life. A survey of referrals to the local mental health clinic and school psychology services showed that they were of the same nature as referrals in the center of Israel (Lahad, 1980) About 5-10% of the population manifest acute stress reaction following an incident.

If that is so, what helps the rest of the population to continue as if nothing happened?

Today the notion that children and adults exposed to critical incidents are not necessarily badly affected is well known, but in the late '70's this concept was rather new. Our observations and interviews of hundreds of adults (parents, teachers and community workers) as well as pupils (children and adolescents) have led to the development of the Integrative Model of Coping - BASIC Ph (Lahad 1993, Lahad & Cohen 1993).

By asking people "What helps you to continue living in this situation", or "what do you do to continue?" We learned the secret of communities and how inadequately trained the psychologists were for working in the community, due to their training based on psychopathology as their major frame of reference. In other words, people are usually stronger than we give them credit for. Momentary disability does not predict pathology and their reactions are simply normal reactions to abnormal situations.

The model relates to the six dimensions at the core of the individual's coping style, as summarized in the major theories: Belief and values, Affect and emotion, Social, Imagination, Cognition and thought, and Physiology and activities. Lahad called this model BASIC Ph. The integrative model relates to the individual's coping style as a combination of all six dimensions

The Community Stress prevention Center (CSPC) was established in 1981 in the north of Israel in order to prepare the civilian population to cope with crisis and disaster, to train local authorities to cope with the situation and handle it effectively, before, during and after these incidents and to train professionals in emergency intervention techniques. The CSPC has a psycho-social team to help communities, families and individuals during crises. The basic idea is that every critical incident is akin to a stone cast into a pool of water, the ripples spreading throughout the pool out to its edges. Similarly, the effects of the incident are felt throughout the entire community.

Consistent with the salutogenic approach, we made efforts to identify the most useful and effective support for those in each circle. Thus, scarce professional help is utilized only when needed. An immediate outcome of the concept of circles of vulnerability and support was the training of non-professional in various ways. This has had a major effect. People in the community started to feel that they are able to help themselves, their families and their neighbors. Thus, they projected an air of confidence and reassurance so important for the community in troubled times. Since the 80's this

model has been adopted by many local authorities in Israel and many communities now have groups of social and mental health volunteers providing help and support, not only during critical incidents and emergencies, but also during day to day crises. We called these volunteers “Islands of Resiliency”.

Local authority planning for disasters

The 1991 Gulf War and the ensuing missile attacks on Israel brought home an important lesson to many local authorities, namely that both the government and citizens expect the local authorities to play a major role in providing relief, support, and rehabilitation services to the local residents. Since then the CSPC community support model has been adopted nationwide.

The model provides psychosocial support through an interdisciplinary team. The main concept is that no one single service can provide all the help that is needed in the wake of a critical incident. Therefore, all psychosocial, educational, social, community and medical services need to function under one coordinating committee. This committee should be headed by the director of the social services, who should also be the consultant to the crisis management team on the psychosocial aspects of the incident.

During the emergency, the psychosocial teams will be dispatched to the affected areas. They will assess the situation and provide immediate support - food, shelter, medical and psychological support to the affected population. They will also open information and relief centers as required. They should be in charge of locating and providing help and support to the population with special needs. These integrated services will also take charge of evacuation centers including the provision of formal and informal education to the evacuees. The team will have representatives in hospitals and they will liaise with them when patients or relatives need assistance (such as lodging, or finding other relatives or providing financial assistance).

Helping the Helpers

Contrary to some beliefs about helpers' invulnerability, we now know that they are affected by their close work with the victims and the relatives. The term coined by Figley (1995) is “Compassion Fatigue”. Supporting disaster workers, crisis intervention teams and other helpers who work with human suffering and distress during and in the aftermath of a disaster. One very important aspect of being a helper is the fact that in many cases, the helpers themselves are also in the “near-miss” category as the teams are based on local professionals that is in close proximity to the incident.

Where do we go from here?

Community resilience is a broad multidisciplinary concept that appears using slightly different terminology in diverse fields, yet it is perceived intuitively and commonly used (sometimes meaning different things, and often confused with preparedness) by lay people.

Our experience shows that the following are important:

- To instill a social-community approach in all models of intervention following disaster
- To make psycho-social aspects part of the decision-making process in headquarters
- To identify target populations various needs, to develop responses and approaches for effective coping with the new situation and its implications
- To assist in the identification of coping resources and to mobilize them, while creating opportunities for recovery, rehabilitation and renewal on the levels of the individual, the family and the group
- To strengthen the administrations, the reciprocal relationships and the cooperation between the community systems and the defense and economic systems
- To ensure good communication with and within local communities is crucial from perspectives of both ethics and efficiency.
- To recruit the mass media and the social media to help to strengthen the coping efforts and to assist them in temporarily refraining from their tendency to negatively report and criticism

Some ways to facilitate the above would be to develop the following:

A local system of volunteers, flexibility in providing solutions to problems, guidelines on the role of the local, national mass media and the social media during and following a disaster, protocols for assessing the efficacy of interventions, and finally, further the concept of individual capability and community resilience based on the characteristics of the community.

Future conferences of interest:



NEWSLETTER CONTACT INFORMATION

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Comment from our newsletter readers is welcomed. The primary purpose of reader comment is to briefly address the issue's theme writings (guest editorial and abstracts). Please include your name and e-mail address.

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