Terre des hommes

CHP
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Humanitarian
Psychology

A Psychosocial Programme of Recreational Centres in Bam (Iran)

Evaluation

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SUMMARY

For several years now, it has become quite evident that the psychological damage after a disaster has been generally overlooked by humanitarian assistance. Agencies, worldwide now, are beginning to integrate a so-called ***psychosocial approach*** into humanitarian programmes, which seeks to take care of the psychological trauma through community dynamics, where the efforts of some have an effect on all the others.

This new conception of rehabilitation is particularly pertinent in the case of children. The simple fact of placing them in a "healthy" context in which they are given the necessary resources to recover naturally, particularly through play, has an immediate and positive repercussion on the adults around them. Families regain courage to rebuild and the helpers react positively.

A year ago, the town of Bam (Iran) suffered an earthquake of 6.7 on the Richter Scale, killing more than 30'000 people and destroying 85% of the town. More than 80'000 people lost everything and almost 120'000 lost members of their family.

Very shortly after the earthquake, Terre des hommes (Lausanne) launched a psychosocial project of recreational activities, based on play and sports, and sheltered in "centres", with the aim of reaching 5'000 children. At present time, these objectives have been more than achieved: 17 centres have been created, reaching nearly 10'000 children, thanks also to the support given by TdH to kindergartens, sports clubs, cultural activities, etc.

Terre des hommes has asked Claire Colliard, Director of the Centre for Humanitarian Psychology, to assess if their Programme had lessened the degree of stress and trauma of the children who had been attending the Recreational Centres for nearly a year, thus giving scientific support regarding the impact of the play activities on the traumatic condition of the children.

The author went to Bam in December 2004 for three weeks and surveyed 527 children within their psychosocial environment, using two questionnaires, the Child Behaviour Check List and the Davidson Trauma Scale. The following report gives the results of this survey together with an analysis of the Programme's pertinence and some recommendations.

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INTRODUCTION

A year ago, the town of Bam in the south eastern part of Iran (near the Afghan border), experienced an earthquake of 6.6 on the Richter Scale. More than 30'000 people were killed and 85% of the town was destroyed, with more than 80'000 people losing all their possessions, and almost 120'000 having lost members of their family. In spite of the fact that 6.6 does not seem to be a large earthquake, it killed many people because it occurred in a city built of adobe, at five o'clock in the morning. Bam was a city where the inhabitants lost everything in an instant; it looked as if a bomb had exploded and flattened every house.

Soon after the earthquake, the **Foundation Terre des hommes (Lausanne)** launched a psychosocial project focused on building recreational activity centres for the children of Bam (Iran) with an initial aim of offering their services to 5'000 children. A second part of the programme was created later which supported a population of 4'000 children in 10 schools. A year later, thanks also to the support given by TdH to local kindergartens, sports clubs, cultural activities groups, etc., these objectives have been more than achieved: 17 centres have been created, reaching 2400 children on a daily basis, and over 10'000 children in all.

According to the mandate's term of reference, this writer was to assess the improvement of the psychological well-being of the children who had been attending the "Recreational Activity Centres" Programme for nearly a year. It was hoped that this assessment could give scientific support regarding the impact of the play activities on any traumatic conditions the children may be experiencing after the earthquake. It was also hoped, that through making a certain number of recommendations about how to improve the "Recreational Activity Centres" model being used, that this could lead to its subsequent development and replication for use in other similar situations.

The need for such child-friendly programmes in a post disaster environment is manifold. It creates a focal source of hope for children in the middle of trauma and despair, and this can in turn positively impact the children's family and community environment. Besides acting as an important resource where children can focus their energies in positive ways, the "Recreational Activity Centres" can be utilized as a tool to spot and evaluate the more vulnerable children, who then could be referred to the mental health system of the region. This avoids the danger of singling them out and labelling them as "ill", before the child has had a chance to use their existing emotional resources to develop a healthy resiliency. Such a programme also compensates for the lack of schools right after a disaster, which in this case, were reduced to ruins. Additionally, the "Recreational Activity Centres" function as an intermediary milestone in the reconstruction process of the education system.

The following points refer to the key conceptual framework used in this survey: a child oriented and psychosocial focus on rehabilitation, rather than a programme oriented towards a structural, psycho-diagnostic perspective of mental health. The author shall develop these points later.

As stated above, the reasons for this survey are, first, to give a scientific basis to the questions involved in the successful implementation of recreational activity centres. The central one being: how efficient are they in helping the participating children achieve a reasonable level of well-being?

Secondly, the evaluation helps to explore whether this type of intervention is worth pursuing, and assess what kinds of mistakes or problems have occurred that may need to be corrected, in order to make it a more efficient and effective programme. Recommendations may give some guidelines to a reshaping of the Programme.

The research then has also the potential to map new possible developments in the program, and create new tools that could help make the use of this model more efficiently. Finally, it is hoped that this research will help reflect on the relevance of a contextual psychosocial approach, versus a more individual and trauma counselling approach.

CHAPTER ONE – THE DIFFERENT CONTEXTS

1.1 Bam after the earthquake

At the end of 2004, on the eve of the first anniversary of the earthquake (which was December 26th, 2003), this writer arrived to find the whole population busy cleaning up the cemeteries and mourning their dead.

The rebuilding process was much slower than foreseen by the authorities, in spite of the construction of thousands of prefabricated houses, which still did not meet the needs of the population. However, the irrigation system had been quickly repaired in the first month after the disaster, enabling the population to harvest the dates, which is the basic economic resource in Bam, along with tourism. Unfortunately, a severe drought had also been causing a serious problem for agriculture, and by the end of 2004, there had not been any rain for over six months. Living conditions continued to be very hard, however, and in December, when there can be periods of intense cold, 30% of the population were still living in tents.

However, small businesses have mushroomed all over Bam, sheltered in containers, which shows the beginning of a resilient response to the crisis. Large numbers of the local population had fled Bam after the earthquake, but other people from the nearby area of Kerman (as well as from other areas) have come to Bam to start businesses. With the flow of departing and returning people, it is difficult to know just what is the present population number is, or how many of the original inhabitants are still there.

The disaster of the earthquake has of course caused a terrible drain in terms of human resources. In the community network, in the city as well as in the surrounding country side, the governmental institutions and the religious authorities are beginning to function again, however these are developing at a slow pace. At the beginning of the post disaster period, from January on, the whole population of Iran mobilized in response, and came to help their fellow country men. The citadel of Bam, a great historical site and a very important symbol for the whole country, became the flag for the citizens to rally around. However, a year later the people from the North have gone back to their own problems, and Bam is more or less left to its own resources.

On the local level, the municipality of Bam and the "Shuras" (the elected village authorities) are relatively cooperative in helping to implement Tdh's programme. But this writer perceives that, at the time of her mission, many families remained immersed in their grieving process, and thus showed a lack of motivation or incentive to rebuild. The Iranian way of mourning (tens of thousands of Bamese go to the cemetery on Thursday afternoons to cry on the graves of the deceased), comes across as a very powerful way to unite, and perhaps heal, the survivors. However it is the belief of Iranian health professionals that this might impede a quicker rehabilitation, possibly breeding so-called complicated grief and they do their best to convey that message to the population.

One significant barrier to the reconstruction of Bam, has to do with the very high rate of unemployment, which is likely impacted by the very high usage of and addiction to opium, which is believed, according to Government figures, to be a problem with 50% of the employable men. This has a significant impact on the kinds of problems the children bring with them to the Centres. They live with a father, or other male figure, who smokes opium in the tent, and it appears that now a number of the women in the community are also beginning to use the drug (and in the past, women were never known to use opium). So now the children are coming in the mornings either impacted

indirectly by family addiction problems, or half way drugged themselves. Alcohol usage also appears to be increasing, even though it is illegal.

Another challenging aspect of this whole situation that is worth mentioning, is the culture clash that has taken place between the Western world of humanitarian NGOs, the people in Bam and the political authorities. Mutual understanding has not been easy, and Teheran has often tried to tightly control the implementation of the humanitarian programs, since they are concerned about the cultural impact of western values on its population, and especially on the youth. On the other hand Western NGOs have often had difficulty understanding Iranian and Islamic values, and have themselves behaved in insensitive and intrusive ways at times. In general, the “invasion” of a well-meaning, but Western humanitarian workforce, into devastated zones of the planet that hold different values is being now opened to more and more debate. It has sometimes been equated to a "second disaster" for distressed populations.

1.2 The Disaster

Any population that has experienced a significant disaster, passes through several different healing stages towards its reconstruction, as shown at the end of this chapter. At the present time, Bam has reached what is called a depressive phase, which is expressed via a stunned disillusion, shocked by the awareness of the enormity of the reconstruction tasks it faces. In general, the inhabitants feel angry, and tend to blame the government, as well as agencies and individuals responsible for the relief effort. Many people are entrenched in a deep feeling of being victimized in all aspects of their lives. The basic assumptions of these people are shaken, as well as their religious beliefs, as they have lost their sense of security in "terra firma", and thus their illusion of invulnerability has been shattered. Whole families have been torn apart or destroyed, and one has the feeling that they are unable to fully engage in the mourning process because of their still being in deep shock. The psychological trauma of a whole population, and the immense grief, is preventing them from healing and moving towards hope. So the general impression is one of "sluggish despair" and depression, which classically comes with the second phase after a disaster.

In contrast to this heavy atmosphere, Tdh recreational centres have been able to create a kind of oasis, an uplifting and healing spirit for a few thousands of children and their families. Even more important, these programmes suggest and map future paths for the reconstruction of the community, as it has an influence on all levels.

In general, there is an important distinction between man made disasters, such as wars or terrorism, and natural disasters, and the effects these have on a population. Wars display an evil intent in human beings, a deliberate socio-political act, with often considerable human cruelty expressed in violence, which begins a vicious cycle of revenge and hatred. In contrast, natural disasters are an act of nature, with an emotionally neutral impact on every living being, and the “intent” is impersonal in essence. It provokes awe of an almost religious quality about the destructive power of nature. Therefore the degree of guilt experienced by survivors of natural disasters is often less pronounced than after a conflict.

It is usually believed that the consequences of a natural disaster (like an earthquake, for example), will have more of a benign impact on a population, than the impact of a man made disaster. It has come to be recognized that psychosocial reactions to natural disasters usually resolve naturally over 18 months, and there are lower rates of diagnosable mental health disorders in contrast to post war situations, where psychosocial consequences can continue to plague a whole population for decades. One should not forget that Iran went through a long and terrible eight year war with Iraq, not so long ago, and that the scars and hatred from that conflict are still present.

At any rate, this is an important piece of information to be aware of when setting up a natural disaster psychosocial rehabilitation plan. It is the belief of the author that there is no apparent gain for both the local community and the humanitarian NGO in pursuing post disaster intervention longer than two

years after the event. At the end, the program should be handed over to the local community, in a spirit of sustainable development.

The effects of earthquakes on children

Such traumatic events as an earthquake impose severe psychological strain on every member of a community, but children are a particularly vulnerable group. The most obvious experience that Bamese children had during and after the earthquake, was experiencing and witnessing very frightening scenes of devastation and death. And the suddenness and unanticipated characteristics of earthquakes is known to make the traumatic experience much worse. It included the destruction in a few seconds of their homes, their property or personal possessions; being personally injured or faced with physical danger; or witnessing the death, injury, or pain of members of their family.

The earthquake then set off a chain of events disrupting the day-to-day living conditions, causing long-term difficulties. The changes for example may include strains in the relationships between family members and expectations they have about each other, such as changes in responsibilities and roles in the family. These disruptions in relationships and routines make life unfamiliar or unpredictable, which in turn can be unsettling or frightening for the children.

Then, stress builds up, where little hassles become more difficult to deal with, when there are other problems that also have to be faced. Difficulties that parents face may sometimes "filter down" and affect children in direct or indirect ways. This increasing stress may lead to strains that continue long after the physical signs of destruction have been cleared away. The biggest impact on children comes from the parental adjustment problems after the disaster. Moreover, many of the negative effects of a disaster may be due to the exacerbation of pre-existing issues. These daily strains can have a bigger impact on children's adjustment than the experience of the event itself. This is where the child friendly “Recreational Activity Centres” come into the picture: as safe and healing, structured and neutral environments.

1.3 The psychosocial context: trauma and grief within a shattered community

Psychosocial intervention in a humanitarian assistance programme focuses on the wounds of whole communities and individuals in a ***systemic way***. As we shall see further, it aims at supporting communities' resources and not only targeting the vulnerability and risk factors of individuals.

However, like it or not, trauma and grief of both individuals and communities are the raw material the Tdh Recreational Centres are trying to work on. Their effectiveness are difficult to measure, as you would be able to with food or medication. However, scientific research has been done in the areas of psycho-traumatology and disaster psychology for many years now. Reliable tools have been created to assess, evaluate, measure and treat those invisible wounds. As we shall see further, this survey has used two well known questionnaires (Child Behaviour Check List and the Davidson Trauma Scale) to evaluate the impact of the Tdh play activity Programmes on the emotional state of the children.

Addressing the invisible wounds

Children and adolescents also experience symptoms of trauma, and findings (La Greca et al. 2002) reveal that children's reactions to disasters can be severe, not merely fleeting or transitory events whose impacts quickly dissipate, as some have thought.

In order to know exactly what we are going to work on, the following definition of psychological trauma is proposed here, as defined by the US National Institute of Mental Health (www.nimh.nih.gov), which refers to trauma as "an experience that is emotionally painful, distressful, or shocking, and which often have lasting mental and physical effects. It involves the creation of

emotional memories about the distressful event that are stored in structures deep within the brain. It is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm."

The field of psycho-trauma in humanitarian assistance has been considered up to now as a purely ***mental*** health issue. And it is only in the recent years that it has been envisaged to address the distress of whole traumatized populations in a more ***psychosocial*** perspective. More specifically, the use of play in the Tdh Recreational activity centres, is considered an important psychosocial tool towards emotional healing in an emergency setting.

It is important at this stage to understand these emotional wounds and the dynamics of their healing, if one wants to make interventions more efficient.

How do disasters impact children?

In the first few days and weeks after a disaster, in children just as for adults, trauma is said to be acute. If after a month or more, symptoms are lingering, then one should be concerned about a psychological disorder called Post Traumatic Stress Disorder (PTSD), the four main symptoms of which have been widely described as:

- re-experiencing the traumatic event, either through flashbacks or nightmares,
- avoidance of all situations or people that remind of the traumatic event
- numbing of feelings
- and hyper-arousal, usually seen in psychosomatic reactions, allergies, etc…
  (DSM-IV Fourth Ed.)

Though community studies seem to suggest that approximately 24% to 39% of children and adolescents exposed to traumatic events, meet the criteria for a PTSD diagnosis in the first months following the trauma, very little is known about the evolution of those symptoms in children over time. But it is highly unusual for children to report significant symptoms of trauma a year or more after a traumatic event, ***if no signs of distress were evident within the first few months after the trauma***. This is especially true for children in the case of trauma in natural disasters.

This is an important element to consider when creating psychosocial programs in an emergency context. It speaks of the importance of early intervention, mainly during the first year after the event, basing it on the children's resiliency factors. However, it is also not advised, according to UNICEF, to intervene too early (i.e., within the first two months) with Western emergency techniques such as debriefing. Rather it is important to allow people the opportunity to "breathe" and protect themselves emotionally in their own way; not only to take care of their basic needs such as food, shelter and safety, but also to believe, as a relief worker, in their capacity for resilience.

Later, a programme may need to evaluate the presence of PSTD, and the evaluation should take into account the developmental level of the child. Our survey has shown that the reactions of children were different according to age groups and gender, which we shall address later in the study (see chapter on Play).

When building an effective psychosocial program, it is important to focus on the child's needs in the context of the disaster. UNICEF, in the previously referred Manual, has suggested some paths:

- first address the basic survival needs (food, water, shelter) in the first days and weeks
- at the same time, and as long as necessary, cater to the needs of safety and security of the children
- later on, offer developmental opportunities, when any symptoms have subsided.

All this of course has to be implemented within a supportive social network, within the context of family and community. Play, as we shall see, offers a perfect forum to accomplish all this.

Complicated grief

The children of Bam have not only witnessed horrible scenes during and right after the earthquake, but they have lost at least one member of their family, and sometimes all of them. When a loss is sudden and unanticipated, normal grieving may be compromised, leading to a picture of what is called "complicated grief". Complicated grief results from the loss of a loved one in traumatic circumstances, and this can provoke a long lasting negative effect on the well being of the survivor. The first consequence is that it becomes very difficult to complete the full process of grieving, as the person is still in shock and frozen in a startle reflex, beyond the usual length of time that grieving usually takes.

Resiliency

What is important to know for the development of recreational activity centres, such as the ones Tdh has created, is to take into consideration both risk factors (i.e., some children have to survive in very difficult life conditions), and protective factors that can help them heal. The recreational activity centres should focus on these risk and protective factors, developing in the course of the program ways to support the process of a child developing resilience. For instance, the Iranian Islamic culture has its own mourning rituals that help children grieve and make sense out of the chaos of their shattered lives. These are protective factors that Tdh must not only respect, but integrate into the activities of the programme. These protective factors may be enhanced, for instance, by discussion groups on death and dying, with a local religious figure or supervisors trained in grief work.

EMOTIONAL PHASES IN DISASTER RECOVERY

Heroic or rescue phase	Honeymoon/Inventory phase	Disillusionment phase	Reconstruction phase
Prior to/immediately after Shock	One week to 3-6 months after	2 months to 1-2 years after	May last for several years after
Fear	Attend to basic needs in a chaotic environment	Reality of impact on lives and community	Light at the end of the tunnel
Adrenalin rush	Concerns: about safety, food for today and a place to sleep tonight	Realization of losses and work to be done	Begin to put the disaster behind
Heroic acts	Unrealistic expectations about recovery	Steps to get assistance, bureaucracy	Renewed feeling of empowerment
People coming together	Sharing of resources/ willingness to help others	Community politics begin to emerge	Or full PTSD and/or chronic depression
	Denial of extent of needs or emotional impact	Grieving, generalized anxiety	Return to pre-disaster activities
	Onset of PTSD	Many psychosomatic complaints	
		Abuse issues, drugs and violence	

Source: from Virginia Dpt of Health - 2001

CHAPTER TWO – THE TDH PROGRAMME: THE RECREATIONAL CENTRES

2.1 The concept

For several years, it has become quite evident that the psychological damage after a disaster has been generally overlooked in humanitarian assistance. It is not enough to give bricks and mortar for reconstruction without concern for the traumas of tens of thousands, which notably block the process of rehabilitation of victimized populations and their future capacity to lead a normal life again.

Humanitarian organisations, worldwide now, are therefore beginning to integrate a so-called psychosocial approach into humanitarian programmes. Contrary to the notion of mental health, with its medical and psychiatric overtones, "treating" the victim according to a Western model of thinking, the psychosocial approach leads to systemic and globalising action: it seeks to ***take care of the psychological trauma through the dynamics of the community where the efforts of some have an effect on all the others***. It stresses also the need to draw on one's own resources in order to heal and rebuild, rather than being locked into an attitude of helpless victim. The notions of vulnerability and of at risk populations are replaced by the notion of protective factors and resilience.

Many studies relating to Western psychosocial programmes for traumatised persons have shown that the rate of relapse and of emotional and moral disintegration were notably lessened through the use of this approach, compared with medical models only.

This new conception of rehabilitation is particularly pertinent in the case of children. The simple fact of placing them in a "healthy" context in which they are given the necessary resources to recover naturally, particularly through play, has an immediate and positive repercussion on the adults around them. Families regain courage to rebuild and the helpers react positively, which the author could witness at quite a high level in Bam.

Play is central to the idea. Its aim after a disaster or even after a war is not necessarily to educate and improve learning, as it would be in a normal society at peace, but to rediscover the joy of living which will, indirectly, restore the path of learning. Moreover, it is well known that memory and the capacity to symbolise through the use of imagination, are the first elements to be hurt in the context of a trauma. Play contributes to restore them. It enables, for example, death and violence to be viewed in a symbolic form and thus provides a certain control over residual anxiety. Furthermore it is therapeutic to the extent that it re-socialises the child and prepares him for return to school.

2.2 Starting from the needs of the children in disasters

UNICEF has stated, in its Manual "Working with children in unstable situations" (2002), a number of needs that are at the crossroad of developmental factors and the post-disaster stages in recovery.

- As we have seen before, during the first three months, it is important to address the basic survival needs as well as safety and security issues, for instance through a return to a regular daily routine as soon as feasible.

- This helps build a sense of control which strengthens life skills and self confidence. Certainly school is central to this.

- Children also need a sense of empowerment. They should be encouraged to participate in the reconstruction of their community and not stay as passive victims in the face of terrible ordeals.

- More psychological harm after a disaster may be prevented if the child is cared for by supportive adults. Which means also supporting the caregivers's emotional and educative capacities.

- Furthermore, children need friends and a peer group to grow and develop social skills. It helps enhance a sense of belonging.

- Finally if these needs are taken care of, the children will have a chance to strengthen their resiliency and capacity to "bounce back".

General objectives of play activities

So if we start from the perspective of the child's needs, the objectives of such recreational centres should be to:

- normalize the life of children as soon as possible
- bring back security and safety to their surroundings by building on predictability;
- offer them a possibility to express and hopefully integrate their terrible experiences;
- help the children develop their coping strategies in order to face the hard consequences of the earthquake in their daily life,
- work inside a supportive network of families and peers
- give them community responsibilities as much as feasible.

Those objectives can be met through offering them:

- a child-friendly place with rules to abide by,
- where they can freely play, express their pain, but also look to a brighter future through activities that foster their development,
- animated by a caring staff who offers a quiet and resourceful support, in constant contact with families and the rest of the community.

We shall see that play is a highly interesting tool to reach those objectives. Tdh has started to develop an interesting model.

In the middle and longer term, the Centres will finally prepare the children to go back to school.

2.3 Building on the resources of traumatized communities

The psychosocial interventions start with an assessment of the needs of the shattered community. In the first months, the material needs will of course be in the forefront.
However, very quickly the more emotional side of the situation will be clearly witnessed, while social reorganization will gain momentum, providing a different angle on the needs of the traumatised group. The people themselves will begin to voice them and suggest what they are expecting from the agency, provided they are given a chance to speak out.

The role of a child friendly centre is unique here, as it is a potential forum to understand the needs of the whole community, as it is a focus point for all generations and gender.

2.4 The Tdh Recreational Centres – Objectives

Tdh carried out an exploratory mission to evaluate the needs for a psychosocial program for the children of Bam (Jan. 14, 2004). Those were also identified by the local authorities, UNICEF and other NGOs. At the time, resuming school activities was determined as top priority. (Table 2-1)

At the time of this survey in December 2004, there were 17 recreational centres that had been set up since early April, in line with the first objective of the program to target 5'000 children, with their families, and giving them "a ***safe place*** in the community". The following table gives more details.

2.5 Description of the Recreational Centres:

The children: 2'387 attended the Centres on a daily basis from early April on. Eight sub groups of children were determined by age groups: below 6 – 7-10 – 11-14 – 15-18, and gender (as in Iran boys and girls after 10 years old are not allowed to play together). They come in different shifts of two hours. Together with the other part of the programme which targets 4'000 school children from 10 schools, and other activities supported by Tdh in Bam, an overall 10'000 children were reached and helped within 10 months by the end of December, way over the original target. Each centre is supposed to accommodate at one time a minimum of 50 children and a maximum of 80. In actual fact, there was a mean number of 129 children per Centre attending, which is well over what had been initially planned.

The staff: the general management of the whole program was done by four expatriates, helped by approximately 20 local staff (office assistants, accountant, logistician, translators, drivers, cooks). As for field monitoring, seven female supervisors from Teheran and other northern cities, with an academic background in social sciences (min. BA) were recruited: 4 from Teheran, 1 from Kerman and 2 from Bam. Each one of them supervised from two to four Centres each day and coached a team of animators, which grew over the months to be over 120 at the end of the year. The animators, mostly aged between 18 and 25, were selected from the beginning in their respective community. They were required to have a high school diploma and recommendation by the Shuras of their own village. Further they were selected on the basis of their proven competence with the children after a trial of one month, as well as for their self-confidence, commitment and availability.

However, they needed some kind of basic training in order to be able to meet the needs of big groups of children of all ages. They were given basic psychosocial training in child development and Tdh's Child Protection Programme.The training and supervision were limited though for a number of reasons, one of them being all the time and resources given to creating new centres.

Links with families and community: The animators are part of the community where the Centres are and an active link with it. They have been through the same terrible ordeal as the children and the families they are trying to support, and as such they understand them more than anybody else, even if in the beginning their traumas and grief were more of a liability for their work. We shall see further though how their caring activities were a form of therapy for themselves over the months.

Mothers and female caregivers were encouraged in the beginning to stay with their frightened child until they would become accustomed to the place and further on participate to some of the activities. They also come to "tea parties" once a week in their Centre; they bring feedbacks about the progress or problems of their children, as well as their suggestions as to what could be improved. Fathers or family male figures however were not part of the
Centre's everyday life, but were encouraged to follow the local sports activity program (Sports clubs).

The recreational activities: they were classified in three categories: sports and physical activities – artistic and creative activities – psycho educational activities. As a component of the program, a total of 50 excursions were organized to different places in the region, for recreational and cultural purposes. Some 1'507 children have taken part during the summer of 2004. Other activities are supported in a form of partnership between Tdh and other associations, such as sports clubs, as well as educative ventures (kindergartens…). More will be said in the chapter on play.

In addition, hygienic kits were distributed. And snacks were giving twice daily.

The sites: each Centre consists of a tent or a container, a play ground for football/volleyball and with other game facilities (roundabouts, slides, swings, etc.) – water – latrines – compound fence – an air cooler.
The selection of the site was originally done by the local authorities (shuras) with Tdh giving technical support to select safe environment and accessible for all children in the community. Accordingly there was a local participation from the start in the development of the project and corresponding to the criteria selected by the Ministry of Health: security, accessibility, convenience and in a well known location.
The rules applied are the ones of basic child protection. A guard recruited from the community is appointed to each centre, even sleeping there to protect the site from vandalism during the night. Actually, the whole site is under the responsibility of the community which is of course an empowering element of the programme.

The Referral System for the more vulnerable children: it was agreed, in the Memorandum of Understanding signed with the Iranian government, that the Tdh would install Centres, equip and facilitate the recreational activities and that the Ministry of Health (MoH) would assign health professionals to work with the children in the Centres. The Tdh team of supervisors and animators were to refer all the cases identified as pathological to the psychologists of the Ministry of Health, who would then "carry out their consultations, debriefings or working groups in the Centres' facilities". Initially, a meeting was also "planned on a monthly basis with relevant authorities to share experiences and debrief animators".

From April to August, the MoH appointed professionals from various universities, who visited and insured psychosocial support to the vulnerable children of five Tdh Centres. They came to work in the tents with both children and parents.
According to information gathered from the mental health professionals there, the chosen counselling model for treatment of the traumatized children was based on the Brief Trauma and Grief Model of AK. Goenjian et al., created in Armenia after the 1996 earthquake. It is a cognitive and behavioural model and consists of four 45minute group therapy sessions and two one-hour individual sessions over a three-week period. There are five issues that are addressed in each session: the traumatic events, the traumatic reminders, stress and hardships after trauma, bereavement and secondary stress. A follow up was done for some month, but on irregular intervals.

The outcome of this psychosocial work is not quite clear at the time the author was in Bam, probably for lack of mental health staff from the Ministry of Health. No assessments and figures were produced that could have been addrd to this survey. It must be said however that after the earthquake, all institutional structures were also completely destroyed.

Network with authorities and the humanitarian community:
From the start, Tdh has built an important network with the Iranian institutions and international community. The first days after the earthquake, all humanitarian interventions by over 80 NGOs were coordinated by an Iranian Task Force. Tdh started then to build a close connection with the Ministry of Health and the Ministry of Education, who continue to collaborate in the implementation of the Program, based on a Memorandum of Understanding.
Also, since the beginning, Tdh has knit a very close collaborative network with the local authorities (Shuras) of each village where Centres were built. Each Shuras was to select the site for the tent and play field, choose the animators and register the children. They are responsible for the place and the equipment.

Monitoring: a daily follow up and feedback, mornings and afternoons, by the supervisors to the Project Coordinator was the main source of assessment and evaluation of the progress done. The supervisors spent their day going from one Centre to the other to support and coach the animators, pinpointing the problems, acting as mediators between the animators and some parents or local authority if necessary. There was also weekly follow up meetings for the supervisors and written

reports done by the animators for each child. Regular and periodic visits done by the Project Coordinator to the Centres and the Shuras. There were also regular meetings with the Mental Health Department professional. The well kept reports and statistics, definitely helped to build the survey.

CHAPTER THREE – APPLYING A PSYCHOSOCIAL FRAMEWORK

3.1 A problem of definition

While there has been in the last few years little dissent about the need for psychosocially oriented interventions in humanitarian programs, there is growing concern and debate about the definitions and effectiveness of the different activities put under this heading. A concern of the donors also, who increasingly ask NGOs to be accountable for their achievements in the field.

The confusion starts though around definitions, principles and types of activities. Because of the mental health model used almost exclusively until recently, some agencies remain focused on counselling and see psychosocial work as counselling alone. Others want to stay away from counselling at any cost and use the communities' social resources to cope with the aftermath of disasters. However, organizations are increasingly aware of a paradox: it is not possible to put a trained psychiatrist or psychologist, international or local, behind each victim. On the other hand, ignoring the traumatic aspects of the children and communities experiences empties play activities of their efficiency.

But there is even a greater confusion in labelling what are "psychosocial interventions"? What kinds of activities are proposed under that heading? One may find activities ranging from an explicit psychological or medical service, to training on issues such as child rights, conflict resolution or peace building, and as varied programmes as interpersonal skills for community members and supporting social networks in a community or the strengthening of spiritual dimensions.

For instance, it seems obvious that recreational centres are a typical psychosocial kind of intervention. Why? Because the children in Bam are definitely one traumatised by the earthquake and in need of psychological support; and the intervention is taking place in a well defined social setting: a city and a number of surrounding village communities that have been stricken and are struggling to come up again, and based on drawing from their social resources and skills.

Last January 2005 in the wake of the tsunami tragedy, a group of agencies (IRC, Save the Children UK, UNICEF and WVI) has proposed the following definition: "The expression psychosocial refers to the dynamic relationship that exists between psychological and social effects, each continually inter-acting with and influencing the other. It impacts the cognitive, emotional and behavioural aspects of individuals and communities through a number of interventions". The organizations here have forgotten to say that this "dynamic relationship" takes place in the context of emergency operations.

Best practices in that new field are painstakingly being drafted, with varied results. I shall refer here to the pioneering work of the Psychosocial Working Group in London (www.forcedmigration.org/psychosocial). Many other institutions or programs however are in the process of defining the field and coming up with guidelines and principles.

The two main points that stand out in this groping effort, are first the belief that it is central ***to empower*** the communities and help them regain control over their own lives as soon as possible. A second focus is to help them develop their resilience in the face of disasters and their coping skills. It is the more important when addressing children. Those two major principles are at the basis of the Tdh programme, as we shall see. Actually they have been basic to all Tdh's development programmes since its foundation.

3.2 Principles for psychosocial program implementation

During the last six or seven years, the debate over the mental health versus the psychosocial issue has led many international experts to try and define guidelines and at least minimal standards and principles to achieve sound psychosocial programs in complex emergencies.
For instance, the above mentioned group of agencies has proposed a few of them in the wake of the tsunami, such as:

- the starting point of a rehabilitation programme should be the different degrees of ***psychological distress*** suffered by the beneficiaries, including the children;
- once basic survival needs as well as safety and security are met, most children and adolescents ***regain normal functioning;***
- the beneficiaries should be offered ***empowering activities within a safe environment;***
- children should have the opportunity to ***talk about and express*** their painful memories and emotions;
- "trauma counselling" ***should never*** be the point of departure for psychosocial programming;
- psychosocial programs should provide a ***caregiver-focused section;***
- all psychosocial interventions should be respectful and grounded in the ***culture*** (supporting grieving practices and rites).

3.3 Tdh's application of psychosocial principles

Let us examine now how close the Tdh Programme has come to these psychosocial guidelines. This should give us a frame of reference to point out the stronger and weaker aspects of it.

General Psychosocial Principles	Tdh Programme
- Initial appraisal defining the needs of the victims	- Done two weeks after the earthquake.
- Negotiation with the community on the programme	- Done very early with MoH and MoE, and with the shuras for the creation of each Centre. Regular monitoring with the Community thereafter.
- A supportive role, not a leading one	- A leading role was necessary to start the project off the ground and implement it in the midst of rubbles.Phase of socio-education of the community was necessary for smooth handover at the end.
- A supportive role in the social post-disaster transformations of the community, if wanted by it.	-Transformations seem to be more of a political nature right now in Iran. Tdh is an independent organization, fighting for the Children's Rights, with no political affiliation.
- A programme empowering the community.	- Helping children empowers their immediate environment and indirectly the whole community.
- Normalizing daily life	- All activities and schedule are focused toward normalization.

General Psychosocial Principles	Tdh Programme
- Acknowledging the reality of trauma and building the programme from there.	- Tdh programme is more " socio " than "psycho Focuses more on resiliency than trauma. The Iranian MoH referral system should have catered to this, but was ineffective presumably for lack of personnel.
- Structured, normalizing, empowering activities from the start of the programme	- "Trauma counselling" was given too soon after the disaster by the referral system.
- Possibilities for the children of expressing and sharing painful experiences, grief and worries.	- Specially through the creative and artistic part of the recreational activities. No particular support to the grieving rituals of the children and communities.
- Developmental opportunities.	- Too many offered (more than 40 activities) and not sustained enough on the longer term.
- Safety and security needs met from the start	- Programme set in the Child Protection concept of Tdh. The Centres are safe proofed: fence, one guard per centre, reliable staff, regular schedule…
- Supportive psycho-education for the animators and families.	- Apart from "tea parties" for mothers, no real support system for the adults living with the children. What about fathers?
- Grounding of all interventions in the local's culture and values	- Many excursions in summer, festivals, exhibitions, etc…
- Have in mind a return to school as soon as possible	- This is the focus of the second section of Tdh programme.
- Have discussion groups with the children where they can ask questions and voice their concerns and hopes.	- The psycho education activities include those. However, they have been done at random with no strategies/objectives. No follow ups either. Should be animated together with the psychologists from referral system.
- Preserve and reinforce family cohesion;	- Too few activities with families, especially mothers;
- Training of the supervisors and animators on psychosocial issues ; regular supervisions and case analysis.	- Little training and occasional supervision with the Supervisors.

Table 3-1

3.4 A different starting point: a child centred approach

As we may see from this listing of applied principles, the overall programme can definitely be defined as a psychosocial one. Perhaps slightly more "socio" than "psycho", in the sense that the only part that addresses the children in their deep suffering through the referral system did not really work out as initially planned.

Another point stands out as having taken the leadership role instead of focusing on more support to resilient mechanisms. Perhaps this has come from a more managerial way of organizing and working with the people. One may argue though that in a situation where a whole population is in a state of shock, someone needs to take the leadership, at least in the beginning.

However, I believe that the starting point of the programme should be more child-focused and not structurally focused. The following diagram shows a top to bottom set up of the program (Diagr.3-2).

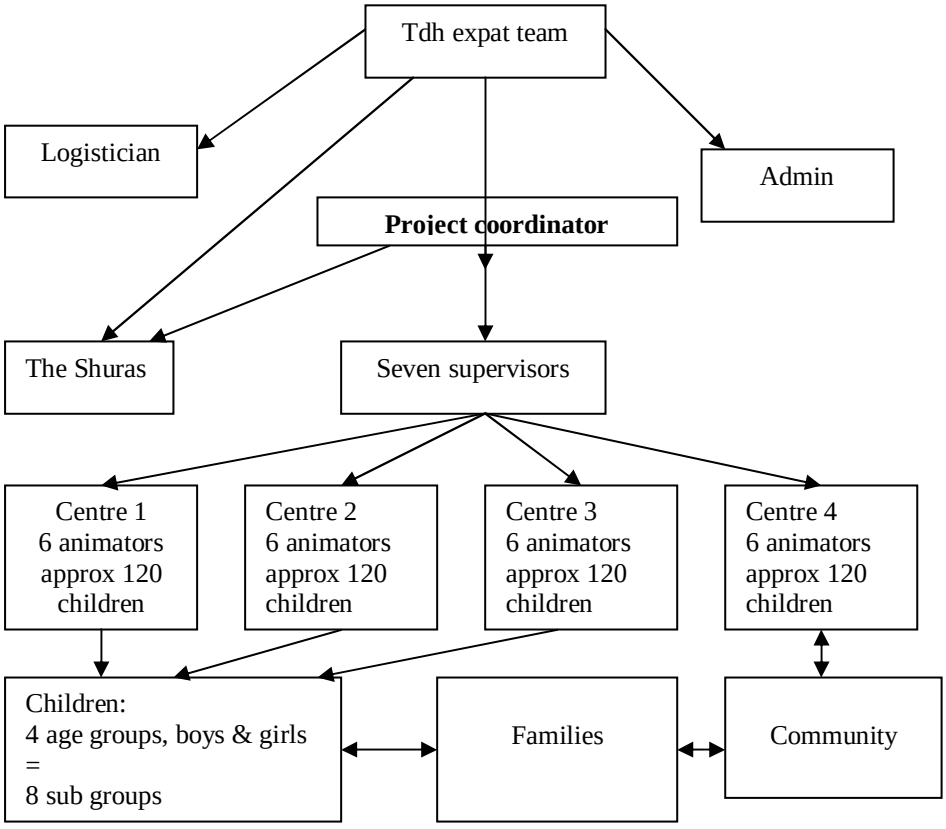


Diagram 3-2 A structural approach to the programme

A model that would be child and family oriented instead would put the emphasis on their psychosocial needs first, define them and then start from there (Diagr.3-3). It would also work more on the relationships between the stakeholders, their communication system in the context of distress, and finally on the best ways to help them cope. Perhaps the conceptualisation of such a model would look like the following:

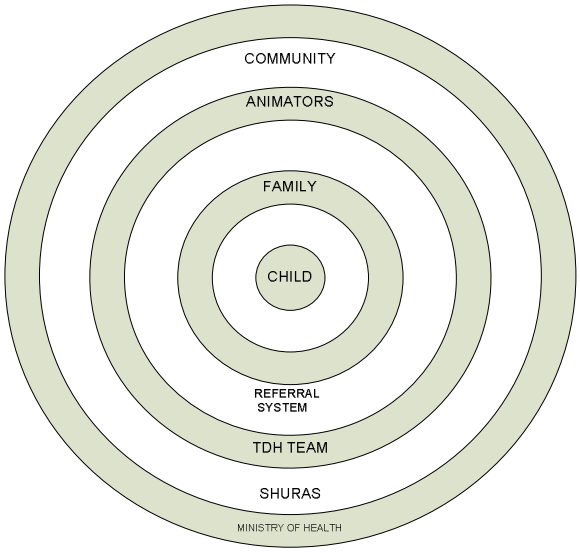


Diagram 3-3 – A child-centred approach to the programme

The centre of this dynamic structure is a triad that takes into account, in an interactive way, the child, the family/mother and the animators. If one wants the role of the agency to be rather a supportive than a leading one, this triad is going to be the motor and the shaping factor of the program and the decision process will start from that reality (Diagr.3-4).

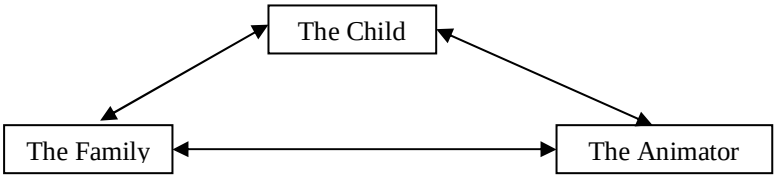


Diagram 3-4 The core of the Centres

Ultimately of course, this has been the case, even if most decisions, of a material nature such as setting up the logistics of the Centres, choosing the kit of toys or organizing excursions, have been done "for" the children's sake. However, one may see that mothers, for instance, were not supported as a group in their struggle towards their own recovery, even though they had occasional tea parties. And the potential role of fathers or male figures was not taken into account either. Perhaps also the children themselves could have had a voice in the organization of their activities and more responsibilities in the community.

Moreover, a better focus on relationships and communication instead of the more material aspects of the activities would have helped define what was really needed, and perhaps discard or not even consider some of them. We shall see in the chapter on Play, that too many activities were taken up in such a short period, and sometimes even abandoned, which took a toll on the budget. Perhaps just focusing on activities such as drawing and playing football during such a short period of 10-12 months could have sufficed, taking more time to support the parents in their distress or giving more psycho-educative training to the animators.

Finally, the objective of targeting 5'000 children in a few months was a heavy one for the team, especially in a perspective of an efficient leadership that was asked of them.

3.5 The staff and training

In the above mentioned triad, one of the major element is the staff, namely the animators, who are the direct link between the Programme and the community. Structured support to them is essential and an additional guarantee for the programme.

As said before, they have been through the terrible sufferings of the earthquake, just like the children and the mothers/caregivers, and some of them last December, were still living under a tent in terrible solitude, having lost all the members of their family. However, the support structure of the Programme is well thought out and structured. The coaching of the supervisors is certainly a guarantee that the animators have the energy and dedication to give all their time to the children in the best possible setting.

We can see therefore that a strong support network is the condition for a good functioning of the animators. Besides, other factors have helped them: being integrated in their own community thanks to their role in the Centres, with a responsibility in the reconstruction plan, which gives them a sense of empowerment and self-esteem.

However, they remain vulnerable. Perhaps they could benefit from:

a. Regular focus groups where they could share their grief and fears in a supportive environment, where they feel they are also taken care of;
b. some light psycho-educative training, with a skill building approach and solution oriented;
c. and supervisions by their supervisors for the more difficult cases they encounter in their work.

This can only take place if the supervisors take up again some kind of training. They have already been through two major training sessions: Counselling techniques and Child Protection. However, there was no follow up and they are in demand of some kind of supervision with case analysis. They could also benefit from the setting up of a peer-support system, involving them together with the animators.

CHAPTER FOUR - THE SURVEY AND RESEARCH

4.1 General considerations

The initial objective of the mandate was to understand how and to what extent the recreational activities of the Centres had been able to help the children overcome their condition of distress and set them on the road to recovery.

If the author has placed so much stress in the previous chapter on the concept of psychosocial intervention, it was in order to define from which conceptual basis the data from the research would be quantified or qualitatively analysed, or in addition which indicators we could use to make this evaluation: should we start from the medical model of trauma, for example, or the psychosocial one that chooses the concept of well-being as its focus, a model based on mental health, or a more holistic and systemic one? Or one based on vulnerability or one based on the faith in resilience?

For the past ten years or more the quantification of traumas has been facilitated by numerous questionnaires relating to Post-Traumatic Stress Disorder (PTSD). These have a recognised scientific basis, at least within Western cultures. Theoretically speaking, at one end of the spectrum, they yield an interpretation of mental and behavioural problems as having essentially biological. The hypothesis here is that they are therefore universal, and can be applied to any societies. At the other extreme, trans-cultural psychiatry positions those in the context of a specific community. Some of the evaluation tools though have been successfully validated in numerous countries, including a majority of developing countries.

In the case of children, these questionnaires target the individual independently of the social and cultural context. And there are very few of them which are based on a psychosocial concept which integrates the child in a dynamic way within the context of the family and community, and not necessarily pertinent in a disaster context. Thus in the coming years, a new field of research will be opening up to help evaluate humanitarian programmes and to monitor them in a more scientific way.

The quantitative survey: methodological difficulties

Right from the start, the methodology of this research was difficult to install. Indeed no questionnaire had been administered by the team in the field when the first Centres were opened in April 2004, which would have enabled us to assess the degree of trauma of the children. We would have had then a baseline to determine whether or not the recreational activities had had any impact on them.

We were able somewhat to overcome the problem, knowing from the beginning the limitations of the steps we were taking, by comparing the group of children who had attended the "old" centres with a control group of children who were starting to attend the "new" ones. The first twelve centres had been opened a few weeks after the earthquake, then five new ones inaugurated in November and December 2004, around the time the survey was launched. All the children who had been victims of the earthquake on the same day had at least a common base, namely the same time span since the earthquake.

The choice of instruments

Two questionnaires were chosen, the Child Behaviour Check List (CBCL), and the Davidson Trauma Scale.

A. The Child Behaviour Checklist (CBCL) is a quantitative instrument and, as just said, designed to define child behaviour empirically. It can be used also to measure a child's change in behaviour over time or following a treatment. A checklist of 113 questions records the behavioural problems and competencies of children aged 4 through 17, through three questionnaires, all with a similar list of 113 questions, addressing:
    - parents/caregivers
    - teachers, educators or others who know the child well (the animators in the case of Bam), and
    - the youths themselves.

    The questionnaire for the animators and the parents/caregivers is based on observation. The one for the youth is self-reporting, though with the possible help of an animator.

    It is scored on a 3-point scale, 0 =not true, 1=somewhat true, and 2= very true. It has a high test-retest reliability and validity of 0.84 to 0.97. The instrument provides three scores: a total score and scores on internalizing behaviours (fearful, shy, anxious, and inhibited) and externalizing behaviours (aggressive, antisocial and under controlled). Quite a few questions refer to the PTSD symptomatology, however not essentially focusing on it.

    The choice of the CBCL was made because, a year after the disaster, it was thought to be better to move away from the realm of trauma strictly speaking. The focus of this survey is on the psychosocial approach and not a mental health one. The CBCL is a fairly general questionnaire describing the behaviours and skills of the child. It was also chosen because, from its creation in 1978 by Dr. Thomas Achenbach, it had been translated and validated in 61 countries, including Iran. Finally, we wanted to be able to evaluate possible progress more in a child developmental framework.

    The CBCL questionnaire, as filled in by the animators, concerned the previously defined four age groups: below 6, 7-10, 11-14, 15-18 years old. However the parents' questionnaire, mostly for lack of time, was addressed only to the age group of children below-6. And the self-reporting youth questionnaire was filled in by the 15-18 age group, but for lack of more time was not developed in this survey.

B. Apart from the CBCL instrument, another quantitative questionnaire, the Davidson Trauma Scale, was given to the mothers or caregivers of the below-6 age group. It was hypothesised that the PTSD of the mothers might curtail the resiliency of their child.

The Davidson Trauma Scale is a 17 question self-report and brief measure used for Posttraumatic Stress Disorder. It is designed to cover all types of trauma, including natural disaster and bereavement. It has been widely used so far. The 17 items cover the symptoms of trauma as described in the DSM-IV, a psychiatric diagnostic manual used world-wide. It was chosen for this survey for its brevity and relative ease to administer through interviews by the animators, who sometimes were hardly literate. (Table 4-1). The CBCL for the youth was filled by N = 123 in the 15-18 age-group.

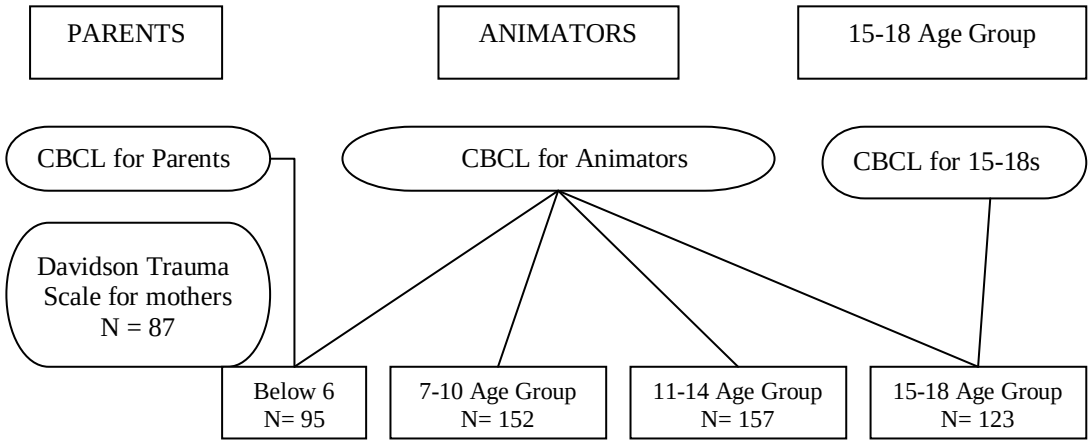


Table 4-1 Organization and implementation of the questionnaires

An adjunct to the quantitative survey

A short qualitative survey had been initiated by the Tdh field team during summer 2004, and added later on to this survey. It targeted children (N = 65), parents (N = 25) and animators (N = 49) who were interviewed on their perception of the various recreational activities. Permission was given to use the outcome of this qualitative survey and merge it into the quantitative one as deemed fit. The full results of this survey are to be found in the Appendix.

4.2 The methodology

Time frame:
The survey was conducted during three weeks, between December 3 and 17, 2004. This was a very short time span to collect data from the 832 questionnaires distributed. But thanks to the patience and energy of the whole team, this was done very smoothly.

Target and sample population:
The population targeted was an overall figure of 527 children, 281 girls and 246 boys aged from 6 to 18 years, out of a total population of 2387 children attending the recreational activities from the beginning. They were selected at random amongst the 17 existing centres, both the 12 "old" ones and the 5 "new" ones.
In order to operate a comparison, the total targeted group of 527 children was divided into two groups, the basic one and the control group, with approximately equal numbers of children in each. The survey covered all age groups: below 6/ 7-11/ 12-15/ 15-18, divided each into boys and girls, which thus defined 8 sub-age groups. Random choosing of children was done in order to have as equal as possible number in each sub-group for each Centre and the two main groups. Besides the whole group of children, 87 mothers of the below-6 age group were selected at random and interviewed for the Davidson Trauma Scale questionnaire. They were also the same that answered the CBCL parent questionnaire for the below-6 age group.

Translation:
The questionnaires were translated into Farsi (Persian) by an Iranian, then double cross-checked by the supervisors and then by the animators from the team. It should be mentioned that no pre-test has been made, as the two questionnaires, the CBCL and the Davidson Trauma Scale, have been largely validated in Iran.

Training of interviewers:
In order to ensure a maximum efficiency in the survey implementation and a fairly reliable data collecting, with a team that was not a professional one, two 6 hour sessions were given to 60 animators

divided in two groups, together with the 7 supervisors. We first explained the survey in great details, underlining the pitfalls. Then a focus group was held about their own possible post-disaster distressful symptoms and they filled in the Davidson Trauma Scale for themselves which they later would give the mothers. They then role-played the interviews and finally built the protocol to be used in their centre, with the help of their supervisors. It then took one week to have all the 800 questionnaires completed.

The outcome of the training sessions insured a very smooth implementation. Three out of six animators per centre were chosen to monitor the questionnaires. They were chosen by the Supervisors on the basis of academic level, demonstrated competence with the children, personal maturity and morality.

4.3 Procedure and implementation

1. Packages of questionnaires were handed to the animators by the Supervisors, who came every morning and every evening to TdH office to report. Their role was to monitor carefully the whole process within each centre.
2. The filling of the CBCL Animators' questionnaire was easily and quickly done. Supervisors encoded them.
3. Interviews of 87 mothers/parents was well prepared during the training through role plays and went smoothly, including the recording of informed consent.
4. The 15-18 sub-group of 110 individuals was given the CBCL for youth with no major problem. An animator was available for questions from each teenager upon request.
5. Supervisors cross-checked each questionnaire before they were computerized.

4.4 The Statistical Results

<u>Demographics</u>

1. Child population surveyed N = 527
2. Four age groups – boys and girls:

Below 6/Boys-Girls		7to10/Boys-Girls		11to14/Boys-Girls		15to18/Boys-Girls	
50	45	65	87	81	76	55	68

Total boys N = 251 - Total girls N = 276

3. Orphans (fathers and/or mothers):
   total:17.2%; girls: 14%; boys: 21%.

4. Handicaped (eye sight and locomotion): 1.2%
5. Socio economic status of families:

Socio economic status of families	%
1. Farmers (25%) 2. Shopkeepers/small business (2.4%)	27.4
3. Civil servant	17.64
4. Independent	23.7
5. Other (often daily workers)	18.8
6. Jobless	5

The Results of the Child Behaviour Check List (CBCL)

A. Data of the total BAM Sample

On the total sample of 527 children (N=527) the mean score is 51.67. According to the Iranian validation, this score was found for the clinical group of children (i.e the children with problematic behaviour), whereas the non-clinical group scored lower at a mean score of 30.0.

With a cut-point of 45, the distribution of subjects is as follows:

	N	%
Normal range (0 to 45) Clinical range (46 and above)	243 284	46 54

(A **cut-point** at 45 points was used to categorize children into two groups: normal range is at or below 45, clinical range is at or higher than 46 points, i.e a "normal range" is one of healthy children, whereas the clinical range define children exhibiting symptoms of trauma and still at risk).

This means that the general level of problematic behaviour at the time of doing the survey in December 2004 was still quite high. As we do not have a way of comparison, as previously explained, we cannot say if there has been a definite progress since the opening of the Centres, just by referring to this total score.

B. Length of attendance: impact on children's level of well-being

However, the following results answer the main objective of the mission to Bam, namely to evaluate the positive or negative psychosocial effects of the recreational activities on the children attending the Centres.

The results show that the CBCL mean score ***is significantly lower for children having participated during 10 months or less***, than for children having had a maximum of three weeks of attendance in the Centres (p.000). The first group scores below the clinical cut-point with a mean score of 44.99, while the second scores higher, within the clinical range, with a mean score of 58.32. (Fig. 4-1)

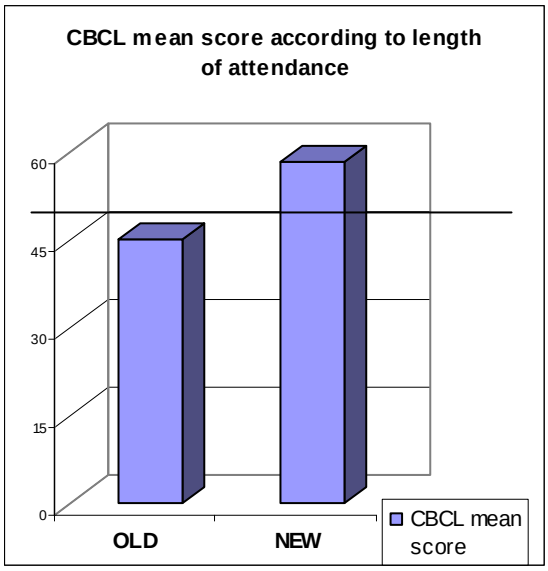


Fig. 4-1

1 = New Centres (average one month of attendance)
2 = Old Centres (average of ten months of attendance)

In terms of percentages, the difference is even more evident: 45% of children from the "old" centres have a clinical score, 55% a non clinical one; while 63% of children from the "new" Centres have a clinical score and only 37% a non clinical one. (Fig. 4-2)

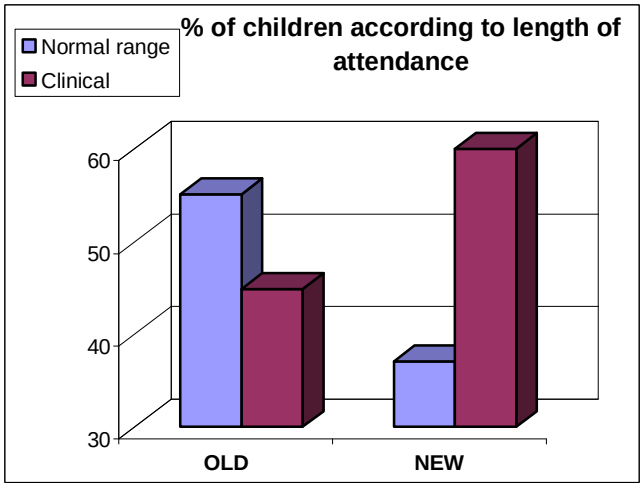


Fig. 4-2

	% Normal Range	% Clinical Range
Old Centres	55.13	44.87
New Centres	37.12	62.87

This general result provides an answer to the main question of the study concerning the benefits of recreational activities during the first phase (10 months) after the earthquake. These activities definitely had a "therapeutic" effect on the distress of the children. We shall discuss in the next chapter the process underlying these effects.

C. Differences between the "old" and "new" Centres

If one examines the results differentiating the recreational centres, it is worth noting that the mean score of some of the older ones is highly clinical, and some of them are similar to the clinical level of most of the new Centres. This finding could be explained by the fact that some of the older problematic centres are located in parts of Bam which have been particularly affected and are slow in reconstruction – or that the communities where the Centres are, are themselves badly hurt and highly dysfunctional. It would be interesting to have further empirical testing of the differences between Centres, which could become part of a monitoring system based on results in progress, both of children and community in general.

D. Differences in the CBCL according to gender

In the total Sample, CBCL mean score of girls (n=281) is significantly lower than the boys' mean score (n=246) (p.000), as shown in Fig. The latter falls within the clinical range, above the usual cut-point of 45 between clinical and non clinical range, whereas the girls' mean score, is just at the cut-point. (Fig.4-3)

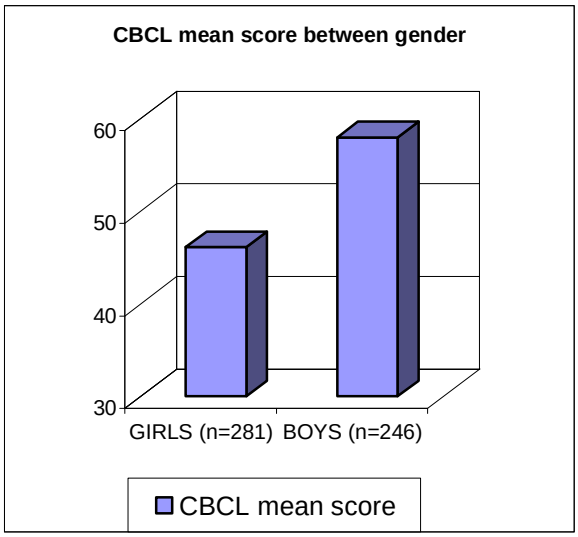


Fig. 4-3

The behaviour problems of the girl population are significantly lower than the boys'. This finding is actually quite well known in gender issues within and outside psycho-traumatology studies. In the wake of disasters affecting whole populations for example, women usually get by more easily than do men. Also child development studies as well as recent studies in psychopathology and in genetics, particularly with school age populations, document the same differences between genders, in many countries, including in developing countries

In the group of girls, with the cut-point of 45 as previously, 47% of them have a clinical score and 53% are in the normal range, while in the group of boys, 62% of them have a clinical score and only 38% scored in the normal range (Fig.4-4).

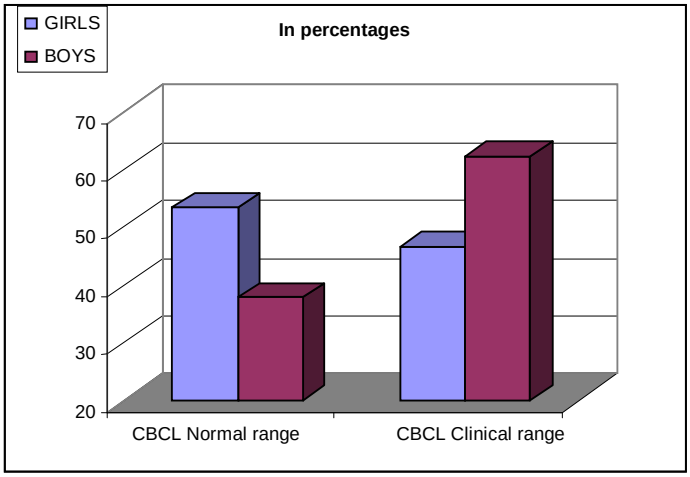


Fig. 4-4

E. Summary of the CBCL results

1. The main findings show that there is a positive confirmation on the role recreational activities have had on the level of rehabilitation of the children who attended the Centres.

   However, even if the overall result is positive, breaking down the results between the two groups of "old" and "new" centres shows that half of the children, that have been attending the centres since last Spring show a level of dysfunction which is as high as children attending some of the new centres.

2. The results also show that the girls' population is doing better than the boys'. They are usually within the normal range or very close to the cut-point.

4.4.3 The results from the survey with the Davidson Trauma Scale(DTS)

The initial hypothesis was to see if the resiliency of the children (boys and girls) below 6 was affected by a possible PTSD of mothers/caregivers (M/C).
A total population of 83 M/C's (N = 83) of children below 6 attending the Centres, both the "old" and "new" ones, both filled in the CBCL for parents and were interviewed for the Davidson Trauma Scale (DTS) by the trained animators.

A. Mothers/caregivers (M/C) general level of PTSD

The first finding was the general level of PTSD of the Mothers/caregivers (MCs) in the targeted population. The theoretical score in the DTS varies from 0 to 153.

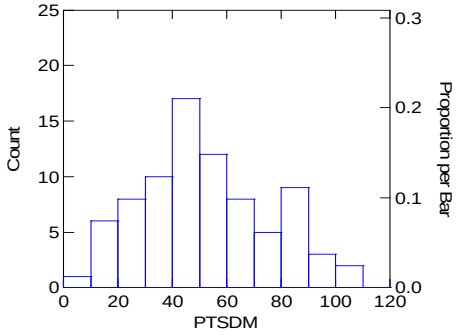


Fig. 4-5

The observed mean score here is of 52.4, on a normal distribution that goes from mothers with a low mean score of 4.2 and a high mean score of 106. This means that ***not all mothers suffer from a post traumatic stress disorder*** and that the level of the disorder in the average mother is below the theoretical mean score of 76. (Fig.4-5)

B. PTSD of mothers/caregivers and their socioeconomic status

Our results show that the level of trauma of the M/Cs is significantly associated with the socio economic status of the surviving families, as may be seen on the following chart:

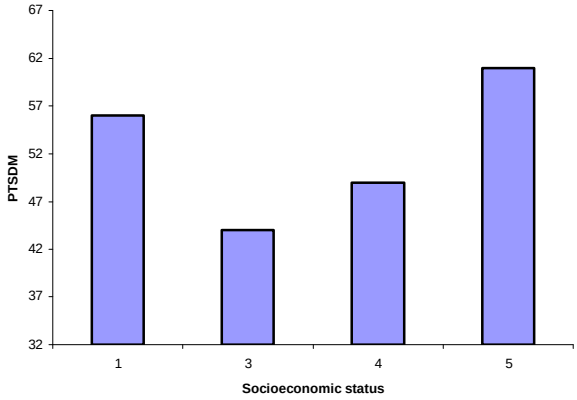


Fig. 4-6

SES1 & 2 = Farmers and shopkeepers/small business
SES3 = Civil servants
SES4 = Independent workers
SES5 = Other and jobless

The M/Cs in the farmers' and shopkeepers' class (SES1&2) have the highest level of PTSD, together with the ones from families with casual jobs or jobless husbands (SES5), whereas the M/C from civil servants (SES3) or independent workers' socioeconomic classes (SES4) show lower levels of PTSD. This association between socioeconomic status and trauma is highly significant.

As has been said previously in the general information table, half of the 527 children of the survey population have fathers or male figures in the family who do not have a decent job or are jobless. When one adds the horrific figure of 50% for the addicted male population in Bam, staying at home or wandering about mostly for lack of work and/or PTSD, this gives a dark picture of the family setting of the children attending the Centres. (Fig.4-6)

This speaks in favour of extending more support to the families of the children attending the Centres in order to maximise their rehabilitation.

C. PTSD of mothers/caregivers and CBCL children

Our results show a weak and non significant correlation (r=.128) between PTSD and the CBCL for parents. This means that the level of problematic behaviour of the children is not necessarily associated with M/C's level at the DST, even if there is a tendency for the PTSD of mothers/caregivers to burden their children. (Fig. 4-7)

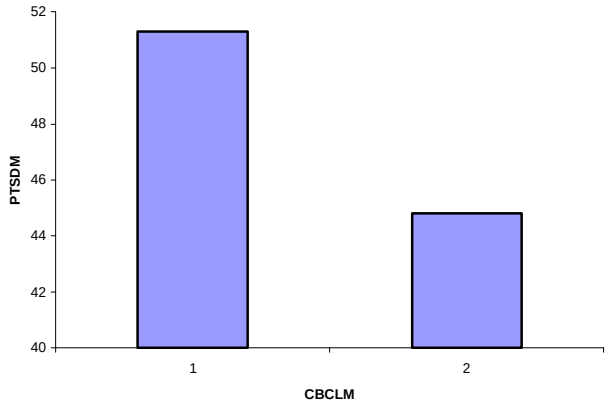
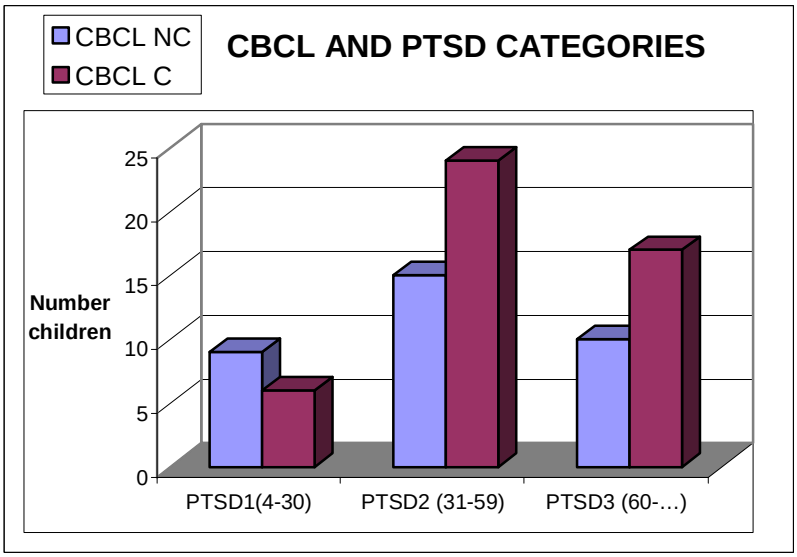


Fig. 4-7

PTSDM = Davidson Trauma Scale
CBCLM = CBCL for parents/mothers filled in by the mothers of children below 6

1 = Clinical range (C)
2 = Normal range (NC)

The next figure shows that when M/Cs' distress have a result at the DST higher than 30 (PTSD2; PTSD3), then children are more often in the clinical range than in the normal range at the CBCL, whereas the reverse is true when mothers have a low score at the DST (PTSD1). (Fig.4-8)



NC = non clinical C = clinical

Fig.4-8

Thus our initial hypothesis is not statistically confirmed – namely that the children below 6, being closer to their caregiver by nature would suffer directly from their caregivers' trauma, even if there is tendency in that direction.

Three main reasons can explain this result:

- First, as mentioned earlier, only 27 mothers (PTSD3) still suffer from full fledged PTSD, while the remaining show a low (PTSD1, N=11) or mild (PTSD2, N=39) level of post-traumatic stress.
- Second, as was also mentioned earlier, children below 6 show a lower level of behavioural problems than children between 7 to 10 years old.
- Third, according to a multifactorial perspective, several other variables, not addressed in this study, could have a mediating effect on the relationship M/Cs' trauma and children's behavioural problems.

Nevertheless, one may wonder what are the protective factors which help the children develop their capacity for resilience, and the recreational activities in the Centres are obviously one of those factors. This interesting topic would need another survey focusing on the protective factors in the context of a disaster.

D. CBCL filled in by mothers/caregivers and animators

This part of the study allows us to compare two points of view for the same group of children (the ones below six), through the CBCL questionnaire for the parents and the one for the animators (r=.35, p.001). (Fig.4-9)

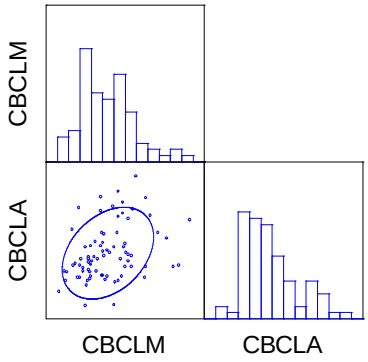


Fig. 4-9

CBCLM = CBCL filled in by the mothers/caregivers
CBCLA = " " " the animators

This result is important because it brings a validation of the procedure adopted so far in the study, and allows us to extend and give credit to the results found for the total population of 527 children.

This also validates the use of the CBCL in this survey as a coherent instrument.
Overall, the quantitative results of the study validates the work done in the Centres by the animators and strongly speaks for their pertinence in their way of relating to the children.

4.4.4 Summary of the Davidson Trauma Scale survey

Our findings in the DTS show that:

- ✓ The level of trauma of M/Cs is in the middle range at the time of the survey.
- ✓ The level of trauma looked at from the angle of the socioeconomic context is greater for farmers, shopkeepers, independent workers (daily workers?) and jobless husbands than for civil servants. This is self explanatory…
- ✓ The traumas of the M/Cs do not really prevent their child from getting better. More research should be done in the future to confirm this and help better understand what are the protective factors.
- ✓ The whole study validates the work done in the Centres, the work of the animators as well as the use of the CBCL questionnaire.

CHAPTER FIVE - PLAY AS A FUNDAMENTAL HEALING TOOL
Second Part of the CBCL Survey

5.1 The importance of play in the Convention on the Rights of the Child

In Article 31, the Convention on the Rights of the Child recognizes play as one of the important rights of children: "State Parties recognize the right of the child to rest and leisure, ***to engage in play and recreational activities*** appropriate to the age of the child and to participate freely in cultural life and the arts."

Why is play so important and why is it recognized by the international community as a right? And why is it even more important when a disaster strikes?

It is worth noting that play has a unique role in a psychosocial approach to disasters, compared with a medical mental health model, which would bring principally therapeutic tools to address the distress of children. Play has a more holistic quality bringing as well into focus the community resources at all levels.

5.2 The phases of child development in a post disaster context

In order to have a better idea of what the Tdh Programme has done for the children of Bam in the area of recreational activities, it is important to have a broader view and understand the impact of play on the child's development and see how disasters disrupt it:

1. From 0 to 3 years old, play helps the child build a world of his own without the mother and outside of her influence. After a disaster, a child of this age tends to cling to the caregiver and cannot get rid of his fears alone. Play has this role of gently separating the child from the mother, bringing back an attractive world which in turn can protect him from the distressed adults around him.

2. From 4 to 11 years old, "make believe" games through role play help the child build a world of limits and rules, important for the socialization of the child and where community traditions and cultural values are learned. Disasters tear apart the family and the community network, as well as more intimate relationships. A child then needs to rebuild his social fabric. Play does just that.

3. At the age of puberty (12-18), play gets youth closer to the adult reality, through flirting with danger, sex and transgression of the collective rules. If the adolescent has not been able before to develop all the psychological capacities necessary to meet with future challenges of life, cognitive, emotional, physical, spiritual, there is little chance that he will be able to function properly. He can even become a liability for his community. By disrupting the social fabric, disasters engenders chaos and breeds violence, drugs and economic distress. Adolescents and young adults then have a hard time to position themselves in such an environment. It is imperative to help them link up again with their community and give them a sense of belonging, by giving them responsibilities in the reconstruction project.

5.3 The CBCL and the age groups

Disasters then impact different age groups differently. This is why it is so important for Tdh's Centres to address each one in a different manner. And it does:
as we have previously seen, the Programme proposes four age groups, which correspond approximately to the development stages we have just described. And from 10 on, each age group being divided in the two genders, this leads to eight sub-groups.

The mean age of the whole child population is of 10.28 years. As shown in the next figure, the "new" Centres have a younger population (10.2) than the "older" ones (11.2), but the difference is not significant. (Fig.5-1)

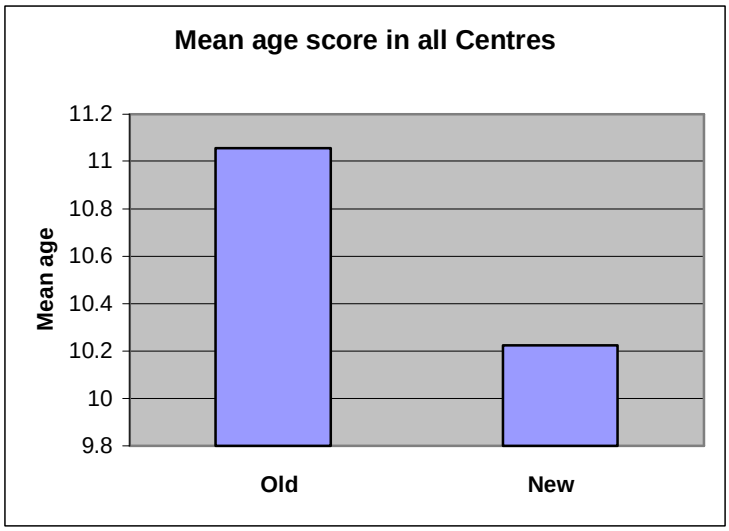


Fig. 5-1

In the organization and implementation of the recreational activities during 2005, a more important effort should be put on the children between 9 and 11, especially the boys with reference to their higher level of behaviour problems revealed by the CBCL.

So according to the needs described for each age-group, play activities in the Centres will have to be adapted to the 9-11 years old, mainly focusing on the re-building of the social coping skills.

5.4 The CBCL mean score according to age groups

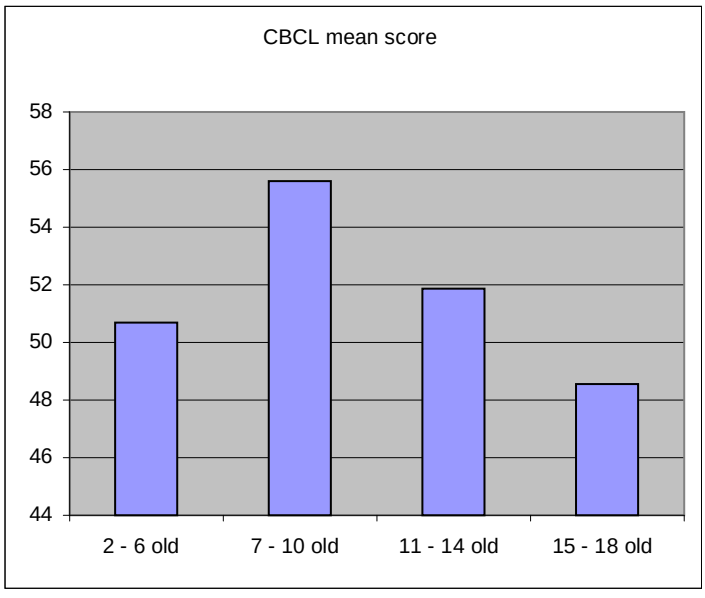


Fig. 5-2

The comparison between the four age groups revealed the highest mean CBCL score for the 7 to 10 years, and the lowest score for the adolescents of 15 to 18 years. As illustrated by the two next figures. The differences between age groups are highly significant (p.004) (Fig.5-2). So it can be said that the age group of 7-10 has the most difficulties in adapting to the aftermaths of the earthquake. And if one takes into consideration that boys are also a difficult group, objectives for 2005 should be to focus more on the boys between 7 and 10. Later, we shall see that until now very little activities, except for physical exercise, have been proposed so far to the boys in that age group.

5.3 The role of play in a post disaster context

After a disaster, the aim of play is not to foster learning, as in a school setting, but to help find a way out of the invisible wounds left by trauma, which will bring later the child more naturally back to school.

1. First, play has an important impact on memory. The traumatic experiences have made a "hole" in the fabric of the child's memory and play helps mend that hole. One of the supervisors in a Centre explained: "Some children, even older ones such as 10 or 12 may have completely forgotten how to draw a simple house or a tree as they used to before the earthquake. The animator then will sit by the child and gently help him remember first how to draw a simple straight line, later other geometric forms, etc. so that slowly forgotten knowledge comes back". Before this repair is completed, if ever, a child cannot function properly in a school structure and is liable even to loose the little self confidence he/she will have if he/she is pushed too soon. An example of a positive focus on memory in the activities are poetry and story telling

2. Next, play has an extremely important role in rebuilding the symbolical capacity of representing the world. This representation is based on the inner intricate weaving of our experiences since our birth, interpreted through images, day dream and fantasy, but also through playing the various social roles he or she will have to perform later, for instance through "make believe" games. Or, when a child plays with a box, he does not just play with a box. His imagination weaves a whole world around the box, which becomes real for him. This is a very important stage of his development, paramount for facing later challenges.
   But when a disaster breaks in, death and horror become the sole reality of the child and he/she looses instantly this capacity of transforming his world. Future rebuilding, which needs imagination, with all related capacities, becomes impossible. A good example taken from the Centres' activities is doll-making. It is actually one of the most appreciated one.

3. The third important role of play is to help the child model the rules, as well as structure his time and space, which will become the basis of living within a community. And this construction takes place by interrelating with his peers, in group games for instance, or sports. A disaster destroys the whole space and time frame of a youth. Houses and roads that used to shape his space are destroyed. Schools that used to shape his time frame are destroyed. The network of his relationships with family, neighbours, local authorities such as the religious ones, is destroyed by death and sorrow, for years to come. His body has perhaps been wounded and he is now handicapped. He cannot use it to structure his world again in an independent way through sports for instance, where motility and rules are learned.

Play is thus an extraordinary way of healing the scars left by a disaster. It not only lessens anxiety and depression, but restores hope and creativity. It brings back pleasure and desire, which are the foundations of psychosocial life.

5.4 The effect of the children's play activities on their community after a disaster

It is interesting here to see how the psychosocial concept is illustrated by the systemic effect of the children's play on their surroundings.

1. There is a definite influence of the progressive well-being of the children on their ***caregivers.*** This is shown by the interview of 25 mothers (N = 25) in the qualitative enquiry. Many mothers have testified to the fact that, because their child can attend the Centre's activities, it has calmed their child's anxious and aggressive behaviour and made atmosphere at home much more pleasant.

   They describe the changes on their children as radical. They were "***scared of everything, very dependant".*** The clinging reactions, common after a catastrophe, slowly disappeared as well as bed wetting. They say that their child "***better faces the reality, and gets rid of their suffering"*** in the Centres. They "***become more independent***". Also: "***they don't bother us anymore***". Then the mothers have time off to do their chores, such as standing in line to get the pension for the family, buying food or taking care of the smaller ones. And they feel very grateful to Tdh for this little time off. The Centres are described as "***safe and quiet places, where they trust the staff***". They also complain about their own aggressiveness against their children and feel happy that these can attend a more pleasant place than home.

2. There is also an important impact of the improvement of the children on the ***animators.*** One must not forget that they were chosen by the shuras (local authority) to care for the children belonging to their own community. They are all victims of the earthquake as well as the other people and have suffered the same horrors as the children. However, the other side or the coin, is that they know the community well, in particular the families of the children and their problems. They have an emotional tie to them. They feel more responsible and empowered by being part of the reconstruction of their community.

   In the qualitative enquiry, a sample of 49 (N = 49) animators were interviewed. They testified to their own psychological improvement through helping the children in their recreational activities. They described themselves at the beginning of the program as "***sad and irritable; they had lost their hope in the future and did not care about their environment***". They also said that they suffered a lot "***from loneliness, doing nothing".*** In contrast, working with the children, they say, made them "***feel better"*** because "***feeling more responsible".*** It helped them "***know themselves better***" and "***react and communicate better***". Today they feel "relaxed" and have "***energy in life (I don't waste time, I am punctual, I am active)"*** and are "***more confident in the future".*** One of them says: "***I have lost my parents in earthquake. I didn't know how to take care of my little brother. Taking care of the children in the centre, I have learned how to take care of my own brother***".

It is important to note that the findings in this enquiry correspond broadly to those of the quantitative survey one.

5.7 The recreational activities used in the Centres

In the Tdh project, recreational activities were classified into three categories, addressing each part of the child's personality:

- physical exercises and sports, addressing the physical level
- creative, imaginative and artistic activities, addressing the emotional level
- cognitive and psycho-educative activities, addressing the thinking level

The qualitative enquiry interviewed a sample of 65 children (N = 65) and describes what they like most doing: "***The activities that gather most of the votes are group activities, such as all the ball games; handicraft activities, such as doll and flower making, drawing and painting, sewing activities."*** Less mentioned are: playing with toys, religious education, English classes and karate. The other activities are not mentioned at all. "***Collective activities are mainly appreciated because of being together and playing outside***". Sports activities help them "***become strong which gives them a feeling of security***". They explain that "***we improve not only physically, but also mentally".***

The main reason mentioned for coming to the Centres is the will to "***be together with other children***", in opposition to "***being alone at home***". The centres are described as "***places of life***", in contrast with their home or the rest of the village where, usually, there is "***nothing to do***" and "***nowhere and nobody to play with***". Some have said: "***We didn't have any place to go and we played in the street***". The numerous activities, physical, artistic and educative, are not only an opportunity for them to "***learn many things***", but are also a way for them "***to think about something else***", "***to have fun and feel happy***". They find the Centres to be "***clean and quiet, with kind and polite teachers".*** They are also places where they feel "***safe and relaxed to share their feelings and experiences"*** with the animators and the other children.

5.8 Analysis of the choice of recreational activities in the Centres

The following lists give the activities for each age group/genders in each of the category:

List of physical activities in all centres					
Below 6	**6 to 10**	**11 to 14 (boys)**	**11 to14(girls)**	**14 to 18 (boys)**	**14 to 18 (girls)**
Alakam Dolakam	Outdoor activity	Football	Volleyball	Football	Volleyball
Swing	Volleyball	Running	Badminton	Table-top football	Ping pong
Merry-go-round	Table-top footballl	Ping pong	Basketball	Badminton	Badminton
Handicap race	Badminton	Table-top football	Skipping rope	Basketball	Aerobic
Musical chairs	Hoola Hoop	Badminton	SOO game	Handball	
Hide & Seek	Skipping rope	Skipping rope	Taekwando	Rock climbing	
Bala Bolandi	Taekwando	Handball			
Cat & Mouse	Push-ups	Volleyball			
Ball games					
Seesaw					

Table 5-1

List of expressive and artistic activities in all centres					
Below 6	**6 to 10**	**11 to 14 (boys)**	**11 to14(girls)**	**14 to 18 (boys)**	**14 to 18 (girls)**
Drawing	Drawing	Calligraphy	Dress design	Handicraft	Hairdressing
Play dough	Handicraft	Handicraft	Crochet		Embroidery
Pantomime	Watercolor painting	First Aid	Needlepoint		Flower making
Story telling	Painting		Sewing		Sewing
	Pastel drawing		Sculpture		Crochet
			Watercolor painting		Dollmaking
			Painting		Dress design
			Pastel & charcoal drawing		Quilting
			Quilting		Bead work
			Knitting		
			First Aid		

Table 5-2

List of cognitive and psycho-educative activities in all centres					
Below 6	**6 to 10**	**11 to 14 (boys)**	**11 to14(girls)**	**14 to 18 (boys)**	**14 to 18 (girls)**
Poetry	Moral instruction	Koran	English	First Aid	Computer
Moral instruction	Poetry	Chess & Board games	Puzzles	Discussion groups	English
Handicraft	Koran		Koran	Koran	First Aid
Alphabet	English		Chess & Board games	Chess & Board games	Koran
Cartoons (videos)	Puzzles				Chess & Board games
	Story telling				
	Videos				
	Chess & Board games				

Table 5-3

Let us now examine the list of games inside the three categories previously described:

The physical category of activities:
Besides sportive activities such as football or badminton, quite a few on the list are group games such as cat & mouse, hide & seek or tag, played in an Iranian form. They all foster socialisation (for instance through following rules), control over one's body movements and positive competition which channels aggressiveness. All age groups, as well as each gender, have a big choice in this category of activities. (Table 5-1)

Physical activities are among the most important ones after a disaster. By default, an example will give an idea how. The programme coordinator, remembered how, in the earlier days, after the football field had been set up, he had laid the ball on the ground in the middle of the new team of children, happy to finally start playing after all the hard construction work. He was surprised to see that they just stood there, staring in front of them. He invited them to start a game but no one moved. They were totally inhibited as if they had stayed frozen since the earthquake and they looked like frightened little birds. It did take them a few weeks before they could play wholeheartedly.

This is a typical reaction to what a disaster provokes in people: a frozen startle reflex. Hopefully, the capacity to move and be happy comes back slowly, together with self confidence, usually within a few months.

At present, sports can also be played by the 15-18 outside the Centres, in the sports clubs supported by Tdh, where they can meet with young adults from all over Bam.

The creative and artistic activities:
as has been said earlier, that category of play activities helps rebuild the symbolical function. Drawing, painting and play paste are basic to the emotional healing process. This type of activities should take the central stage in the second phase of rehabilitation. On the other hand, handicraft helps rebuild self esteem and self confidence. It is also more in tune with the culture and traditions of Iranian women and brings the girls back into the traditional web of the community. It has an aspect of capacity building for the individual within her/his community. (Table 5-2)

What we can see here on the list is that they are generously proposed within the age groups of children from 6 to 10, and only to girls from 11 to 14, together with handicraft activities, which are usually seen as a more feminine activity. Boys from 11 to 18 are not really helped in expressing their disastrous experience of the earthquake through creative activities, such as drawing or painting. The CBCL results have shown that the boys in general are particularly hurt. Perhaps they could be given more attention when it comes to expressing their emotions through artistic and handicraft activities – perhaps through supporting a more cultural activity.
The hypothesis is that there is a cultural bias here where only small children and women seem to choose a more "introverted" and creative personal experience. Boys are probably called very soon to develop more social skills in order to later support the family. And they do that more naturally through sports, and not art.

Drawing and painting, though, are now known after decades of research in clinical psychology, to be a very powerful tool to heal emotional trauma – in as far as this activity is done in the framework of a supportive network, such as family and animators, as well as with the psychologists of the Referral System. It helps the child express in an emotionally safe environment, the pain, grief and fears that come from going through a disaster, for which there are no words. It helps tame the anxieties and aggressive feelings that can become chronic in the long term and a burden to the community.

So it should be the main indoor activity of children of all age groups and genders for quite some time after the setting up of the programme.

The psycho-educative and cognitive activities:
this category is called that way because it is a mixture of psychological support, exercising of the cognitive functions through learning new intellectual skills, as well as religious and moral education. It helps restore memory, attention, concentration, will to achieve, a sense of meaning and purpose, self esteem, a code of ethics, etc… (Table 5-3)

After a major traumatic experience, there are often no words to express the shock and pain. Language seems to betray us and leave us in utter silence. And without words to express ourselves, there is no coherent mental and social activity. It is also important to bring back to memory the painful images of the devastating experience, as we have seen, but also to rebuild the speaking and thinking capacities to express them, in the context of communication with others. Poetry and story telling (from the Iranian folklore) perform that job for example.
Further, between 3 months and a year, the school system has not been rebuilt and in the meanwhile, children need to focus on learning how to use their minds. This is why some activities (see the list above) have been initiated, such as chess or English, so as to stimulate the cognitive functions again.

5.9 A balance between outside and inside activities

The daily activity schedule of a child in Bam is very full. There is not much time to idle and day dream. And in the Centres, everyday, there are eight groups of children: four age groups/boys and girls who play separately from 10 on, which means also a very tight everyday program for the staff. Each group has a daily average of two hours for the recreational activities. Moreover, the program has tried to reach out to as many children as possible. And indeed over 2300 children benefited of the Centres on a daily basis. This does not leave much choice for the more introverted activities of a child.

However, the positive aspect of tight timing as well as a serious structuring of activities allows for an ongoing, dense, supportive communication between animators and children, which, in turn, ensures a sense of security and stability after all the losses the children have experienced. To ensure this sense of stability, punctuality and explanations for a missed session are demanded by the animators, just as it would in school.

One objective of the staff in the Centres however could be to maintain a balance between both elements of structured activities on the one hand, and free space for the child to experience and share their crushed inner world with their peers and adults. In the first instance, the accent is put on the socialising and restructuring role of play, encased in a close and regular relationship with the animators. In the second, rebuilding of the symbolical world of the child is emphasized, where there is a need to fantasize and day dream, thus reorganizing inner representations of the world, in their own timing and at their own pace. Supporting local culture, such as excursions as organized last summer, has been a wonderful way to help establish this balance.

The suggestion made by this author about such a balance is to be drawn from the knowledge of the stages in rehabilitation after a disaster. We have seen that the needs of the child in the first three months are basic ones of a more material nature (food, water, shelter), as well as a need for safety and security. This suggests that the child will benefit better from a material structure (a playground and/or a tent), where food and beverages are distributed, and simple recreational activities that are tightly scheduled with the same adult every day, mostly with physical exercise as the main focus. Regularity I attendance should certainly be the main focus at the time.
Then, in a later stage, from three months on, all types of recreational activities that foster the rebuilding of psychological functions such as the symbolical and cognitive ones, would be advisable. This means giving perhaps more space and time for free activities based on the individual choice of the child. A recreational centre has a unique characteristic compared to school, to address the heart and soul of the child. In the context of a disaster, he does not need to focus on learning. Rather on gentle guidance towards recovery through play.

5.10 CBCL according to the recreational activities

The next analysis of the CBCL shows what we have just been saying. But first, we might remind ourselves that the three groups of activities described before are the ones that attract the children and are chosen by them; they are just the ones which attract them and are chosen by them. They are not taken as being healthier for the children.

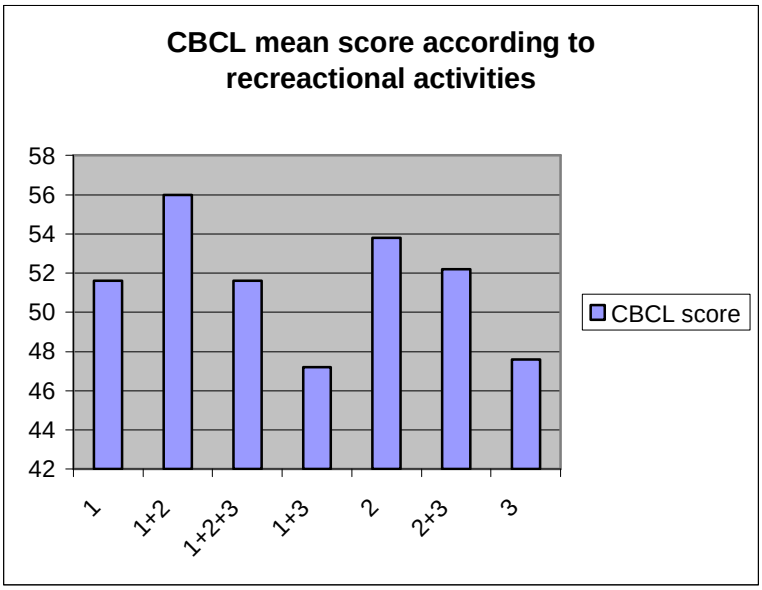


Fig. 5-3

Activities: 1 = creative and handicraft 2 = sports and physical exercise 3 = psycho-education

It is interesting to note that the group of activities that seem to attract the children and help them with their emotional difficulties are in the category of creative and psycho-educative activities (1+3) and sports and physical activities (3) alone. According to these results, it seems that sports (2) alone and creative and physical activities (1 + 2) do not have the same positive effect. However, a look at the next chart, where those figures are broken down according to gender, shows in fact a different perspective. (Fig.5-3)

5.11 CBCL mean score and recreational activities according to gender

These figures show that girls have a lower CBCL mean score, what ever their choice of activities. In all categories of preferred activities, girls are at or below the cut-point of 45, more or less in the normal range. In contrast, boys are in the clinical range, even when they chose creative activities. Finally, the boys' choice of sports and physical activities, as well as a combination of sports and psycho educative activities, are associated with a lower level of behaviour problems.
Here again, we may see that the girls are generally doing better. In all three categories, girls are at or below the cut-point of 45, more or less in the normal range. In contrast, boys are not doing well when they choose creative activities and are way into the clinical range. However they seem to do better when choosing sports and physical activities, as well as a combination of sports and psycho educative activities. (Fig.5-4)

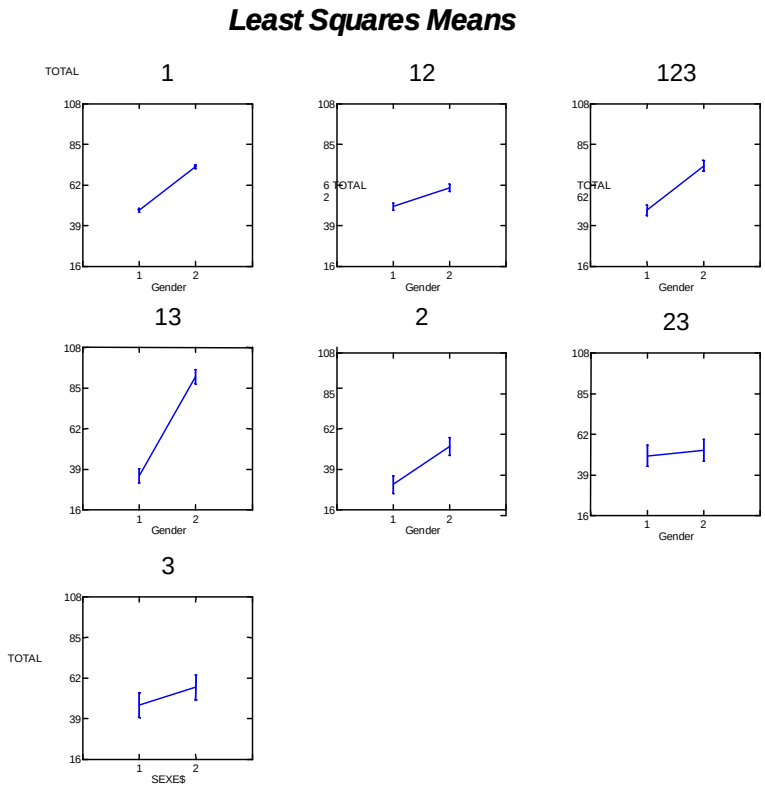


Fig.5-4

So the category of 1+3 (creative and psycho-educative activities), which seemed to have the favour of all children in the results above and help them most, here shows that the boys however are high within the clinical range and not doing very well in that category.

One may hypothesize that boys are not necessarily pushed by their own culture towards creative activities, such as painting, drawing or handicraft. They are perhaps also feeling particularly vulnerable at this time, and by instinct they are not going to be drawn to activities that may trigger a retraumatization.

CHAPTER SIX – DISCUSSION

6.1 General reflections on the Programme

A. The Tdh recreational activity program has many strong points:

- First, it respects the main recognized psychosocial principles generally recognized in the practice of humanitarian psychosocial assistance: the empowerment of the community which help the children heal through their own community, so they can draw directly on their psychosocial resources, thus supporting the resiliency process;

- It is a well thought out "child friendly" and safe environment, which offers predictability to children, as well as to families and staff, which, as we have seen, helps bring down the level of PTSD;

- It has a good overall strategic planning, which helps integrate the Centres into the communities' life. There is a large choice of activities helping the children develop their coping skills at all levels. The programme also includes cultural and sports activities outside of the Centres. The sites are well-thought out, functional and safe, well implanted on the village territory;

- The recruitment, coaching and monitoring of the staff is a very strong point of the programme, as far as such a complex program can allow.

B. The weaker points can include:

- The program is functionally and structurally oriented and could be more "child-centred";

- The whole project seems to be too broad: the number of staff cannot match the general objective of targeting 5'000 children; and the number of activities is also too high and thus difficult to manage practically. Therefore it is difficult not to put the accent on the building of the Centres and the required logistics for them. Actually, too much effort has been put into the material side of the project to the detriment of the training and support of the human resources.

- As has been said, empowering the community in a general sense has been one of the principles that have been respected and integrated in the project. However, the families in particular have been overlooked. Some efforts could have been granted for instance to offering more focus groups to mothers and introductory trainings on education in a disaster context. In particular, there was not enough attention given to fathers: as 50% of them were unemployed, there could have been perhaps some kind of support given there. This in order to help the children of course on the way to more resilience.

- The staff working in the Centres, animators and supervisors, could have benefited from some psychoeducative training and personal support.

- A last point has to be made on the Referral system. It was planned by the government together with the Task Force that some kind of psychological first aid would be given to the more vulnerable children. As we have seen, this was not done for multiple reasons, mostly because of the terrible destructions, which included health institutions. However, this is a subject which should be generally reflected upon, in particular for the next Tdh programs elsewhere. After disasters, which unfortunately happen in countries with already poor health institutions,

most of them are then completely destroyed. How can any NGO with best intentions replace the mental health knowledge needed to take charge of vulnerable children, such as psychotic ones?

6.2 What has the survey taught us?

1. Differences in coping competences between genders; and a more problematic 7 to 10 age group: this means more support should be given to the boys in that age group, as well as for boys in general. Perhaps a thorough review of the recreational activities should be done with this problem in mind, focusing on both parameters: the needs of children and the traumas they are suffering from in the context of their age group. This is all the more important as the new Centres have a young level of attendance, a mean age of 10.5.

2. A thorough review of the list of activities should be done, discarding the ones that have not been used in the last month or two, focusing on the ones that are definitely helping the children, such as the ones in the creative/artistic activities – including boys in them as well – and the psycho-educative ones, according to the findings of the survey. For the latter, it would be interesting to build a concept around them in order to have a more coherent programme with an effective strategy.

3. The Davidson Trauma Scale shows us that if not all mothers/caregivers suffer from PTSD, the overall level of trauma is still quite high (52/76), especially in the socioeconomic class of the independent workers (daily workers?) and the unemployed population. Some kind of support system should definitely be created for them on an ongoing basis (such as regular focus-groups and psycho-education done by the supervisors).

4. For future assessments, it is recommended to plan a research design with at least two assessments: a pre-intervention assessment (before the beginning of the recreational activities) and a post-intervention assessment (after one year). This would enable the team to really document the benefits for children of attending the Centres. Ideally, scholars in the field also recommend a follow-up (18 to 24 months later, after the post-intervention assessment) in order to show either “sleeping-effects” (some children showing no immediate but later benefits), or further progress, or deterioration. It also helps improve the model for the Recreational Activity Centres on a longer term. The pre-intervention assessment could be used to rapidly identify those individuals (children and / or parents) who possibly need more (or less, or different) activities and interventions. This would give the opportunity to differentiate interventions according to individuals needs.

CONCLUSION

According to the mandate, this report is to bring to **Terre des hommes** the fruits of a three week mission in Bam, with a survey answering the question on the benefits of recreational activities to the children attending the Tdh Centres. Recommendations were intended to help improve the Programme with a special focus on the future hand-over to the community next October.

The survey has shown that the Programme has largely reached its initial objectives and was implemented with a level of high psychosocial competence. It also shows that "play" is not just putting a few toys in the middle of a tent. Recreational activities can have a positive impact on the beneficiaries, not only the children but their environment as well, insofar as there is a careful and professional planning of a psychosocial strategy. Only under those conditions will the Programme be beneficial.

The recommendations above do not put into question the psychosocial concept at the basis of the recreational activities. On the contrary, it builds on it and suggests refining it in order to enhance this Programme.

From this experience, it has become obvious that a model has to be created for the future recreational centres as well as new assessment tools, that are not just derived from either the mental health approach or from the field of social psychology only.

This is becoming common research grounds for a number of NGOs now involved in humanitarian psychosocial assistance. And Terre des hommes, as well as the Centre for Humanitarian Psychology, are both involved now in that process. Hopefully the combination of theoretical exploration and practice will build an efficient model for the future.

THE AUTHOR

Claire Colliard is an expert in the psychosocial approach to stress and trauma and has lectured, trained and supported humanitarian workers in difficult circumstances in more than ten countries in Asia, Africa and Europe. She is the founder and current Executive Director of the **Centre for Humanitarian Psychology,** an international humanitarian NGO based in Geneva, Switzerland, offering psychological support to humanitarian staffs and corporate expatriates – as well as expertise in psychosocial rehabilitation to victims of natural and man made disasters. She has created in 1994 the Psychological Support Unit for field personnel for the International Federation of Red Cross (IFRC); the unit continues to operate successfully today – She is a current consultant and a stress and trauma counsellor and has given bilingual English and French trainings to UN Agencies and other NGOs since 1995. Formerly, she was a clinical psychologist within her own private practice during over 25 years.

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Qualitative enquiry done in October 2004
by the field team in Bam

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1. Results from the interviews of a sample of children (N= 65)

All the children interviewed confirmed that they enjoy coming to TDH centres.
The main reason mentioned is the will to ***be together with other children***, in opposition as ***being alone at home***. The centres are described as ***places of life***, in contrast with their home or the rest of the village where, usually, there is ***nothing to do*** and ***nowhere and nobody to play with*** (***"We didn't have any place to go and we played in the street"; "At home, I was alone, doing nothing"***)
Being together with other children and involved in activities is directly linked to the ability ***to forget about the past*** or think about something else than their problem, pain and confusion. The numerous activities, physical, artistic and educative, are not only an opportunity for them to ***learn many things***, but are also a way for them to think about something else, to ***have fun*** and ***feel happy***.
The centres, ***clean and quiet***, with ***kind and polite teachers***, are also places where they feel ***safe and relaxed*** to ***share their feelings and experiences*** with the animators and the other children.
Most of the children confirm that coming to the centres helps them ***get better.***

The activities that gather most of the votes are group activities (football, basketball, volleyball, badminton…), handicraft activities (doll-making, flower-making), drawing activities (designing, drawing, painting), and sewing activities (sewing, needlepoint, crochet). Playing with toys, religious education, English classes and karate have also been mentioned.
Collective activities are mainly appreciated because of ***being together*** and ***being outside***. Sport activities are moreover much liked because it helps them to become ***strong*** which gives them a feeling of security: ***"It helps us become strong and live longer"; "I like karate because I can defend myself".***
They explain that, slowly, they improve ***not only physically but also mentally.***
In general, the activities give them the feeling that they ***achieve something*** (***"I like drawing because I'll be part of that thing I am making"; "I like knitting and sewing because I can show to the others what I am doing in the centres"***). They describe how they can think ***of something else*** and forget about the world they live into (***"I am drawing houses and trees which have not been ruined yet"***), which helps them ***get rid of stress and pressure.*** They confirm that, through these activities, they slowly learn back how to ***concentrate***, and improve their sociability (***"Slowly, you learn how to make friends"***). Religious education is also mentioned as ***necessary*** for them.

In terms of improvement, most of the requests are material (football fields, volleyball fields, shoes, cement area, containers because of the cold, computer classes, etc). A remedial course is a suggestion that occurred several time. More English classes and Karate classes have been requested. Some sport classes for the parents have been suggested, as well as the organisation of an exhibition of the children's drawings and handicrafts.
However, some children answered that they had everything in the centres and that they didn't need anything

2.Results from the interviews of a sample of Parents (N= 25)

The parents seem to appreciate the centres because it is a way to have the children out of home, and so, be quiet for a while (***"they don't bother us anymore"***).
They are also convinced that it is better for their child to be there, ***together with other children***, as opposed to ***being alone, at home***. The centres are described as ***safe and quiet places***, where they ***trust the staff***. They feel secured to have their children come here as opposed as ***being in the street, doing nothing***.
It is a place where their children can have ***a good time*** and also ***learn a lot***, which helps them ***not only now, but also for their future***.

They also have the feeling that the animators, through their support and the activities, help the children ***better face the reality***, ***get rid of their suffering*** and become more ***independent***. The religious education is also much appreciated.

They describe the changes on their children as radical. They were ***scared of everything***, very ***dependant*** on their parents. Today, they feel more ***confident and brave***. They were ***shy and reserved***; today they are ***sociable and friendly***. They were ***irritable***, ***aggressive***, ***nervous and impatient***. Today, they better know how to ***deal with their emotions***, how to ***communicate*** them, and they have a ***good sense of humour***. The children who were ***sad*** and often ***crying*** are today ***happier***.

Improvement suggestions are also mainly material. Some people reminded the need to take care of ***outdoor activities for ladies***. Some ***classes for the parents*** would be much appreciated.
However, many people said that ***everything is ok*** in the centre and that they only hope that they will ***remain open as long as possible***.

3.Results from the interviews of a sample of Animators (N= 49)

The animators interviewed describe how working in the centres helped them, as individuals, to recover from the earthquake trauma. They clearly describe a ***before*** (after the earthquake, but before starting working in the centres) and an ***after***: ***"everything has changed, that's a new life"***.
All of them were seriously damaged by the earthquake. They were feeling ***sad and irritable***; they had ***lost their hope in future*** and ***didn't care*** about their surrounding. They also suffered a lot from ***being alone***, ***doing nothing***.
They explain how working in the centres, with other animators and taking care of children, helped them ***feel better*** by making them ***feel responsible***. It helped them ***know themselves better*** and therefore, learn how to ***react and communicate better***. Today, they feel ***relaxed***, they have ***energy*** in life (***"I don't waste time", "I am punctual", "I am active"***) and are more ***confident in the future***. They developed a ***good sense of humour***.
Working with children during the day gave them skills to better manage in their private life: ***"I have lost my parents in earthquake. I didn't know how to take care of my little brother. Taking care of the children in the centre, I have learned how to take care of my own brother."***
Working in centres, together with children and colleagues, seemed more efficient to heal them than individual therapy: ***"I first went to see a psychologist but nothing happened. But now, working with children and being part of a team, I feel better."***

The animators also describe improvement in the children's health and behaviour. They confirm the numerous difficulties that they had to face at the beginning: the children were ***scared*** of everything, very ***shy and dependant*** on their parents or relatives. They would ***feel alone*** and ***sad*** or would become ***irritable, aggressive, nervous and stressed***. They seemed ***not to care about anyone else*** than their selves, and would ***not respect rules***. A lot of them were ***violent*** and would ***use harsh words***. Some of them, among the teenagers, would ***drink alcohol***.
However, according to the animators, the children are slowly ***getting better***. By teaching them ***how to deal with their problems and fears in a logical way***, the animators help them ***improve the way they communicate*** with the others. ***Sharing their pain*** seems to relieve the children who become ***able to care*** for someone again. They slowly become ***brave enough to accept the truth***. They become more ***independent, sociable and friendly*** and develop a ***good sense of humour***. As an example, some of the children had started ***bed-wetting*** after the earthquake and have stopped again now.
The animators remind however that, if in general they are getting better, ***a lot of children still have a lot of problems***.

The children's favourite activities seem to be ***collective sports*** and ***artistic activities*** like doll making, flower making, drawing and hairdressing.
The animators stress how the children appreciate the centres because ***there is a lot of facilities*** as opposed to elsewhere, where ***everything is destroyed***. Here, they have the opportunity to ***learn a lot on many subjects*** and ***be together*** with other children. It is also a place where they can receive affection

(***"What do the children prefer? Being kind with them"***). Eventually, the children appreciate the fact that they can create things, and therefore, have the feeling to ***be part of constructing***.

Improvement suggestions are mainly materials: containers, cement areas, fences around boys area, new tents, volleyball and basketball fields for ladies, computer classes, balls, toys, sea saw, slide, swig, TV and CD player, …)
They however emphasise the fact that it is important to ***focus more on psychological aspect and activities than on material aspects***. In this context, they feel the need for more ***trainings and sharing experiences*** with psychologists and doctors, and ***books on psycho-social subjects***. They stress that they often feel alone on the field ad that they need more support from specialists (***"We need someone to talk to." "We would like to see a specialist around because we often have many problem and we need help and advices to solve them")***. Some of them remind that the number of ***drug addicted*** is high and that they need special support.
Besides, they wish to ***make the place more attractive*** (decoration) and to make ***advertising to get more children***.
Eventually, it was also said that they don't want to lose their colleagues, even if they have to share their own salary with them.

Evaluation Report of the Psychosocial Programme of the Terre des hommes Foundation in Bam

Executive summary

Claire Colliard, consultant,
Director of the Centre for Humanitarian Psychology

Over one year ago, the town of Bam suffered an earthquake of 6.5 on the Richter Scale, killing more than 30'000 people and destroying 85% of the town. More than 80'000 people lost everything and almost 120'000 lost members of their family.

Any population after a disaster passes through several stages towards its reconstruction. At the present time, Bam has reached what is called a depressive phase, stunned by disillusion and by the awareness of the enormity of the tasks facing it. Unemployment figures are very high, as well as the consumption of opium and alcohol (50% of men, according to government figures), and also violence. Families are torn apart and destroyed. One has the feeling that they are unable to mourn. Reconstruction is slow. The psychological trauma of a whole population, the immense grief, is preventing the beginnings of healing and hope.

The Project

Very shortly after the earthquake, Terre des Hommes launched a psychosocial project of recreational activities, in the form of "centres", with the aim of reaching 5'000 children. At the present time these objectives have been more than achieved: 17 centres have been created, reaching nearly 10'000 children, thanks also to the support given by Tdh to kindergartens, sports clubs, cultural activities, etc.

The concept

For several years, it has become quite evident that the psychological damage after a disaster has been generally overlooked by humanitarian assistance. It is not enough to give bricks and mortar for rebuilding without concern for the traumas, which notably block the process of rehabilitation of victimized populations.

Humanitarian organisations, worldwide now, are therefore beginning to integrate a so-called psychosocial approach into humanitarian programmes. Contrary to the notion of mental health, with its medical and psychiatric overtones, which tends to "treat" the victims according to a Western model of thinking, the psychosocial approach leads to systemic and globalising action: it seeks to take care of the psychological trauma through the dynamics of the community where the efforts of some have an effect on all the others. It stresses also the need to draw on one's own resources in order to heal and rebuild, rather than being locked into an attitude of helpless victim. The notions of vulnerability and of at risk populations are replaced by the notion of resilience.

Moreover all the studies relating to psychosocial programmes for traumatised people have shown that the rate of relapse and of emotional and moral disintegration were notably lessened through the use of this approach.

This new conception of rehabilitation is particularly pertinent in the case of children. The simple fact of placing them in a "healthy" context in which they are given the necessary resources to recover naturally, particularly through play, has an immediate and positive repercussion on the adults around them. Families regain courage to rebuild and the helpers react positively.
Play is central to the idea. Its aim after a disaster or even after a war is not necessarily to improve learning, as it would be in a normal society at peace, but to rediscover the joy of living which will, indirectly, restore the path of learning. Moreover, it is well known that memory and the capacity to symbolise through imagination, are the first elements to be hurt in the context of a trauma. Play restores them. It enables, for example, death and violence to be viewed in a symbolic form and thus provides a certain control over residual anxiety. Furthermore it is therapeutic to the extent that it re-socialises the child and prepares him for return to school.

The Tdh model

After a natural disaster, schools are very often destroyed and may remain so for some time. Often children may be idle for months and left to themselves, because parents and adults are too preoccupied and shattered to take care of them.

In Bam, TdH has created a certain number of "recreational centres", in the form of integrated modules, consisting logistically of a tent placed in the middle of a plot which has been cleared of rubble, fenced, with latrines and a supply of water. For recreational activities, the land can be used for sport and for physical activities, whilst the tents house play material such as toys and creative games. Numerous activities are offered to the children that helps them on the physical, emotional and cognitive levels: artistic and manual activities; physical and sporting; and psycho-educational.

A team of six animators work in each centre, headed by seven supervisors who are university trained.

The centres are also well rooted into the community because the village council is directly involved into the building and maintenance of the project.

Moreover a service for the provision of mental health care has been created with the Iranian authorities of both the Ministries of Health and Education, who provide staff to identify and give psychotherapeutic treatment to the children who are most affected.

My mission

My mission was to assess if this programme had improved the psychological state of the children who had been attending the centres for nearly a year, and thus giving in particular scientific support regarding the impact of the play activities on the traumatic condition of the children. Through making a certain number or recommendations this should improve the model being used and lead to its subsequent development for use in other situations.

The Evaluation Survey

I carried out the study during three weeks, from November 27 to December 16, 2004. It was both quantitative and qualitative and covered a sample of 530 children of all ages, both boys and girls. Two questionnaires were used: one to examine the behaviour of the children, the other to determine the extent of post-traumatic stress disorder in the parents of children below the age of six. I trained 60 animators to administer the questionnaires as well as their seven supervisors.

Moreover, a qualitative enquiry enabled me to analyse the recreational activities and to assess their pertinence to the psychological objectives being sought.

The initial results

The analysis of the quantitative data gathered has been carried out also with the help of Madame Christiane Robert-Tissot, Professor at the Faculty of Psychology, University of Geneva. The first results indicate that the recreational activities offered to the children in the centres has had an impact on them and on their emotional state which is *more than significant*. Quote: "The first results show that there is a highly significant difference (p.000 statistically, which means that there 1 chance of error out of 1000) in favour of the "old" centres, compared to the new ones that opened in November or December. The CBCL questionnaire's mean score is significantly lower for children having participated during 10 months than for children having less than 3 months of activities. This means that the children belonging to the older centres are basically doing well. However the ones from the new centres are within the clinical range."
Moreover, it shows that the activities of the children also had a positive effect on the families as well as on the care teams who had also experienced the devastating effect of the earthquake.

Thus we have now scientific support for the initial working hypothesis. Not only was there a significant improvement in the population of children, but the basic psychosocial concept involving also the families and community around the child is also being validated.

More may be found in the complete report.

Some recommendations

The model has thus been tried and tested. At the same time, it can be improved. Here are some of my recommendations:

- Re-focus, both thought and action, more on the needs of the child and on improving his psychological rehabilitation, rather than on investing most of the energy and resources into structural and logistical implementation. Further quality psycho-pedagogical training for the staff are necessary for that.

- Include psychological support for the mothers in the psychosocial model (focus groups, psycho-education, workshops for manual work…) It is also very important to help the fathers: our survey has shown, as has been known to psycho-traumatology for years, namely that boys reacted much worse than girls in the group of children surveyed and have more difficulty in coming through all right. It is also known that

men are more vulnerable psychologically than women after a disaster. An effort could be made to rehabilitate fathers by means of sports, community activities, etc… Parent meetings would also go in the direction of rebuilding and strengthening the family network.

- Devote more effort to the training of the helpers, as much as to improve their psycho-pedagogical skills as to help them overcome their own traumas.

- Don't forget the adolescents. They are often left out of the programmes. They too are vulnerable and have fewer means of overcoming their vulnerability than the younger ones. For instance, now in Bam, they are more susceptible to drug abuse and violence than the younger ones.

Conclusions

The psychosocial module devised by TdH in the form of child friendly centres for younger victims of disasters is excellent. It offers a very important improvement in the emotional and mental state of the children. Besides, it is flexible and can easily be imported into numerous difficult contexts. It enables the activities and resources to become rooted in the community and, directly or indirectly, it improves morale in the entourage of the children.