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From the editor

This issue is centred on a variety of themes: alcohol use in refugee camps, psychological first aid after emergencies and care for the caretakers. Furthermore, within those themes, it also provides different perspectives from differing parts of the world.

Alcohol, a forgotten problem in refugee camps

In refugee settings, the use of alcohol and illegal psychotropic substances constitute a

huge problem for which neither the health services, (often only aiding those who present themselves to the health care system), nor the community services (often focused on '*vulnerable groups*', such as survivors of gender based violence, orphans, widows or people living with HIV/AIDS) have adequate interventions. This issue of *Intervention* contains three contributions on alcohol related problems. *Nadine Ezard, Annabel Debakre & Raphaële Catillon* introduced '*screening and brief intervention*' (SBI) for alcohol in a Burmese refugee camp in Thailand. Using a wellknown international screening tool, the AUDIT, enabled trained health workers to identify problem drinkers. Subsequently, those refugees who scored above the threshold for excessive drinking were offered information on possible harmful consequences of alcohol use, and advised to reduce their drinking. They were also offered further individual counselling appointments, or referral to specialist services, but a disappointingly low number of clients took advantage of these opportunities. Therefore, the experience of Ezard, et al. show us that while it may be feasible to train general health workers in the use of a brief screening tool, this in itself will not be sufficient to tackle the problem. In order for a screening tool to be usefully implemented it needs to be embedded within a larger framework of interventions. This is exactly what *Emmanuel Streel & Marian Schilperoord* emphasise in their field report, using their experiences in refugee camps in Kenya and Guinea. They argue that interventions to reduce the impact of alcohol and psychoactive substances should not only focus on users, but must be complemented by preventive interventions and activities to support families and carers of persons with alcohol and drug disorders. A participatory process, involving the refugees themselves is an absolute necessity in creating a behavioural change in communities. As Streel & Schilperoord state: '*training only the staff or providing single sessions with information for the community are not enough.*' In his invited commentary on these two articles, *Colin Brewer*, a psychiatrist with over 40 years of experience in alcohol use interventions in the UK, notes striking similarities between the work in the low resource setting of refugee camps and conventional practice in the west. In developed countries too, alcoholism treatment services concentrated disproportionately on those drinkers who have classic physical dependence symptoms, rather than focusing on the whole spectrum of problematic alcohol use. According to Brewer, once alcohol abusers accept that they have a problem and decide to do something about it, many of them improve for useful periods regardless of whether or not they have formal treatment. Therefore, initiatives to change behaviour and attitudes, such as self help groups, should be encouraged. Readers, who have experiences with successful implementations of such groups, in post conflict or post disaster contexts, are invited to share their experiences in the next issues of this journal.

Psychological first aid after emergencies

A second theme in this issue is how to provide psychosocial assistance in the early aftermath of disasters. Until a few years ago, experts advocated the use of group '*debriefing*' to reduce psychological harm after involvement in shocking events. Debriefing refers to structured sessions that encourage survivors to share their stories and emotions soon after the event. In the past few years debriefing has been thoroughly discredited. Analyses of available evidence showed that

such interventions are ineffective at best, and sometimes even harmful in preventing mental health problems (Rose, Bisson & Wessely, 2003; Wethington et al., 2008; Roberts et al., 2009). The *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007) discourage the use of single session debriefing, and advocate the use of psychological first aid (PFA), a set of simple interventions that can be used by helpers with limited professional training. PFA provides guidance on methods to help people experiencing acute distress, in a way that respects the dignity, culture and coping styles of the survivors. Additionally, it focuses on addressing practical needs, providing basic comfort and connecting people to available support structures. This sounds simple, and indeed it is. However, many fieldworkers in post conflict and post disaster settings still have no clear idea of what PFA means and how the broad principles should be translated into concrete action. A problem with existing materials, such as those of the National Child Traumatic Stress Network and National Center for PTSD (2006), is that they are initially made for use within the United States. It is therefore good that three organisations, World Vision International, the War Trauma Foundation and the World Health Organisation, have developed a PFA guide for low and middle income countries. *Alison Schafer, Leslie Snider & Mark van Ommeren* report on a pilot project to test this PFA guide in the first months after the devastating earthquake in Haiti. Their experiences are quite positive. The field report of *Amber Gray* describes how she integrated PFA in a staff support programme in Haiti and provides inspiring examples of how bodywork techniques and local techniques were integrated into PFA. A different, and perhaps more controversial, approach to helping survivors of mass violence is described by *Ronald Law* from the Philippines. In the aftermath of a violent political attack, his team developed a one day group intervention to assist the family members of the murdered victims. This day contained elements of debriefing, but was also different in other, and perhaps critical, aspects. The intervention was situated within a context of a social event, and the day itself was a powerful example of mutual support among survivors and relatives. The approach developed by the Philippine team was well received by the survivors, and the authors felt it was a good intervention. However, they wisely conclude that more evidence is needed to evaluate whether their approach was effective. An important first step in gathering evidence is to document what was done, and the authors are to be lauded for taking this first step.

Caring for caretakers who work with survivors of disaster and violence

A third theme in this issue is how to support the helpers of people in distress. In the last issue of this journal we published two articles on the subject (Curling & Simmons, 2010). In this issue, the aforementioned field report by *Amber Gray* describes a staff support programme in Haiti that included psychological first aid for the staff of an international nongovernmental organisation (NGO) (who were as much affected by the earthquake as any other group in Haiti), training of a local staff support team, with ongoing training and mentoring. The experiences draw important lessons for the future of staff support in humanitarian situations. Staff support needs to be an integral part of all international humanitarian programming. *Natan Kellermann*, in his review of Christian Pross' book on

therapists dealing with stories of suffering and trauma, places the work of Pross within a small, but important body of literature, on care for professionals who work with survivors of collective violence. It highlights how *'wounded'* therapists can impact the teams they work in, and can affect the institutional culture and structure of their organisations.

Other articles

Sophie Yohani & Kristine Hagen provide a literature review on how sexualised violence is used as a tool of war, and how this practice and its' impact are shaped by cultural factors. They describe how a combination of psychological trauma and sociocultural barriers may prevent refugee survivors of sexualised violence from seeking help. This is illustrated by a case example of a community based mental health initiative in Canada for survivors of war related sexualised violence. Finally, this issue contains an article by *Femke Verduin & colleagues*, describing how qualitative research techniques informed a survey on treatment outcomes in Rwanda. One could argue that what Verduin did should be part of any good survey. I could not agree more, but feel that this lesson needs to be emphasised time and again in order to ensure that our research measures and indicators makes sense to the people involved.

Peter Ventevogel
Editor in chief

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