*Nyssens*
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# After the December 2013 Central African Republic civil unrest: getting psychosocial support to Red Cross volunteers

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I was contacted in mid January of this year by the International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support to see whether I was available for a four week mission to the Central African Republic, with the objective of supporting local Red Cross volunteers in their humanitarian work.

The country was then at the centre of media attention as civil unrest had broken out in early December 2013, leading to deadly violence among civilian groups. I had seen pictures of Red Cross volunteers actively supporting recovery of the bodies of those killed, and I could easily imagine their involvement in caring for the wounded.

The terms of reference pointed to the provision of immediate support to Central African Red Cross volunteers, to the development of coping strategies and management practices to promote staff and volunteer wellness. Additionally, I was asked to plan the deployment of psychosocial support (PSS) for the general public affected by the unrest.

Unusually, for the first time in my Red Cross career, a PSS[1] deployment was the first line of service activated in the field. It was also impressive to anticipate working in the capital of Bangui, a city affected by violent civil unrest. I agreed to the mission.

The reader should know that I am a social anthropologist by education, with a diversified experience as an ethnographer in tribal Africa, an academic researcher on mourning and rituals, a human resources manager and management consultant in the private sector, active for 10 years as a Red Cross volunteer in psychosocial support in Belgium and for nine years as a fulltime psychosocial delegate with the Belgian Red Cross. Besides that, I have also strongly invested in personal development for more than 30 years. I tend to label my field of activity as social engineering.

I was pleased that the call for support had been launched by the head of the health department of the Central African Red Cross, who I had trained with the basics of community, based PSS two years earlier. It meant I would be cooperating with a known character, who was also well acquainted with the Red Cross organisation.

My personal preparation consisted of a private session during which I wrote down the risks of the mission, my fears, my assets and my motivations, as far as I could anticipate them before being in the field. I chose to share it with two good friends who provided feedback, not so much on the content, but rather supporting the clarification effort and showing their full availability should further support be necessary once in action.

I also chose to explain to my close relatives (including my three children, aged 19, 21 and 25) the purpose of my deployment. All of them reacted fairly positively. My family support greatly contributed to my mission. I enjoyed full peace of mind as to their own autonomy in their activities and their backing of my involvement in the Central African Republic, in its entire dimension.

I anticipated the fact that the support I would be offering would not come so much in the form of a programme or training courses, but to a great extent through contact with my fellow Red Cross volunteers and staff. In this respect, what counted was less the knowledge, the expertise or years of experience, as the capacity to establish genuine contact with people who have been exposed to some of the toughest aspects of life. In my eyes, this requires a double aspect: first, to somehow get rid of the daily life particulars, and second, to connect with life fundamentals within myself.

My inner connection links my motivation to serve with my own experience of being vulnerable and my experience of negotiating life's hurdles. I also relate to my capacity to establish a listening and supportive communication environment, and my confidence that authentic connection reduces isolation, which in turn alleviates suffering. This gave me confidence in approaching a large suffering community with empty hands.

Considering the ambitious mission scope defined in the terms of reference, I had set for myself a more restricted objective of contributing to the "*better-being*[2]" of Central African Red Cross volunteers and staff through personal contact, support and programmed changes.

Within social sciences and activities, most types of contact, interviews and surveys have an impact on the subject matter, whatever the size of activity or duration of contact. From the onset I knew that my presence, along with my status (expat, IFRC delegate, psychosocial professional, short term mission) would have some form of impact on the members of the local Red Cross. I, therefore, paid attention to the quality of the first contact with staff and volunteers, mentioning the purpose of my visit, my esteem for the work done so far, the greetings from members of my communities of origin (Red Cross, family, friends), and the knowledge the international community had, via the media, of the key services they were delivering to their country. This had an impact on the Red Cross volunteers and staff, as it responded to a recognition need and provided some sort of a validation of their efforts and commitment.

In the contact with my Central African Red Cross fellows, be it individual or collective, I balanced my attention between listening to the actual experiences they had gone through, and jotting down the factual aspects of their activities. In this case, as one of my mission objectives was to provide immediate support to Red Cross responders, the focus was less on fact finding than to share the genuine personal experience people have had; i.e. to get closer to the emotional dimension and personal impact of the last weeks and months.

In this respect, I not only paid attention to their achievements, but also to the circumstances they were working in and the obstacles with which they were confronted. Once again, my attention covered the factual situation and the volunteer's personal experience. This contributed to the satisfaction of two basic needs, acknowledged as living among affected communities and individuals: the need for social sharing of emotions, and the need for recognition.

Another need, obvious throughout my contacts, was the need to understand the psycho and somatic reactions people were experiencing. Depending on, and varying from, individual to individual, comments were made on uncommon reactions that showed up, or that they kept exhibiting.

Most people were ignorant of basic psycho trauma phenomenon and were pleased and relieved to hear that their reactions were utterly normal.

Through these individual interviews, and through a number of group sessions with Central African Red Cross members at different levels, I developed a vivid understanding of volunteers' activities and concerns.

On my first day at the Central African Red Cross, I was invited by the head of the health department, as well as by the body recovery team leader, to accompany the team in their body identification and burial work. This was an offer to get to know the horror volunteers were confronted with, as well as an opportunity to jump into the volunteer role and realise how bad it could feel.

I declined the invitation. Initially, I had some guilt feelings about not being willing to be confronted by body parts and blood, nor to be close to people I was supposed to fully encourage. Later, I felt better about sticking to my initial intervention zone. Indeed, I have had my share of morbid curiosity, combined with a willingness to stand at a volunteer's side, yet in this case I felt it was not my place. I explained that my role was to be *their* support, and therefore I had to keep my sensitivity intact to listen and support them. I suggested I could participate in those tasks at the end of my mission, provided all other duties had been completed. This response was well received.

I later had various opportunities during my stay to develop a strong relationship with the body recovery team and participating in their job was no longer an issue. The connection was well established.

Psychosocial support is often understood as a service provided by psychologists. This mission has challenged other areas of my experience. My Africanist background was useful to understand how the "*violent death*" cultural concept played a role in people's perceptions of their implication in deadly violence. I had learned about *violent death* 32 years ago, during my ethnography experience in the Mandara Mountains of northern Cameroon. Violent death implies that people being exposed to a sudden or violent death need to be cleansed of the evil death spirits by a traditional practitioner before being returned to their homes, otherwise there was a risk of making his close relatives and those nearby ill. Somehow it translates into the current concept of primary, secondary and tertiary victims. The concept is well known in the Central African Republic and helps connect modern day victimology to local perceptions.

Once I stayed overnight at the Red Cross compound with the body recovery team. It was a good chance to talk, get to know the group dynamic and show appreciation. In the early evening, as we were having a shower, a volunteer started a solo song, supported by a refrain sung by the rest of the group. I quickly recognised a known African pattern: the soloist was improvising, commenting on the good and bad events of the day with the rest of group singing along. This was as close to an emotional debriefing as it could be.

## Conclusion

Offering psychosocial support to an affected community, and to shattered souls, is made-up of different intervention layers. During this brief experience, I paid special attention to the quality of the interpersonal contact. Programmatic interventions ensure longevity and coherence of the provided support effort. As René Descartes once wrote: '*science without conscience is but the ruin of the soul*'

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[1] I was deployed with Belgian Red Cross to Sri Lanka after the 2004 tsunami; to Pakistan after the 2005 earthquake; and to Chile after the 2010 earthquake.

[2] Usually we refer to "wellbeing" as the goal of PSS interventions. Achieving such change seems unrealistic. "Better-being" (from French "*mieux-être*") points to a slight improvement of one's condition.