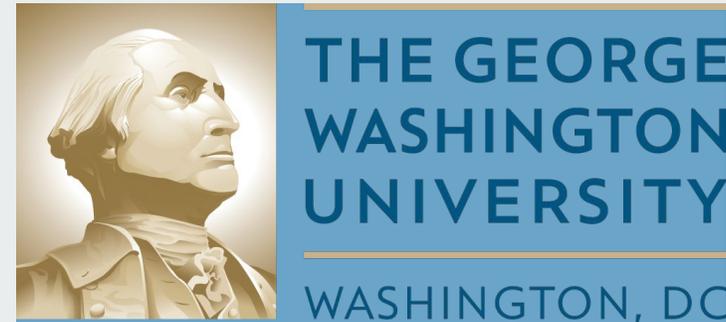


Building Resilience in Humanitarian Workers

CAIR Coalition Workshop

October 12, 2018



Schedule

- 930-945 Welcome and Introductions
- 945-1000 Agenda – Forced from Home –
GW Resilience Workshop:
<https://sites.google.com/site/gwresilienceworkshop/>
- 1000-1015 Stress, Resilience and Vicarious Trauma (Take it from Resilience Man)
<https://www.youtube.com/watch?v=K-aAOLM5oSY>
- 1015- 1100 – Psychological Skills for non-psychologists – Caring for self; Caring for others
 - Mindfulness meditation (Stretch break)
 - Psychological First Aid (PFA)
 - Hope modules 1100- 1145
- 1145 -1215 Small group exercises -
- 1215- 12:45- Lunch
- 12:45-1:30 Reconvene and wrap up

Who We Are



Allen Dyer, MD, PhD – Professor of Psychiatry at GWU – Formerly Senior Health Advisor at International Medical Corps – extensive experience with psycho-social impact of natural and human-made disasters including the Great Sichuan Earthquake, the Haiti earthquake, the Japan triple disaster and the war in Iraq



Catherine May MD – Clinical Professor of Psychiatry at GW – Past president of the Washington Psychiatric Psychiatry – She is an emergency physician as well as a psychiatrist, who has extensive disaster experience, having provided medical and psychiatric response to Hurricane Katrina and the Haiti Earthquake as well as different phases of the refugee crisis in Greece



Eric Kocher JD, EMT-2 is an attorney-at-law as well as an Emergency Medical Technician, former legal director of the Georgia Law Center for the Homeless, the Georgia Indigent Defense Council, and the Georgia Pro Bono Project. Through the height of the refugee crisis in Greece, he has provided both extensive medical and legal assistance - Advocates Abroad



Jeremy Tyler Safran, MD – psychiatry resident at GW, a graduate of Hamilton College, where he majored in neuroscience and fine arts. And received his MD from GW School of Medicine and Health Sciences. Prior to medical school he worked as a residence counselor in a school for children with special needs. At GW he was elected to the Gold Humanism Honor Society.



Carl Quesnell, MD – psychiatry resident at GW, graduate of Virginia Polytech Institute and Drexel College of Medicine. Prior to medical school, he did research at an urban sexual assault forensic center, and served as head coach for local varsity lacrosse teams.



CAPITAL AREA
IMMIGRANTS' RIGHTS
COALITION



OUR VISION



Equal justice for all immigrants at risk of detention and deportation in the Washington, DC region. We are driven in our pursuit of this vision by our understanding of the grave human costs of the American detention and deportation system.

Human Rights

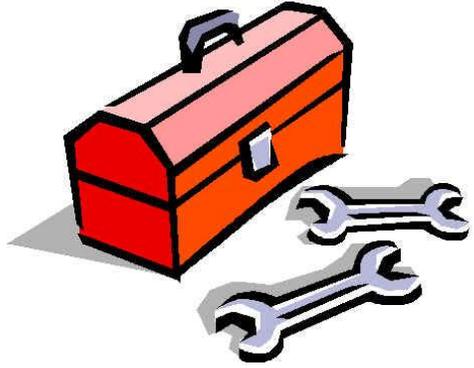
- Human rights are “those rights which are inherent to the human being.”
- The modern human rights movement developed after the Second World War and the adoption of the Universal Declaration of Human Rights in 1948.
- Governments have an affirmation obligation to respect, protect, and fulfill human rights. The obligation means that government must not interfere, directly or indirectly, with individuals’ enjoyment of human rights.
- The obligation to protect human rights means that government has a duty to prevent third parties from interfering with individuals’ enjoyment of human rights. This obligation requires governments to adopt legal, budgetary, and other measures to ensure that individuals’ human rights are fully realized
- Article 14 of the Universal Declaration of Human Rights states that "Everyone has the right to seek and to enjoy in other countries asylum from persecution."

Resilience - What is it?

- **Resilience is the positive capacity of people to cope with stress and adversity.**
- The term *resilience*, like the term *stress*, derives from engineering (the ability of a strained body to recover its size and shape after deformation caused by stress),
- like Hans Selye's "stress of life," resilience has a biological parallel in what Selye called the "general adaptation syndrome."
 - Psychologically, as well as physically and biologically, **resilience is understood as the ability to "bounce back" from adversity**

Resilience

- Across cultures, family support, social support, civil society, and religion and spirituality are among the recognized factors that promote resilience.
- Humanitarian assistance may be seen as among those factors in which the international community allies with local support systems to tip the balance from distress to adaptation and to promote resilience and recovery.



Psychological skills for non-Psychologists

- PFA Psychological First Aid
- Mindfulness Meditation
- Hope Modules
- Compassionate Listening

Forced From Home

“People don’t abandon their homes because they want to, and they know the risks they will face on their journeys. It is out of desperation that they flee war, torture, misery, poverty, and persecution.”



MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

CURRENT DISPLACEMENT STATISTICS



54% of refugees worldwide are from three countries:
Somalia: 1.1 million
Afghanistan: 2.7 million
Syria: 4.9 million

Triple Trauma of Migration

1) Trauma at Home

→ Forced from Home

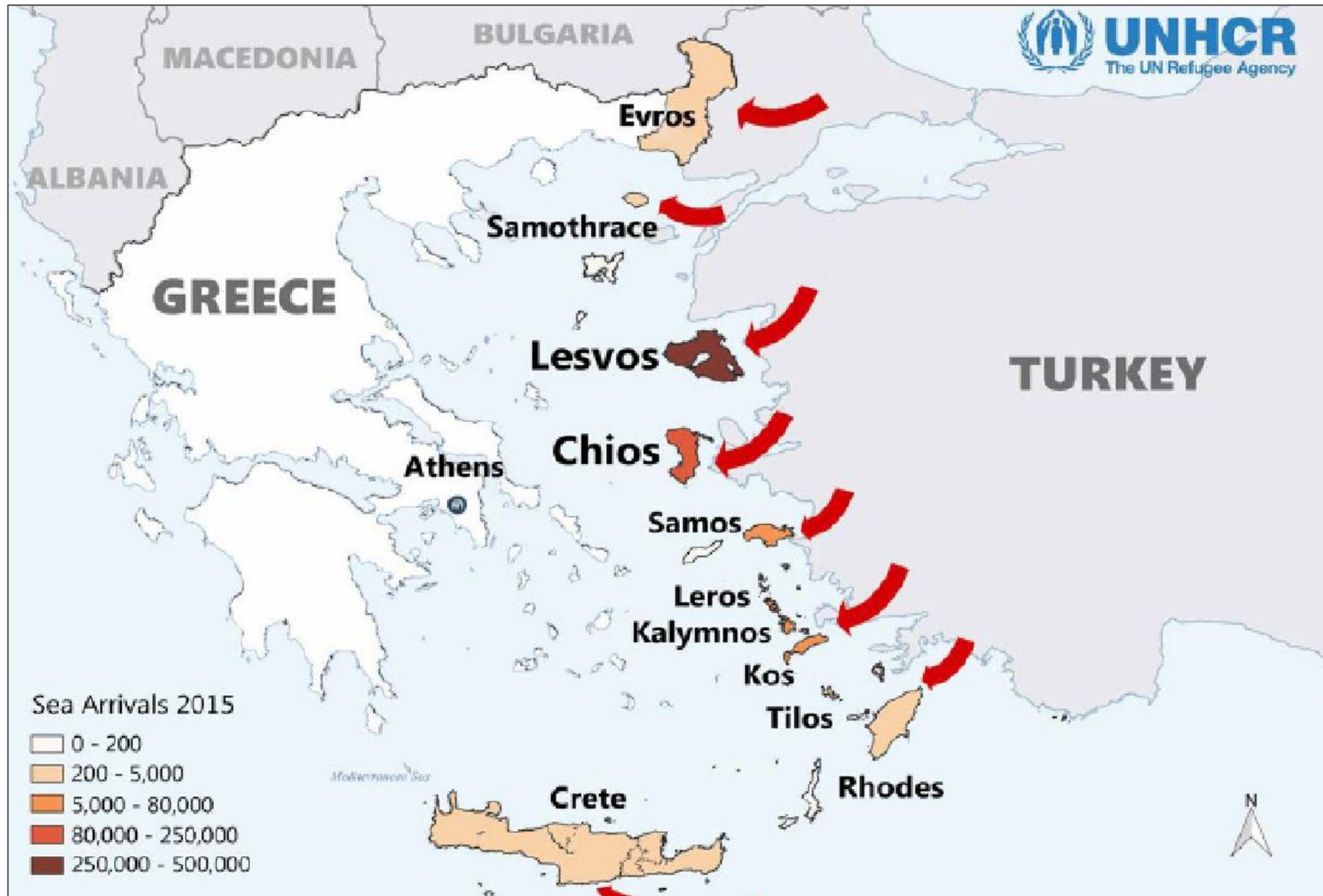
2) Trauma of the journey itself

→ violence and separation

3) Trauma of Immigration process

→ stateless and not counted as a person

Background and Context



Lesvos Stage 1 camp -- Child-friendly spaces –
-- warming, dry clothes, hot drinks +



Unattached minors, MSF Lesvos Camp, June, 2016



moria camp lesvos



Idomeni near Macadonian border



Refugee Crises

- A refugee crisis is not the same as a natural disaster
- Planning and response must account for the entire spectrum of the individuals' and community's needs
- Self-care is an essential part of the response for humanitarian workers

**Inclusion
Form**



**Control
Storm
(Structure)**



**Affect
Norm
(Trust)**

Tuesday, June 14 Workshop Day One-

Well being

09:30 Workshop registrations

10:00 Start of workshop

Welcome and Overview – Drs. Dyer and May

Session One – Stress and Resilience

11:00 Small Group Exercises – Hierarchies of Need,
Needs assessment, strength assessment

12:00 Reconvene in Large group

Session Two Vicarious trauma -
Dr. Dyer with Resilience Man

13:00 Lunch break – snacks

14:00 Continue workshop -
Session Three - Mindfulness – Dr. Dhumad

15:00 Small group exercises –
Mindfulness

16:00 Reconvene in Large Group –
Session Four – Professionalism and Burnout –
Drs. Candilis and Dyer
A Hippocratic Oath for Humanitarian Workers?

17:00 Conclude workshop Day One

Wednesday, June 15 Workshop Day Two-

Caring for Self - Caring for Others

09:30 Start of Day Two

Session Five – Psychological First Aid – Dr. May

1030 Small group session – Practice skills

1130 Reconvene in whole Group

Session Six – Hope Modules – Dr. Noorani

12:30 Lunch break – snacks

13:30 Continue workshop

Session Seven – Boundaries, Sanctuary, Asylum –
Ethical, Legal, and Psychological Considerations

The Adolescent Passage
Child-friendly spaces
Mentoring Unattached Minors
Panel Discussion –
Mr. Kocher, Drs. Candilis and Dhumad

1430 Small Groups – Mapping Exercise

1530 Reconvene in Large Group –

Session Eight – Healing a Community –
Wrap up – Review – Evaluation - Next Steps

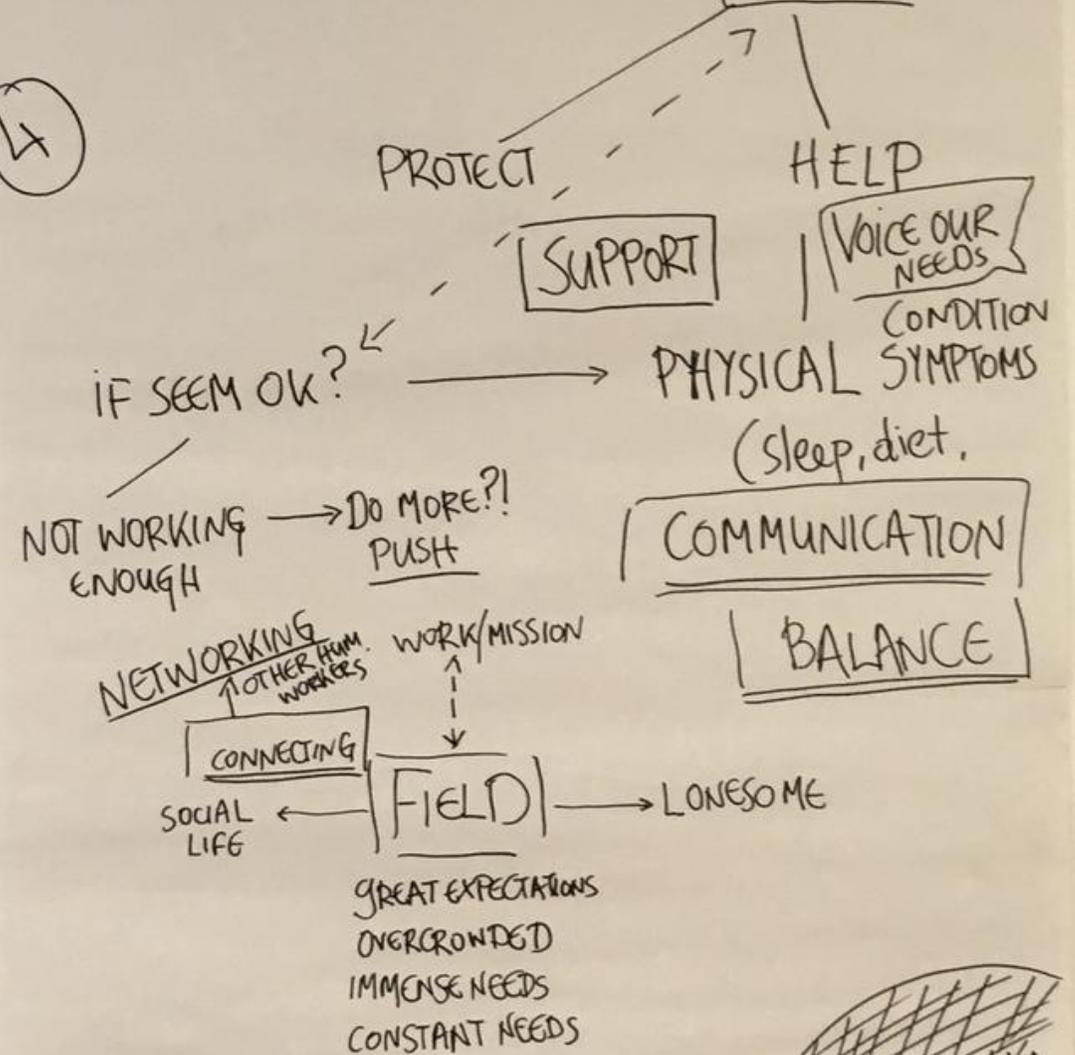
16:30 Conclude workshop

Small group activities



BE AWARE OF ONE'S LIMITS

(4)



Caregiver Bill of Rights

I have the right to:

- Care for myself.
- Seek help from others.
- Express difficult feelings.
- Reject any attempt to cause guilt.
- Take pride in what I am doing.
- Protect my individuality.
- Maintain parts of my own life.
- Receive consideration, affection, forgiveness, and acceptance.



Vicarious trauma: Helping Hurts

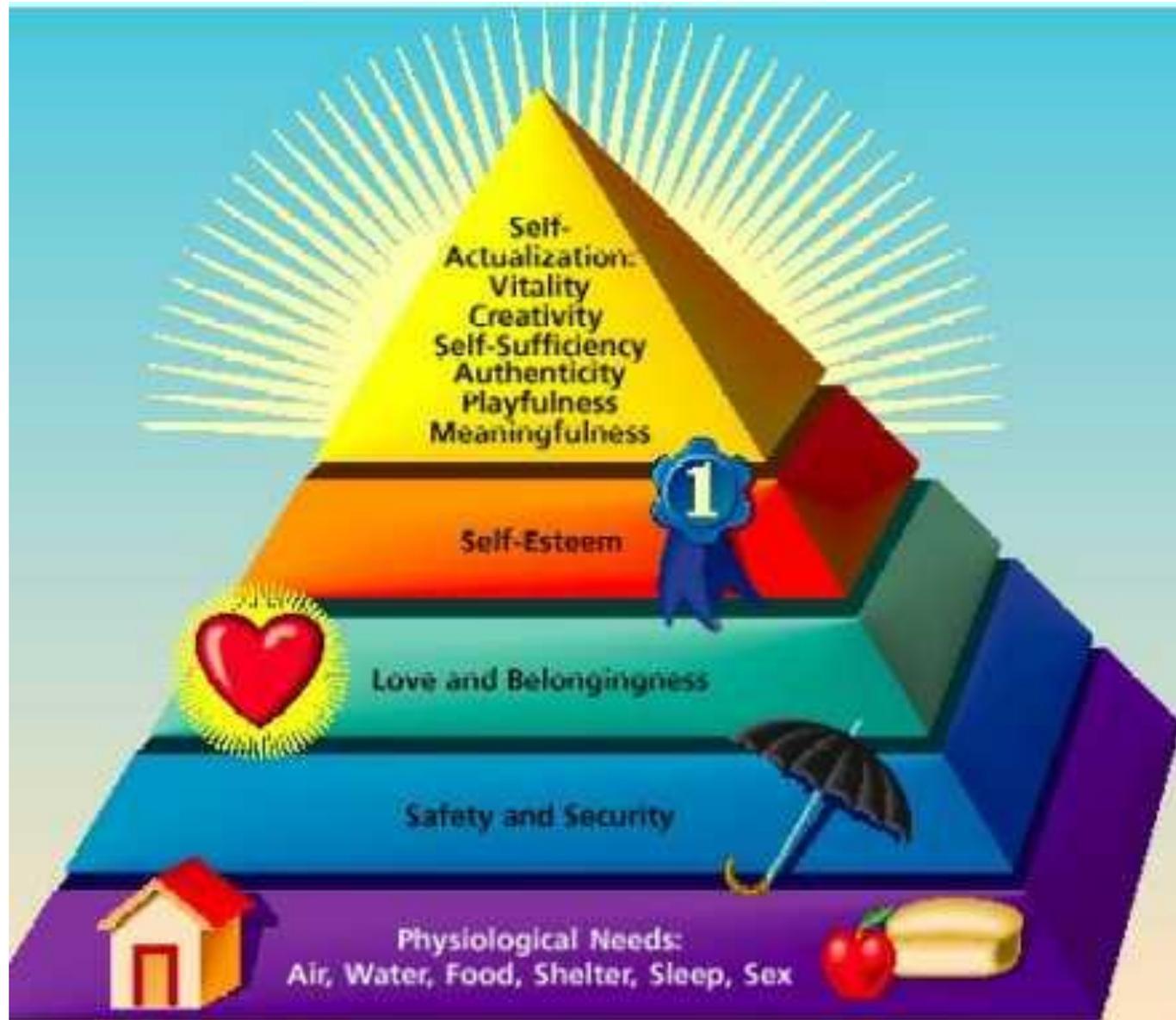


Resilience Man

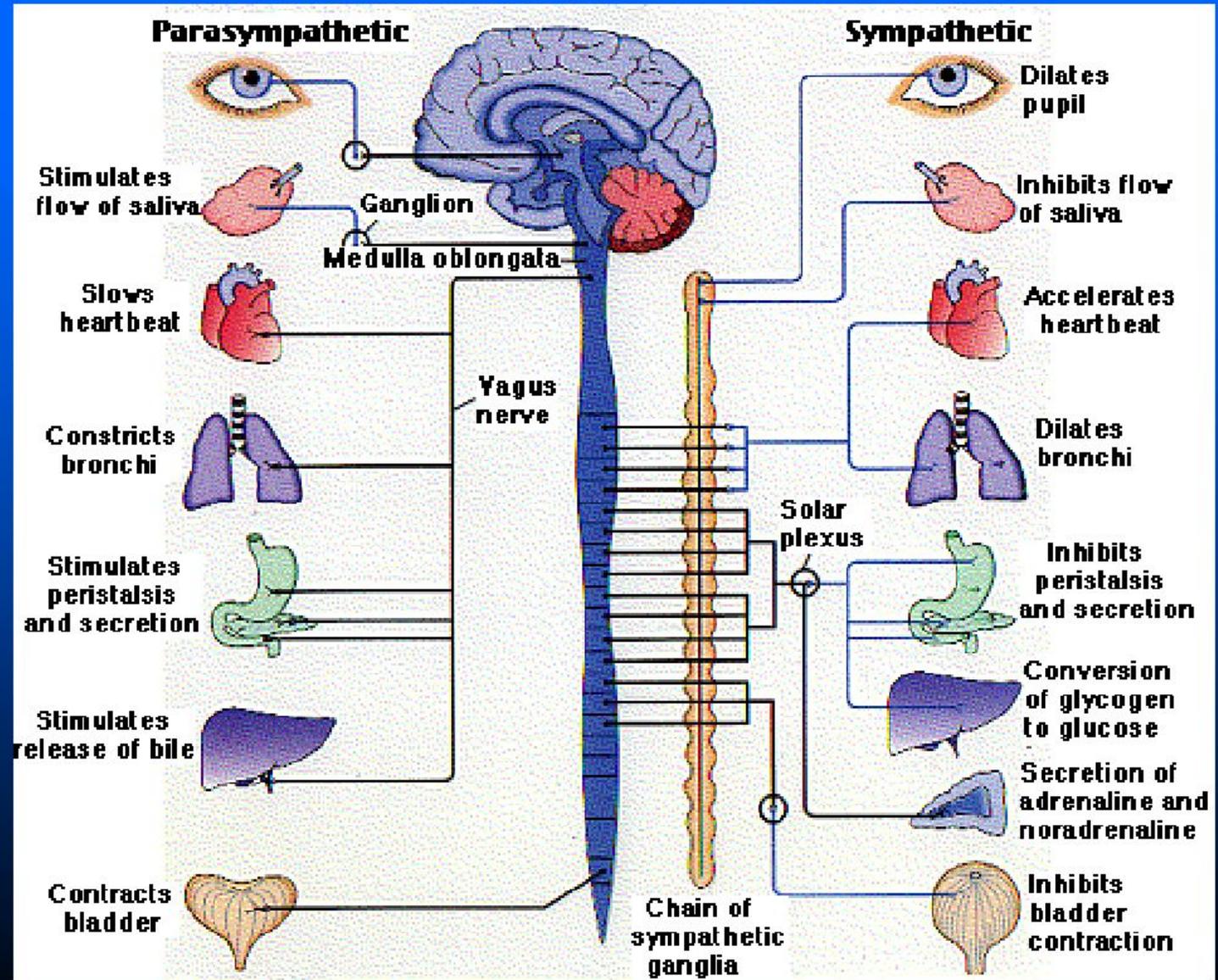
Take it from Resilience Man

- ✧ Regular, moderate physical exercise
- ✧ Plenty of sleep
- ✧ Tell stories often by writing and talking with others
- ✧ Prayer and meditation
- ✧ Strength of social support networks is important: Stay in touch with loved ones
- ✧ Spread out deployments
- ✧ Take long breaks
- ✧ Adequate vacation leaves
- ✧ Talk with a counselor if thoughts or feelings get in the way

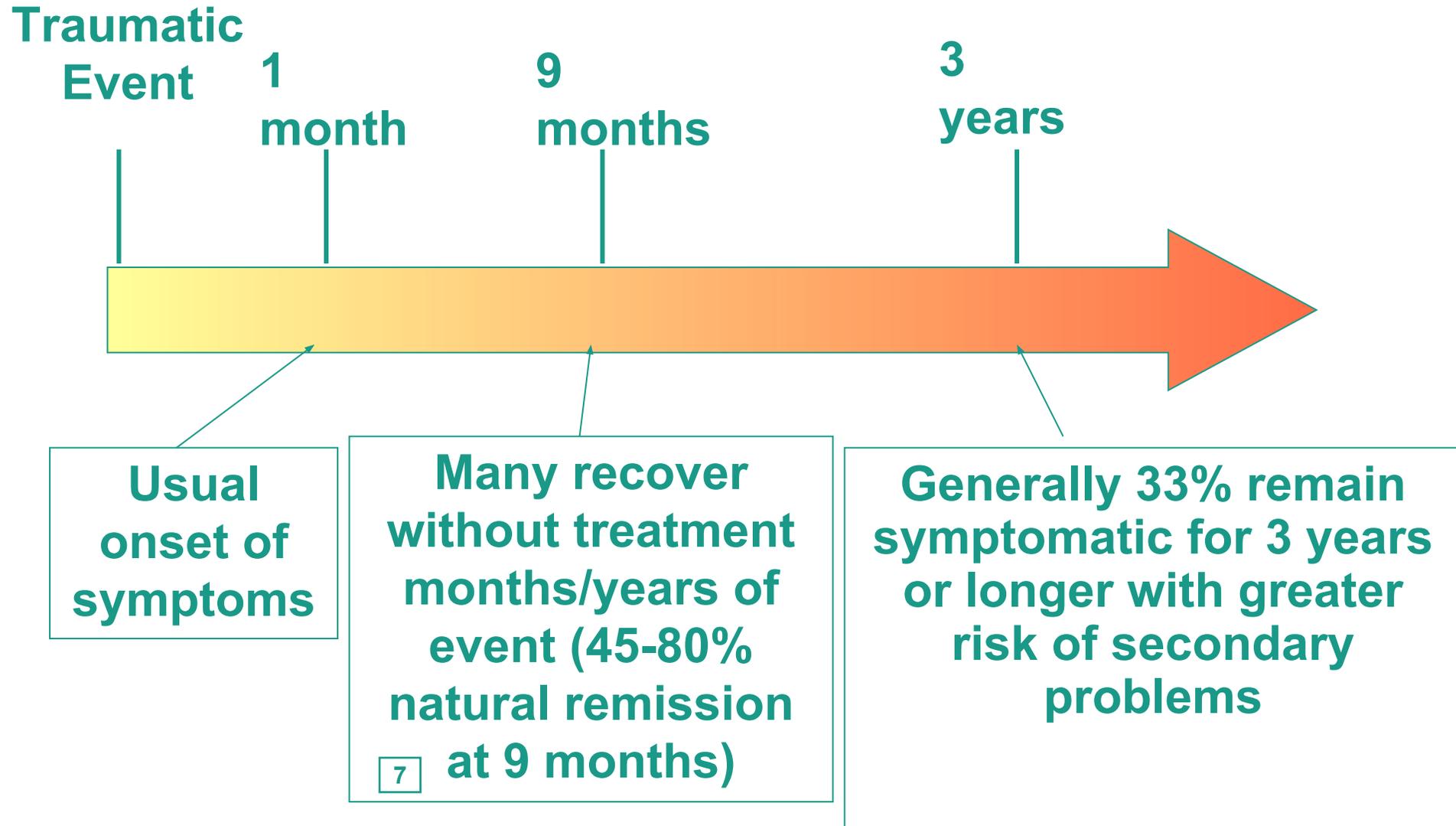
Abraham Maslow's Hierarchy of Needs



Fight or Flight



Natural history of PTSD



In the Wake of the Tsunami

Psychosocial Care of Disaster survivors

PTSD or not-PTSD?



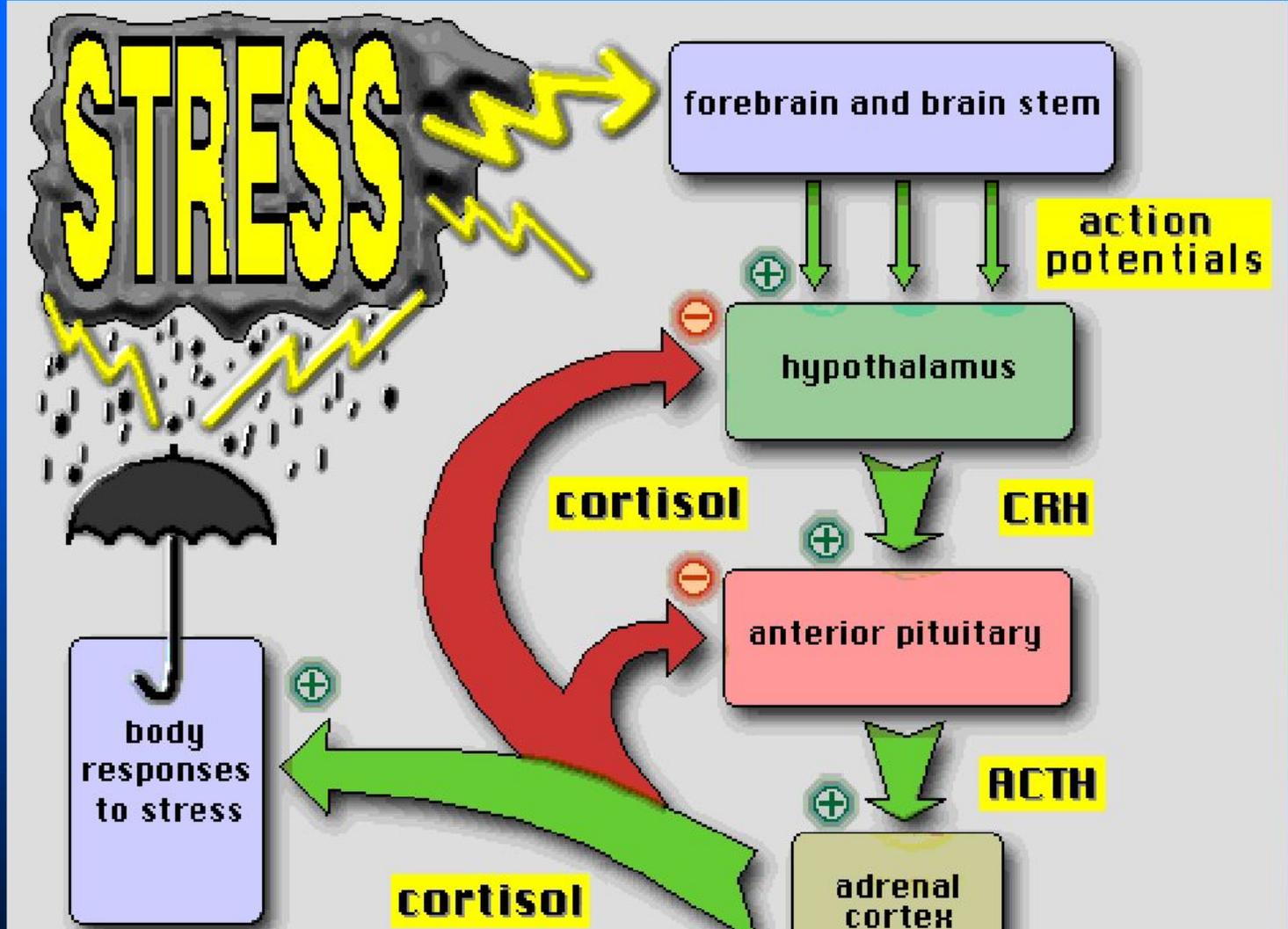
*P. Sabarinathan, 9 years, IV standard at
Government Middle School, Akkaraipettai*

*'I am very scared to sleep. I get nightmares.
I want to play with friends all the time so that I feel better.'*

Tsunami Survivors



On-going Traumatic Stress



on
tials

als

Stages of Grief

E. Kubler-Ross	H. Lowenbach	W. Dyer
Denial	Denial	Unglaube Disbelief
Anger	Anger	Zorn Anger
Bargaining	Accusatory	Selbstmitleid Self-pity
Depression	Self-accusatory	Traurigkeit Sadness
Acceptance	Acceptance	Gott flehend Pleading with God Anerkennung Acknowledgment

5-Minute Yoga = Mindfulness

- 1) Deep breathing
- 2) Progressive muscle relaxation
- 3) Guided imagery

Psychological First Aid

CORE ACTIONS

Contact & Engagement



REMEMBER:

- 🐾 Work within a team.
- 🐾 Protect survivors from harm.
- 🐾 Be calm and compassionate.
- 🐾 Listen and be flexible.
- 🐾 Respect culture and diversity.
- 🐾 Give clear and reliable information.
- 🐾 Know local available resources.
- 🐾 Help survivors help themselves.
- 🐾 Know your limits.
- 🐾 Take care of yourself.

NCTSN

The National Child
Traumatic Stress Network

National
Center for
PTSD
Post-Traumatic
Stress Disorder

PFA Mobile™ can be downloaded on
mobile Apple and Android devices

This project was also funded by SAMHSA,
US Dept. of Health and Human Services
Illustrations by Dr. Bob Seaver

PSYCHOLOGICAL FIRST AID

Are you ready to respond?

GET **P**REPARED

GET **F**OCUSED

GET INTER **A**CTIVE

GET

PFA®



www.NCTSN.org
learn.nctsn.org

What is PFA?

Psychological First Aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support.

PFA involves the following themes:

- » **providing practical care and support, which does not intrude;**
- » **assessing needs and concerns;**
- » **helping people to address basic needs (for example, food and water, information)**
- » **listening to people, but not pressuring them to talk;**
- » **comforting people and helping them to feel calm;**
- » **helping people connect to information, services and social supports;**
- » **protecting people from further harm.**

Core Elements of PFA

- 1. Contact & Engagement**
- 2. Safety & Comfort**
- 3. Stabilization**
- 4. Information Gathering: Current Needs**
- 5. Practical Assistance**
- 6. Connection with Social Supports**
- 7. Information on Coping**
- 8. Linkage with Collaborative Services**

What PFA is not

- » It is not something that only professionals can do.
- » It is not professional counseling.
- » It is not “psychological debriefing” in that PFA does not necessarily involve a detailed discussion of the event that caused the distress.
- » It is not asking someone to analyze what happened to them or to put time and events in order.
- » Although PFA involves being available to listen to people’s stories, it is not about pressuring people to tell you their feelings and reactions to an event.

Do's ✓

- » Be honest and trustworthy.
- » Respect people's right to make their own decisions.
- » Be aware of and set aside your own biases and prejudices.
- » Make it clear to people that even if they refuse help now, they can still access help in the future.
- » Respect privacy and keep the person's story confidential, if this is appropriate.
- » Behave appropriately by considering the person's culture, age and gender.

DON'TS X

- » Don't exploit your relationship as a helper.
- » Don't ask the person for any money or favour for helping them.
- » Don't make false promises or give false information.
- » Don't exaggerate your skills.
- » Don't force help on people, and don't be intrusive or pushy.
- » Don't pressure people to tell you their story.
- » Don't share the person's story with others.
- » Don't judge the person for their actions or feelings.

Professional listening etiquette

- Be genuine and thoughtful
- Thoughtful and compassionate behaviors
- Create appropriate boundaries
- Sometimes etiquette is overwhelmed by the fear that we will say the wrong thing
- Be as candid and forthcoming as you can – DON'T provide false assurances
- If you don't want to hear more personal details, ask a skillful question that elicits what you do need to know

Post Event Response

Task:

To create an outlet for staff to express or ventilate reactions to a stressful event or terrible news without judgment or the pressure to find a quick fix

Function:

To create “a holding space” for staff to simply sit with reactions without getting further triggered or agitated

"We had a lot of trouble with western mental health workers who came here immediately after the genocide and we had to ask some of them to leave. They came and their practice did not involve being outside in the sun where you begin to feel better. There was no music or drumming to get your blood flowing again. There was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy. There was no acknowledgement of the depression as something invasive and external that could actually be cast out again. Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to ask them to leave."

MVI_2267.AVI



~A Rwandan talking to a western writer, Andrew Solomon, about his experience with western mental health and depression.

Hope Modules

- **Demoralization** - Demoralization refers to the *helplessness, hopelessness, confusion, and subjective incompetence* that people feel when sensing that they are failing their own or other's expectations for coping
- **Demoralization is not depression.**
It is not a psychiatric disorder

Hope is not a feeling. It is a practice



A Case Study in Hope Modules:

Mrs. L Can't Go Home

Jeremy Safran, MD & Carl Quesnell, MD
Psychiatry Residents, PGY2
George Washington University

You can hold yourself
back from the sufferings
of the world, that is
something you are free
to do and it accords
with your nature, but
perhaps this very
holding back is the one
suffering you could
avoid

- Franz Kafka

ASSESSMENT

*How did this [illness, loss, trauma] affect you?
How did you respond?*



FORMULATION

- 1) Does the patient have a signature strength for mobilizing hope when stressed?
- 2) Which category appears to represent the patient's "strong suit" for mobilizing hope?
- 3) What hope practices from this category have been available in the past? Are they available now? If not, what are the obstacles?
- 4) Based upon these observations, what strategy for mobilizing hope has the best likelihood for success? What objective should be given first priority?

INTERVENTION

- 1) Intensify use or expand scope of signature strength(s) for hope-building.
- 2) Strategize how to overcome obstacles to accessing hope practices that had been available in the past.
- 3) Resurrect hope practices that have fallen into disuse due to demoralization.
- 4) Add novel hope practices, preferably from category that is patient's strong suit for hope-building.



Mrs. L's Background

- Mrs. L is a 52 year old partnered, domiciled African-American female on SSDI with significant past medical history who was brought by her case manager from her primary care appointment after expressing suicidal ideation and depression in the context of pain after a recent motor vehicle accident (MVA) one month ago.
- Past Psychiatric History of schizoaffective disorder
- Past Medical History of many chronic and acute issues resulting in physical deficits, distress, and pain



- Following the increased stress and pain from the motor vehicle accident, Mrs. L has felt more depressed and suicidal.
- Prior to admission, she attempted to overdose with "pain medications" she had purchased from her neighbors.
- She wanted to "get of rid the pain"
- History of multiple suicide attempts

Conditional Hopelessness

- Mrs. L admitted early on that she her suicidal ideations were conditional on being discharged to her home. She was certain she would kill her herself because drug dealers in her building would seek her out and get her to use drugs and she could not bear this. She had a recent relapse, which made her feel guilty, afraid, and hopeless.

Assessment

Psychiatrist: Is this the worst you've ever felt?

Mrs. L: Yes. I want to kill myself and I'm tired of living.

Psychiatrist: Can you remember any other time where you felt like this?

Mrs. L: No.

Psychiatrist: Or a time that made you feel similar? Or even just close to as low as this.

Mrs. L: Yeah...

Psychiatrist: And when was that? What happened?

Mrs. L: It was over a man.

Psychiatrist: And do you remember how you got through that time?

Mrs. L: My mother. I talked to her all the time. I could talk to her about anything. She always listened

Psychiatrist: Your mother? That's really great that you had such a strong connection with her. Is she still around?

Mrs. L: She died. Now I don't have her.

Psychiatrist: I'm so sorry to hear that. Is there anyone in your life you can rely on now?

Mrs. L: I don't have anyone except my husband.

(At this moment the patient's husband entered to visit with her and the patient lit up with a smile)

Psychiatrist: Right on cue!

ASSESSMENT

*How did this [illness, loss, trauma] affect you?
How did you respond?*



FORMULATION

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Formulation

- Access to attachment relationship is hindered by separation while the patient is in the hospital (i.e. difficult for her husband to visit her in the hospital)
- Physical barrier due to the contact precaution gowns between patient and providers and her husband
- Guilt and shame regarding her fear that she will use drugs again
- Fear of losing her husband
- Husband had difficulty communicating with her (He is a quiet man and often would repeat phrases such as, “she can’t go back there,” rather than engage in dialogue)
- There was no phone in her room due to protocol when patients are on 1:1 sitter (could not contact case manager or her husband)

Intervention

Mrs. L: I've got so many problems I don't know where to start.

Psychiatrist: The first thing we can do is take your problems, put them in a list, and go down one by one to try and get a handle on each of them.

Mrs. L: It's too much to handle.

Psychiatrist: Well it's our job to help you with that.

Mrs. L: If you wanted to help me you would give me my medication. You just want to give me the shots. I hate shots! (Referring to the Lovenox injections)

Psychiatrist: I'd like to think of it like this: we're a team. The staff here are just trying to help. And your husband is too...

Psychiatrist: ...Our goal is to help you be safe, happy, and healthy. The Lovenox shots are to prevent any blood clots, but we can talk to the primary team about restarting your home Xarelto as soon as we can. We just want to get you well

Mrs. L: As soon as I'm better you are going kick me out and I'm going to kill myself. I'm not going home. I'm going to kill myself if I go home. I know it. I will stab myself right in the chest.

Psychiatrist: Well then we need to work on finding you a place to go where you will be safe.

Mrs. L: Can I come to the psychiatry floor?

Psychiatrist: If you come up to the psychiatry floor for a week, won't you still be in this situation?

Mrs. L: I can't go back to that place.

Intervention Continued

Psychiatrist: I would like it if we could talk with your husband and your case manager at the CSA to see if we can get the ball rolling on finding you a new place. He cares about you and although I know you've been frustrated with the CSA, it sounds like you've made some strong bonds there with people who could help you right now.

Mrs. L: They treat me alright sometimes. But sometimes they don't listen to me.

Psychiatrist: Maybe your husband can help coordinate with them so you can focus on your health? And we can also work on a plan for substance use treatment in the meantime. That way you won't have to go home until you feel ready or you have a new place

Mrs. L: If I go back to that place I will stab myself. No one is helping me.

Psychiatrist: I'm sorry you feel like no one is helping you. Do you remember telling me your mother helped you get through a similarly tough time?

Mrs. L: Yeah.

Psychiatrist: What that says to me is that you are skilled with people. And I've seen myself that you can be quite pleasant, even charming. What I would like to work on is figuring out how you can use your interpersonal skills to identify who you can rely on to help you with each of your issues.

Mrs. L: I can ask my husband to bring the papers for the social worker at the CSA. Maybe then we can get a new place.

Psychiatrist: That sounds like a great idea. And you will have your doctors and the staff here to help you tackle your medical issues.

ASSESSMENT

*How did this [illness, loss, trauma] affect you?
How did you respond?*



FORMULATION

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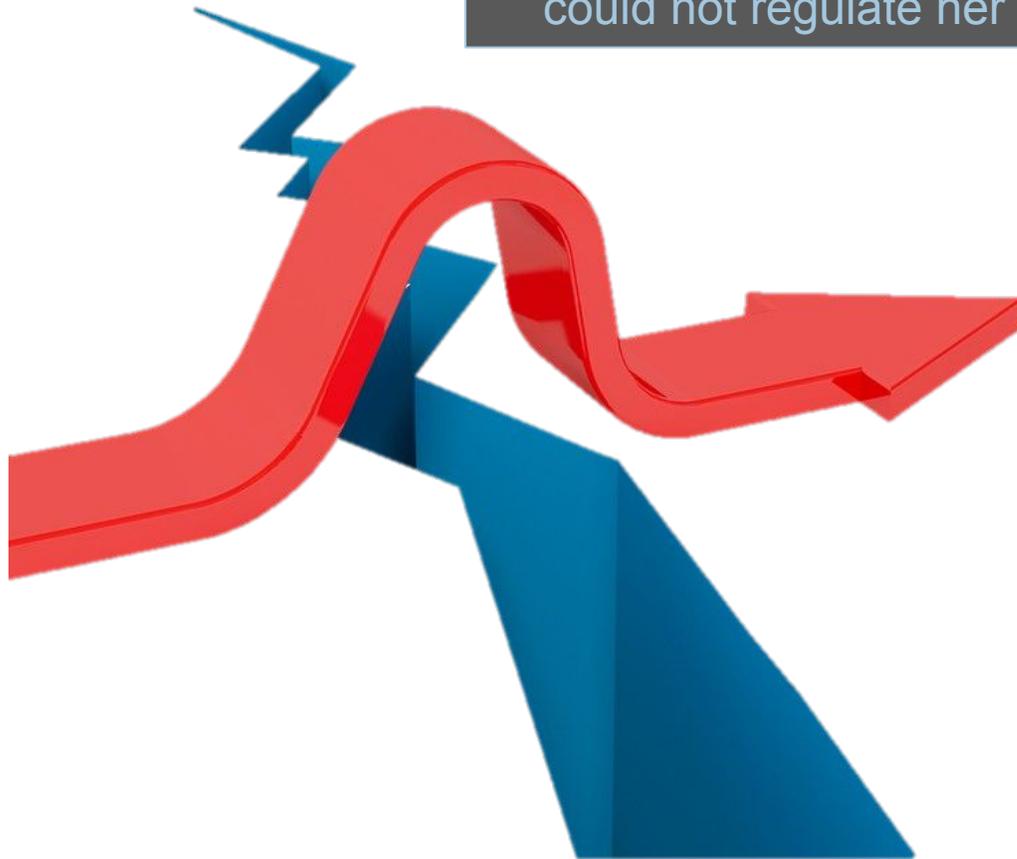
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After the Interview

- **Compromise with medical teams and patient to regain agency**
- **Allowed her to use a phone**
- **Reinforce that we were a team**
- **Helped coordinate with husband and case manager**
- **Continued to discuss the potential for substance use treatment as a temporary solution**
- **Validated her husband for being supportive (in front of patient)**

Techniques used to avoid being drawn into the patient's despair:

- Redirected the patient when she could not regulate her emotions



- Avoided distressing topics until it was necessary to discuss them

Techniques used to avoid being drawn into the patient's despair:

- Met Mrs. L where she was at...



- Utilized humor when appropriate

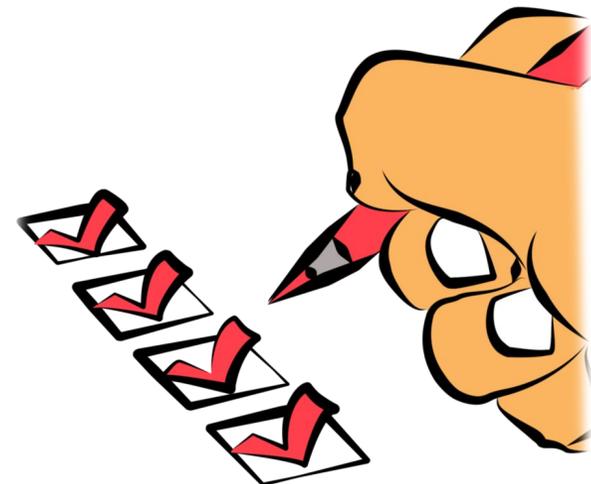


Techniques used to avoid being drawn into the patient's despair:

- Sometimes spoke to the patient through conversation with her husband



- Worked with her to break her problems down into a manageable list to prevent her from feeling overwhelmed





“Hope” is the thing with feathers
That perches in the soul,
And sings the tune without the words,
And never stops at all.



And sweetest in the gale is heard;
And sore must be the storm
That could abash the little bird
That kept so many warm.



I’ve heard it in the chilliest land
And on the strangest sea;
Yet, never, in extremity,
It asked a crumb of me.



— EMILY DICKINSON



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- Griffith, J. L. (2017). Hope Modules: Brief Psychotherapeutic Interventions to Counter Demoralization from Daily Stressors of Chronic Illness. *Academic Psychiatry*, 42(1), 135-145. doi:10.1007/s40596-017-0748-7

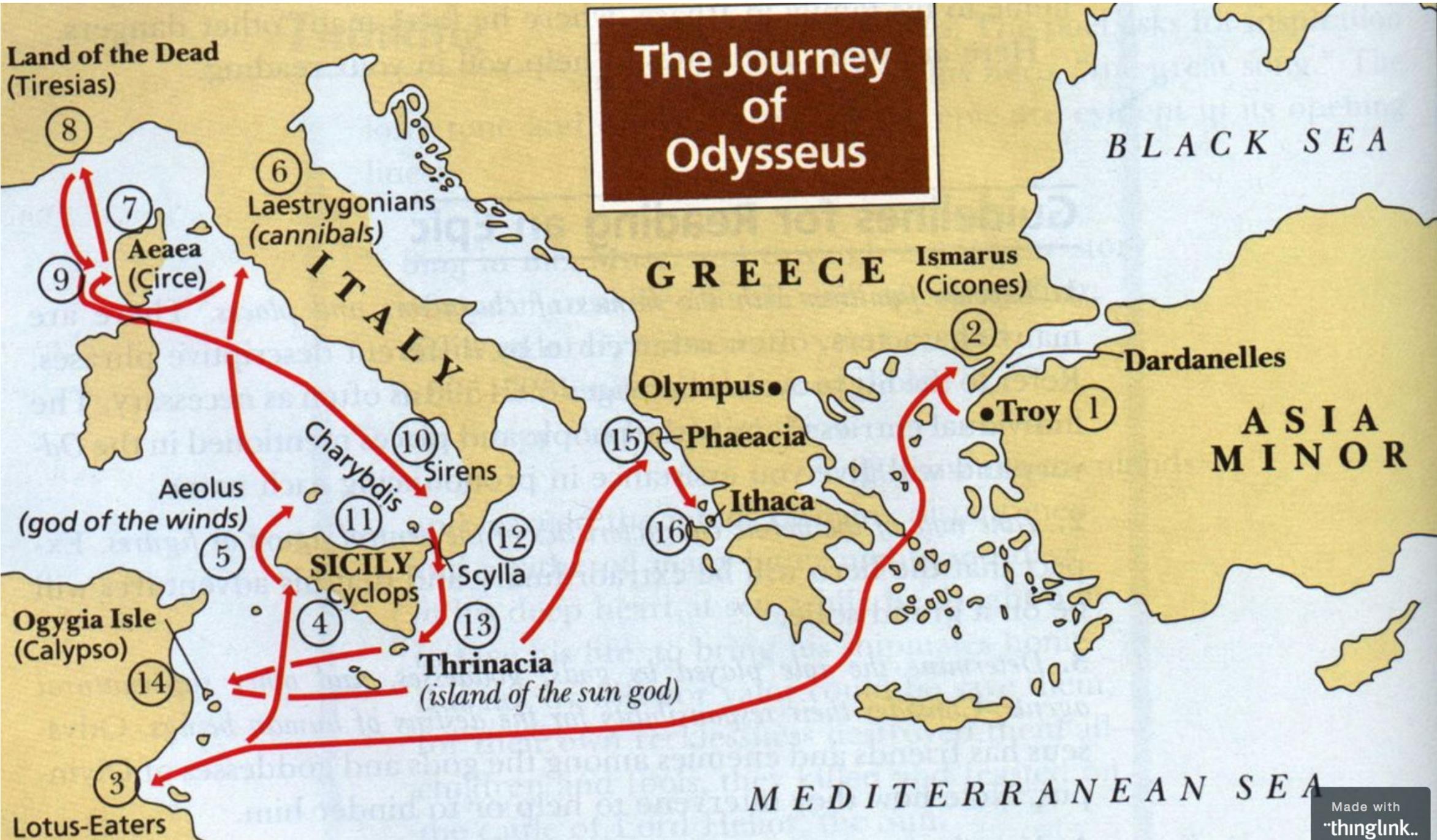
Do you believe this?

WATER WHEEL WORDS OF WISDOM

Staying positive does not mean everything will turn out okay. Rather it is knowing that YOU will be okay no matter how things turn out.

SPECIALS

The Journey of Odysseus



One More Mountain to Climb



Allen R. Dyer

One More Mountain to Climb

What My Illness Taught Me About Health

Dyer

LAP **LAMBERT**
Academic Publishing



Compassionate Listening

Dr. Kavita Avula



Lao Tzu

The wise person never tries to know everything

And therefore she becomes truly wise

The person never acts too hastily

And therefore she finds the best way to act

The wise person never runs from difficulty

And therefore she finds she rarely runs into difficulty

Intentional Listening

Convey compassion

Ask open-ended questions

Reflect back what you hear

Invite reactions to your statements

Never make promises

Genuine

Compassionate Presence

- Attitude based on wish for others to be free of their suffering
- Ability to express care for staffmember's pain and suffering without becoming overwhelmed and disabled by that suffering
- Ability to detach enough to help guide staffmember towards resolving the issue

Counterproductive relating

- Approaching with impression of “Oh my God, this is so terrible!”
- “How are you?” in stricken tone
- “You seriously need to talk to a psychologist!”
- Rescuing (trying to fix complex problems)
- Hastening to minimize uncomfortable feelings
- “Should-ing” on people (blindly giving advice)

Grief: An Opening

- Grief is both a wall and a door
- Neither entirely one nor the other
- Grief is a process

Communication in Times of Grief

- I think it will be important to take one day at a time.
- It is OK to feel upset or worried.
- I can relate to your anxiety about not knowing what the future holds.
- I'm also frustrated that I can't give you more reassurance.
- This is a very stressful situation and if you can think of anything I can do to support you, do let me know.

Small Group Exercise

Center your breath

Identify some of the greatest challenges you face in this work

Identify your own coping strategies

Mapping exercise – Where have you come from? – where are you going?

Where are your beneficiaries coming from? Where are they going?

You decide: Helpful or Unhelpful?

- “I know exactly how you feel.”
- “Everything will be fine.”
- “I can’t imagine what this must be like for you.”
- “I’m really sorry that you are going through this.”
- “This is a difficult time for many of us.”
- “I’m your manager and don’t want to know your personal issues.”
- “I’ll pray for you.”

Global Psychiatry

→ Global Mental Health

→ **GW** Global Well-being



THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON, DC



School of
Medicine &
Health
Sciences

Somos migrantes

Adios y muchas gracias





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