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Humanitarian space and well-being: effectiveness of training on a psychosocial intervention for host community-refugee interaction

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Abstract

Social and fieldworkers face enormous challenges in assisting millions of Syrian refugees in Lebanon since the Syrian war in 2011. We sought to assess the feasibility and acceptability of an adapted version of the SMART-3RP (Stress Management Relaxation Response Resilience Training) training to address the emotional and physical burden on the humanitarian field. Data were collected using the Symptom Checklist-90 (SCL-90), blood pressure, pulse and a brief qualitative survey at months 0, 3, 6 and 9. We compared mean SCL-90 scores and physiological

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measures from these time points and subjected qualitative data to a thematic analysis. Mean values of all measures decreased from months 0 to 9, with significance in SCL-90 changes increasing at each visit. Qualitative themes included decreased stress, increased positivity and problem-solving skills, interpersonal and personal benefits of mindfulness practice and the need to continue and expand the programme. Qualitative and quantitative analyses showed a decrease in stress perception and blood pressure, demonstrating the physiological benefits of mind body approaches. We highlight the importance of self-care for humanitarian workers as the basis for the mission's success. We invite additional research to confirm these findings and their implications for the humanitarian field.

Keywords

Lebanon; Syria; refugees; humanitarian; wellbeing

Introduction

In the face of humanitarian emergencies worldwide, governments and international organizations are being stretched thin and are running out of time to address the needs of conflict-stricken nations. These organizations often lack human resources to attend to the wellbeing of their workers, who in turn are tasked with caring for victims. The wellbeing of workers is rarely prioritized or funded as part of the deployment operation. In the research we present here, we acknowledge the extreme situations in which these people work leading to the need to prioritize wellbeing in the humanitarian field. By providing aid workers with the tools they need to care for themselves, we aim to reduce burnout and staff turnover and protect aid workers in traumatized areas around the world. The wellbeing of these workers such as those attending to the Syrian refugees in Lebanese host communities is crucial to the ongoing mission of caregiving in humanitarian emergencies.

The Syrian conflict and its civilian toll

In March 2011, peaceful demonstrations took place in Syria to demand more freedom from the government. Since then, the clash between civilians and the regime has evolved into a multi-level international conflict, in which the Syrian population is most heavily victimized. The exact death toll of the conflict is still unknown. Of the 23 million people counted in Syria in 2011, approximately 13.5 million (almost 60%) were affected or had to leave their homes to escape the fighting, according to the UN (United Nations Office for the Coordination of Humanitarian Affairs 2016). Among them are 8.4 million children, 6 million of whom still live in Syria's difficult conditions as 2.4 million others live abroad as refugees. With a total of 4.8 million adults and children having fled Syria, Syrian refugees account for the largest group of refugees in the world (United Nations Office for the Coordination of Humanitarian Affairs 2016; UNHCR 2016).

The case of Lebanon

Lebanon, which shares a language and most of its land border with Syria, has been a natural place for Syrians to seek asylum. Lebanon is a small country, covering about 4,036 square miles and hosting about 4.3 million Lebanese citizens. As of the beginning of 2016, an

estimated 1.5 to 2 million Syrian refugees lived in Lebanon (International Labour Organization 2016b). Lebanon has felt the burden of this influx of refugees, due to limited space and socio-economic resources (UNHCR 2015). In Lebanon, Syrian refugees were willing to work longer hours for lower wages, which caused rapidly fluctuated labour and consumer markets faster than workers could adapt, driving a significant number of Lebanese citizens into poverty (Mackreath 2014; International Labour Organization 2016b). It is estimated that the number of unemployed Lebanese citizens has doubled to almost 20% in the past five years, with one in four Lebanese people looking for work unable to find a job (Beirut Madinati 2016; UNHCR 2015). Nevertheless, only half of Syrian refugees contribute to the Lebanese economy and over 70% do not have access to any jobs at all as they often hold labour focused positions and tend to be in unskilled fields (International Labour Organization 2016a).

With the number of refugees fleeing Syria into Lebanon reaching saturation, non-governmental organizations and the Lebanese government have shifted their focus from humanitarian crisis intervention to an assessment of the host communities' needs, addressing unemployment, child labour and exploitation of women in both host and refugee communities (International Labour Organization 2016b). Since the early days of the crisis, the staff at the Lebanese Ministry of Social Affairs (MOSA) organized the ground humanitarian operations and instituted the Syrian Project desk. The fieldworkers were tasked to evaluate the impact of the Syrian refugee crisis on host communities with regard to trauma, poverty and lack of sanitation, and further identify areas where interventions could be feasible and impactful. They navigated the cultures of the Lebanese host communities and Syrian refugees, a challenging task given continuing tensions between these communities. On a daily basis, these workers registered eligible refugees through UNHCR and identified members of both the host and refugee communities who need help securing food and shelter. They build programmes fostering stability among youth, protecting children and ensuring they can reunite with family members, facilitating access to education and addressing the exploitation of women in employment (International Labour Organization 2016b). This year, projects targeting refugees with disabilities and elder refugees were also placed under the responsibilities of the staff of the Syrian Desk Project at MOSA (3RP Regional Refugee & Resilience Plan Lebanon 2015). In these initiatives, aid workers assessed their communities and noted those who could benefit from training, engaging the elder communities in meaningful social roles and cognitive tasks as well as providing business development services such as training, counselling and matching job seekers with potential employers. (International Labour Organization 2016a; UNHCR 2015).

Personal observation on fieldwork progress

While the war itself is a disaster, the needs of social and fieldworkers are a growing problem in the humanitarian field that must be systematically addressed. In the initial stages of the Syrian war disaster, young Lebanese were the first to volunteer as aid workers, undergoing basic training that later turned to protocol as the need for efficiency increased. Staff members were assigned tasks with limited resources, forced to adapt to a rapidly evolving and volatile situation. Necessary materials were seldom provided, and while workers were

understaffed, there were no foreseeable plans in place to hire additional help. At the end of each day, these workers relied on each other to quickly process what they had experienced that day before going to sleep, often interrupted by nightmares. Though they lived in a culture of regular trauma, they seldom had the time or resources to discuss and process this trauma. Aid workers were ashamed to talk about ‘emotionality’, preferring to hide their vulnerabilities. This led many to be angry or impassive, with some reverting to unsafe behaviours to deal with their stressors.

The stress management and resilience training (SMART) relaxation response and resilience programme (3RP)

In this intervention, we sought to implement stress management training to address the enormous emotional and physical burden faced by Lebanese fieldworkers in their work with refugees. Mindfulness training has been shown to be effective in other war-stricken regions-trauma survivors in African settings-(Epping-Jordan et al. 2016; Rees et al. 2013). Our team chose to implement similar strategies for humanitarian work with Syrian refugees in Lebanon. Participants were trained in the SMART-3RP programme, developed by the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital. The SMART- 3RP (Relaxation Response and Resilience Programme) teaches self-care strategies to protect against the negative effects of stress and improve coping skills (Park et al. 2013). This programme has been used with various populations, including members of the US armed services, older adults, and adults with chronic physical illness, to help manage symptoms of depression, anxiety and PTSD (Sylvia et al. 2015; Scult et al. 2015; Vranceanu et al. 2014). The programme also had positive effects with professionals working in stressful medical professions, including palliative care clinicians and interpreters in cancer care (Mehta et al. 2016; Park et al. 2016). We aimed to assess the feasibility and acceptability of the SMART-3RP training for social and fieldworkers in Lebanon, and to assess whether the training decreased symptoms of stress and improved blood pressure and pulse, two physiological measures related to stress.

Methodology

This project, a longitudinal, mixed-methods training evaluation, was conducted from July 2014 to June 2016. In July 2014, the written proposal was reviewed by the team advisors of the minister for the Lebanese Ministry of Social Affairs (MOSA) and senior leadership in the Syrian Project Desk. The project was approved in its final iteration in October 2014. Following MOSA approval, ethical approval was obtained from Partners Human Research Committee for the training of social and fieldworkers through the MOSA Syrian Project Desk.

Participants

Social and fieldworkers were recruited to the training by senior social workers, who disseminated fliers in Lebanese social centres and coordinated workshop logistics. Interested participants were contacted either by phone or during their weekly meetings for the Syrian refugees’ project desk. While there were no specific inclusion or exclusion criteria for this training, attendance was capped at 120 participants. Social workers were recruited from

various regions across Lebanon, with those directly involved with Syrian refugees given priority to enrol first.

Of the 120 social and fieldworkers who attended the SMART-3RP training, 100 chose to participate in the research portion of the programme. All participants were informed that the research study was not a mandatory aspect of this training. For this reason, 20 fieldworkers refrained from participating in the study, with reservations noted. All participants gave written informed consent to participate in the study.

SMART training and data collection

The SMART-3RP programme was translated into Arabic and adapted to humanitarian fieldwork from November 2014 to January 2015, using in-session methods to test for cultural acceptance. The programme was translated by a commissioned certified interpreter, who discussed items with the researchers to ensure the translation's accuracy regarding the goals of the SMART programme. The translation was then reviewed by a council at MOSA, which included four senior social workers and project leaders. This council consulted on the wording of each question to ensure cultural appropriateness and clarity of Arabic usage and approved the use of the translation in this study population. Following translation of the training, participants were assigned to the 3RP training in groups of 15–20 people, following which training sessions occurred from February to March of 2015. The principal investigator of this study, a Lebanese-born and Arabic speaking neuropsychiatrist, led the training. She remained in country for all phases of the intervention to conduct 3RP training sessions and support therapy with fieldworkers.

The SMART-3RP training was held in a centralized location in each of the following four regions:

1. Akkar, Tripoli, Bab Mohsen, and Zgharta centralized to train in Zgharta
2. Shores and Mount-Lebanon (Chouf and Mountains) centralized to train in Beirut
3. South of Beirut, extending to the Lebanese Southern border and Shebaa farms centralized to train in Beirut
4. Bekaa: Bekaa Valley, Zahle, Baalbeck, Aarsal, Bekaa Gharbi, and Rachaya centralized to train in Zahle

The 3RP training was divided into four sessions, which all took place between February and March of 2015. Each training session was accompanied by a specific set of exercises, briefly outlined in Table 1. The first training session, marked as month zero, discussed top-down regulation and stress awareness strategies, along with a 10-minute breathing-awareness mindfulness meditation exercise. At this visit, baseline data were collected from research participants. The second training session discussed trauma and loss. In the context of teaching empathy, along with 15-minute exercises in bodily awareness and reflection. The third training session discussed self-care, connection and positivity, with a 20-minute insight imagery exercise. The final session discussed automatic negative thoughts, thought distortion and coping. This visit was paired with a mindfulness exercise and 20 minutes of

yoga. Participants were encouraged to practice the exercises learned in these trainings at home, as often as was comfortable to them.

Those who consented to take part in the study were assessed in follow-up visits at months 3, 6, 9 and 12 following the first training. During these visits, social workers' cognitive logs and cases encountered in the field were reviewed. In addition, personal and group support was provided. During personal supportive therapy, the principal investigator met individually with all participants for 10–15 min to discuss their progress with the programme, as well as any other issues they wished to discuss. These sessions sometimes related to incidents regarding daily struggles experienced by social and field workers, not all of which were directly related to their refugee work.

Due to the elective nature of the 3RP programme and other setting-specific constraints, 52 participants of the original 100 were able to continue the training to completion. While 61 fieldworkers remained through the third training session, 10 did not advance to graduation due to scheduling conflicts with the allocated programme times, such as the distribution of resources in the refugee camps. To graduate and receive a certificate of training, the participants needed to have attended every session in the programme, engaged in positive supportive therapy work and joined supervised field visits conducted sporadically throughout the project. At the completion of the programme, participants who met these criteria received a certificate from the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital in Boston, MA.

In addition to their certification, participants were encouraged to implement SMART-3RP strategies in their own communities. They were asked to disseminate the SMART-3RP programme to a target of their choice, and provided researchers with ideas for future projects in both the Lebanese and Syrian refugee communities. The two best projects were selected and awarded a prize for excellence at graduation. These projects proposed interventions that, in one case, built resilience and awareness against early marriages in Syrian girls and, in another, utilized arts and sports – namely soccer – to increase resilience among children in Syrian refugee encampments and the Lebanese host communities around them.

Study measures

At baseline and quarterly follow-up visits, researchers gathered information on psychological stress, as well as physiological measures impacted by stress such as blood pressure and pulse. Quantitative information on stress was collected using the Symptom Checklist-90-Revised (SCL-90), a validated quantitative psychometric questionnaire designed to evaluate a broad range of psychopathology symptoms (Al Gelban 2009; Eng and Chan 2013; El-Rufaie and Daradkeh 1996). This instrument allows participants to self-report an array of 90 symptoms on a 5-point scale of severity, with scores greater than 64 signifying clinical significance in psychological distress. Although 90 variables are measured on this questionnaire, this study took specific interest in five variables: (1) Feel irritable quickly, (2) Suicidal thoughts, (3) Depression, (4) Thoughts of death and (5) I want to hurt someone else. These variables were chosen due to their relevance in participant safety and impulse control, as the SMART programme teaches strategies to control

emotionality. Overall change in SCL-90 score was also taken into consideration in the quantitative data analysis. Validated Arabic adaptations were used for all study measures.

During the follow-up visits on months three, six and nine, participants completed a brief qualitative survey, provided by MOSA, on the effectiveness of the training programme. In this survey, participants supplied general comments and responded to open-ended questions regarding ways in which SMART might affect their workplace, the overall usefulness of SMART, and the personal impact of SMART. These surveys were administered in Arabic, and responses were later translated to English by the principal investigator for qualitative data analysis.

Data analysis

For the quantitative analysis, we first ran descriptive statistics of participants at baseline to learn about the mean age and gender distribution of the sample. We ran these descriptive statistics both in the overall group as well as within regions in which the intervention was conducted. Next, we compared demographic characteristics of participants at baseline to the subset of the sample who remained in the study through Time 4 to assess for bias due to loss to follow-up. We ran t-tests, chi-square statistics and Wilcoxon rank-sum tests (in cases of unequal variance) to see if there were any statistically significant differences in the demographics of those who began in the study at Time 1 and those who remained through follow-up at Time 4.

We then examined means and standard deviations of scores on the psychosocial and biological outcome measures at the four time points (SCL-90 questionnaire, systolic and diastolic blood pressure, and pulse). We limited this analysis to those who had remained in the study for all four time points so that comparisons of scores over time would represent the same group of people. We used a repeated measures one-way ANOVA to assess if there was a statistically significant difference in the means across time, measuring if time in the intervention corresponded with changes in the psychosocial and biological outcome measures. Finally, we examined the frequency with which participants practiced 3RP between sessions. All statistical analyses were conducted using Stata 12.1.

For the qualitative data analysis, responses from the brief qualitative survey were translated from Arabic to English and subjected to a thematic analysis, in which responses from each visit were compared to other responses in their visit and sorted into general themes. Following the close of the study, themes from all visits were compared and combined to develop major overarching categories. Responses within these categories were again compared to assess changes across visits and uncover central messages tied to each theme.

Results

Quantitative results

At baseline, mean age of the participants was 35.1 ± 9.6 years and females made up 62.2% of the group. Participants were drawn from eight regions: Akkar (20), Akkar-Zghor (18), Beirut (4), Bekaa-Arsal (1), Chouf Beirut (15), Rachaya-Marj (17), South (13) and Zahle (12), with a total overall sample size of 100 at the start of the trial (Table 2).

In comparing demographics of the group at the start of the trial ($N=100$) with the subgroup that remained in the trial through Time 4 ($N=52$), we found that mean age and ratio of females to males did not differ significantly (Table 3). However, dropout by Time 4 was significantly predicted by region in which study members participated in the intervention. All regions (except for Bekaa-Arsal which had one participant) experienced dropout, but these rates were significantly higher in Akkar, Akkar-Zghorta and the South ($p < 0.0001$). Meanwhile, Rachaya-Marj and Chouf-Beirut experienced less dropout.

Mean values on all psychosocial and biological measures were lower at Time 4 as compared with at the start of the intervention (Table 4). In comparing baseline to Time 4, mean SCL-90 score decreased by 14.7 ± 29.8 points ($p < 0.0001$). While this change was not significant between Times 1 and 2 ($p = 0.981$), the decrease approached significance from Times 2 and 3 ($p = 0.090$), and achieved significance between Times 3 and 4 ($p = 0.001$). As for physiological measures, mean systolic blood pressure decreased by 11.9 ± 18.4 units ($p < 0.0001$), mean diastolic blood pressure decreased by 6.4 ± 10.1 units ($p < 0.0001$) and pulse decreased by an average of 8.3 ± 15.9 units ($p < 0.0016$). The percentage of the group with SCL-90 scores greater than or equal to 64 (a clinically significant cut-off), dropped from 19 to 12% from Time 1 to Time 4, but this difference was not statistically significant ($p = 0.3141$). None of the baseline variables examined (age, gender, region) significantly predicted the extent of change over the study period for any of the outcome measures (results not shown).

Two of the five variables of interest in this study, rated on a Likert scale from 0 to 4, also presented a significant decrease in mean. From baseline to Time 4, 'Feel irritable quickly' dropped from an average of 1.69–0.902 ($p < 0.000$), and 'I want to hurt someone else' dropped from 3.00 to 0.714 ($p = 0.001$). While the other three variables were not significantly reduced, all three measures were lower at time 4, with 'Suicidal thoughts' dropping from 0.13 to 0.04 ($p = 0.200$), 'Depression' dropping from 0.42 to 0.33 ($p = 0.489$), and 'Thoughts of death' dropping from 0.60 to 0.40 ($p = 0.192$).

Due to the importance of regular practice in the effectiveness of SMART, data were also collected on the regularity with which participants practiced mindfulness strategies between sessions (Table 5). Between Times 1 and 2, only 3 participants discussed never practicing SMART, with those who did practice doing so at intervals ranging from monthly to daily. Between Times 3 and 4, only 2 participants did not practice SMART, with those who did exhibiting a similar range of interval length.

Qualitative results

Open-ended survey responses from three time points within the study were translated from Arabic to English and subjected to a qualitative thematic analysis. Major themes emerging from this analysis were the ameliorating effects of positivity on stress, the effect of the SMART-3RP on problem-solving abilities, the personal and interpersonal benefits of the SMART-3RP, and the cultural need for expanded and continued mindfulness training.

Stress vs. positivity—The most widely discussed theme across all time points was the effect of the SMART-3RP training on participants' stress and positivity. While this variable

evolved slightly as participants gained more experience in the SMART approach, an overarching theme of decreasing stress and increasing positivity prevailed in responses from all visits. In the words of several participants, the SMART-3RP develops ‘the capacity to control negative emotions and change them into positive ones’, teaching ‘a positive way to distance self from negativity’ and ‘think rationally away from reactivity’.

After the first SMART-3RP training session, participants mainly discussed the initial effects of mindfulness in a social work context. Following this training, one participant noted, ‘I am starting to feel my own stress’. Another discussed plans ‘to disseminate the information to my colleagues at work, to practice the exercises daily alone and with them, and to start thinking positive’. Following the second training, many described an amelioration of anger and irritability due to mindfulness exercises, which gave them more control over stressful situations. ‘Control’ was a central theme in these data. Participants discussed ‘controlling my emotionality when under stress’, with one noting that ‘this programme was very useful for my personality, as I am very irritable often and I cannot control myself’. Others noted that this increased self-control led to increased external control in the workplace, saying ‘I can be certain to control the stress I live under’ and ‘turn it to positivity in dealing with [the] community’. Following the third session, several participants directly mentioned the long-term physical benefits of this decrease in stress. One discussed feeling ‘relaxed in his body and mind,’ while another noted that ‘my health is better, especially my breathing’ (Figure 1).

Problem-solving—While the theme of problem-solving was discussed less thoroughly than that of decreased stress, these two themes were closely related. Participants directly related increased patience and positivity to increased problem-solving skills, noting that the SMART -3RP ‘had a major impact on my thinking and the way I solved problems’. This theme was discussed in greatest detail following the third round of SMART-3RP training. Participants cited positivity, stability, logic and understanding as benefits gained from SMART that helped in problem-solving, noting that mindfulness practices gave them ‘the strength to control reaction and to deal with issues in a calmer and more focused way’ as well as ‘the capacity to deal positively with the severe cases we deal with’.

Interpersonal vs. personal benefits—When discussing the utility of the SMART-3RP training, participants cited both the interpersonal and personal benefits of mindfulness practices. These themes centred on the ways mindfulness could help in participants’ work with refugee communities and how it could improve various aspects of their personal lives. The discussion of these themes showed a marked change between visits, where responses in the first visit revolved around interpersonal and community-related themes and those in the second and third visits shifted to a focus on personal and lifestyle-related themes.

With regard to the interpersonal benefits of the SMART-3RP training, many participants in the first visit discussed ways in which gaining a better understanding of their own emotions would help them understand others. Empathy and work responsibilities were central to these data, as many participants planned to use the SMART approach to ‘show empathy with the refugees’ and ‘understand them better’. In the words of one participant, ‘I will be more patient when I work and think about what I learned today in the workshop. [I will] analyse what the refugees are telling me, not only hear them. After the analysis I may know how to

help them better'. In the words of another, 'I deal with people every day, and many cases I have had to deal with needed today's training'. Many also voiced wishes to 'spread the benefits' of the SMART-3RP by disseminating this information to their colleagues or refugee communities. Overall, there was a general emphasis on implementing these strategies in the workplace to foster constructive change. However, a small subset of the population did voice concerns that, while the SMART approach is beneficial on the personal level, they found it difficult to translate into their work lives.

The second and third sessions generated a greater emphasis on the personal benefits of SMART. Many discussed how practicing these exercises 'increased my self-confidence' and gave them time to focus on their personal needs. As one participant described, SMART '[pushed] me to be committed to myself'. One participant discussed how the benefits of mindfulness extended beyond the workplace, saying, 'This workshop stated issues as they are and found the ways to deal with them, not only with refugees, but as a way of life'. While fewer participants discussed the interpersonal utility of these practices, several did mention that increased patience and self-confidence better equipped them to handle interpersonal conflicts in their workplaces. Regarding this matter, one participant said, 'I need first to practice the exercises myself, and then I will be able to help others and have them benefit from what I know' (Figure 2).

Expand and continue training—Another widely discussed theme in qualitative survey responses was the need to continue the SMART-3RP training and make the sessions available to others within the community. Understandably, this theme had the greatest emphasis in the third round of SMART-3RP training, as graduating social workers sought to offer suggestions for the programme's future. Many participants voiced wishes to continue this training, discussing a widespread need for mindfulness practices in their cultural context (Figure 3). Several discussed how 'these training sessions are a necessity' and 'have positive impact', noting that 'that is why we urge its continuation'. Others requested that the training be made available to others in the community, saying 'it would be great to disseminate [SMART-3RP] to a larger number of people so everyone can benefit'. With regard to expanding the reach of the training, several participants specifically emphasized sharing these teachings with refugee youth and adolescents. Lastly, participants offered their thanks for the trainings that had been done up to that point, noting that these positive efforts make a constructive difference in their communities. As one participant summarized:

We thank MOSA for their interest in the human being and what we feel from stressors every day, be it the war or others. And we thank [study PI] for her humanity and her culture; that she was very generous in sharing in all what she could for the positive energy and the creation of new beings. We would like to ask to have this training for a long time, as we are in dire need for it.

Limitations

Given the extensive re-iterations submitted to and reviewed by MOSA and the Syrian project desk, it took some time to launch the project. As is often the case in humanitarian programmes, human resources were scarce. Aid workers did not have guaranteed or

protected time for this endeavour, and were often forced to choose between attending training sessions and distributing resources to the refugees in their areas. Due to the design of this study, those who could not attend sessions were lost to subsequent follow-up visits. As such, the generalizability of quantitative results is limited by the dropout of about half of the participants between baseline and Time 4. It is possible that the results from the group that remained for all four sessions differs from what the results would be of those who dropped out of the programme had they remained. We did, however, compare baseline characteristics of those who dropped out of the programme and those who remained for all four sessions and did not find significant differences aside from the location (Akkar region, North of Lebanon, the area closest to the Syrian war and fighting) in which they participated in the programme. Thus, it is possible that dropouts did not bias the results and dropout was more related to who could practically continue attending the sessions based on their location. Another limiting factor of this study is its lack of a control group. While there are clear benefits to running randomized control trials in this form of intervention, this design is not always feasible in resource-limited settings. This is especially true regarding the humanitarian crisis of Syrian refugees in Lebanese communities, where the need for trained personnel to appease the tension is urgent. The decision to limit or stagger groups who receive training poses unique moral concerns and worsens the situation on the ground. In light of this, this study employed a longitudinal model over a randomized controlled trial.

Discussion

Discussion points

In times of conflict, priorities shift. People living in insecure war zones learn to thrive to the extent they can, navigating smaller communities where they often have short-term plans and live in less complex systems. In this context, the population fleeing war, the host community, and humanitarian workers are all affected by the environments in which they live. In the field, psychological wellness is a low priority, as many struggle simply to find personal security. They instead rely on human bonds, developing interpersonal relationships through a combination of extreme shared experiences and isolation from the outside world. The more violent the area they live in, the stronger their relationships. Fieldworkers living in those conditions often acquire tunnel vision, which can influence important group decisions. These decisions may include those related to safety, not only for the fieldworkers, but also for the people they care for. It becomes difficult for workers to acknowledge their needs, though they are often able to do so when they are allowed to distance themselves from the milieu and process their experiences. In doing this, workers begin to talk about their vulnerabilities and recognize the psychosocial support they need to persevere.

In our work, we emphasize the value of human bonds in extreme situations of conflict, especially in environments where family ties are severed or disrupted. We worked to understand the new ‘families’ that form in these environments, in which a diverse array of individuals finds solace in bonds resembling familial relationships. We incorporated this feeling of support and belonging as a foundation for the Arabic adaptation of the SMART-3RP Programme, marking the first time mindfulness and resilience programme has been used to train humanitarian personnel in areas of conflict. Despite the recent emphasis

on 'self-care' in humanitarian organizations, this project took a great risk in actively setting aside time for mindfulness, as it lacked a precedent of comparable work in an area where much was at stake. We explored the intervention understanding that it might fail, and were rewarded with results that attest to the value and life-changing nature of this intervention. In addition to qualitative responses, which describe the personal importance of the SMART-3RP to many participants, our quantitative analysis shows a clear decrease in perception of stress (SCI-90-R), depression (although we note that and reaffirm that SMART-3RP is not an alternative treatment for depression and should not be used as a therapeutic modality for people with clinically significant depression), anger and hostility, as well as a significant decrease in blood pressure that demonstrates the physiological importance of mind body approaches. These data bring about the importance of 'safe spaces' for aid workers, where they would be allowed to discuss workplace difficulties and combat the stigma of 'not being good enough for the field', exposing vulnerabilities and building resilience in the process. Mental health issues such as depression, anxiety, and sleep disorder are real concerns for aid workers, as a recent Guardian survey reports that 51% of aid workers reported experiencing symptoms of anxiety, as well as 44% for depression, 29% for PTSD, 22% for panic attacks and 10% for alcoholism (Young 2015). Because of the high turnover in the field and the rapid change of the landscape, it is easy for MOSA and other organizations to forget the needs and experiences of aid workers.

Our work begs to the contrary and pushes the need to prioritize fieldworkers' wellbeing to impact positivity, safety and productivity on the ground. Meaningful action to address the wellbeing and mental health needs of aid workers will not happen until donors and NGOs are required to fund mental care as a standard part of budgeting and HR procedures. However, our research shows that active listening and mindfulness training are feasible steps in the right direction. Though it is difficult to quantify the effect of mindfulness and other strategies in the success of a composite mind body approach like the SMART-3RP programme, it is possible that active listening played a role in aid workers' acceptance of these practices. Role-playing during field visits and in-programme sessions also facilitated an understanding of refugees' perspectives. As is demonstrated in participant responses, further mindfulness, cognitive skills and positive psychology training and research is necessary to quantify the impact of these programmes, as well as their benefit in peace building through reducing reactivity in volatile environments.

Challenges

Of course, this lengthy intervention did not come without challenges. The interactions between host and refugee communities were often tense, and it took a substantial period of time to peacefully navigate these communities to create change. Relaxation response training allowed for mutual understanding and empathy between the two groups, which could not have been accomplished without the multi-level cooperation of MOSA staff, the Syrian project desk, and social workers. Logistics were at times difficult to manoeuvre, as cooperation between groups was also necessary to extensively cover the Lebanese territory. In this endeavour, there were numerous territorial forces, interpersonal differences, and leadership styles at play, in addition to limitations stemming from context-specific issues such as permanent safe access, availability of transportation and untamed weather

conditions. The strong support from MOSA was vital to the success of this research programme, and demonstrates the importance of local in-country partner support in humanitarian work.

One major challenge in this study was the comparatively lower follow-up rate of participants. As the programme was not mandatory, it was often difficult to keep social workers engaged and practicing the SMART-3RP programme in their individual lives apart from research meeting points. Given the demanding nature of humanitarian fieldwork, these practices required a time-commitment that needed to be prioritized. In light of the benefits perceived by the participants and their supervisors on the field, and the longings of participants to have more training, we urge MOSA leaders – and humanitarian international agencies – to allocate protected time for wellness, active listening, group sharing and meditation practices. Attention will need to be paid to longitudinal booster sessions and alumni groups to maintain involvement in the SMART -3RP approach.

Conclusion

There is an imperative need to attend to the mental health and wellbeing of aid workers in humanitarian settings. Individual staff members should be encouraged to reflect on wellbeing, as these exercises have the power to build resilience in the field and beyond. The feasibility, acceptability and positive response of Lebanese social workers to mind-body training in the centre of the Syrian refugee crisis shows the largely underutilized potential of these programmes. Programmes like the SMART-3RP equip staff to identify and support those suffering from the trauma surrounding them. They provide an alternative to the cultural stigma surrounding vulnerability and weakness, offering moral, financial, reputational and security-related reasons for organizations to promote psychological care and resilience among their employees. It is the responsibility of humanitarian organizations to address mental health and wellbeing in their staff, and this responsibility should be made mandatory by public policies and donor funding. We hope this study continues a discussion on health and wellbeing in aid workers, and invites additional research to confirm its findings and their importance to the future of the humanitarian field.

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Figure 1. Fifty most commonly used words in participant responses regarding 'Stress vs. Positivity'.

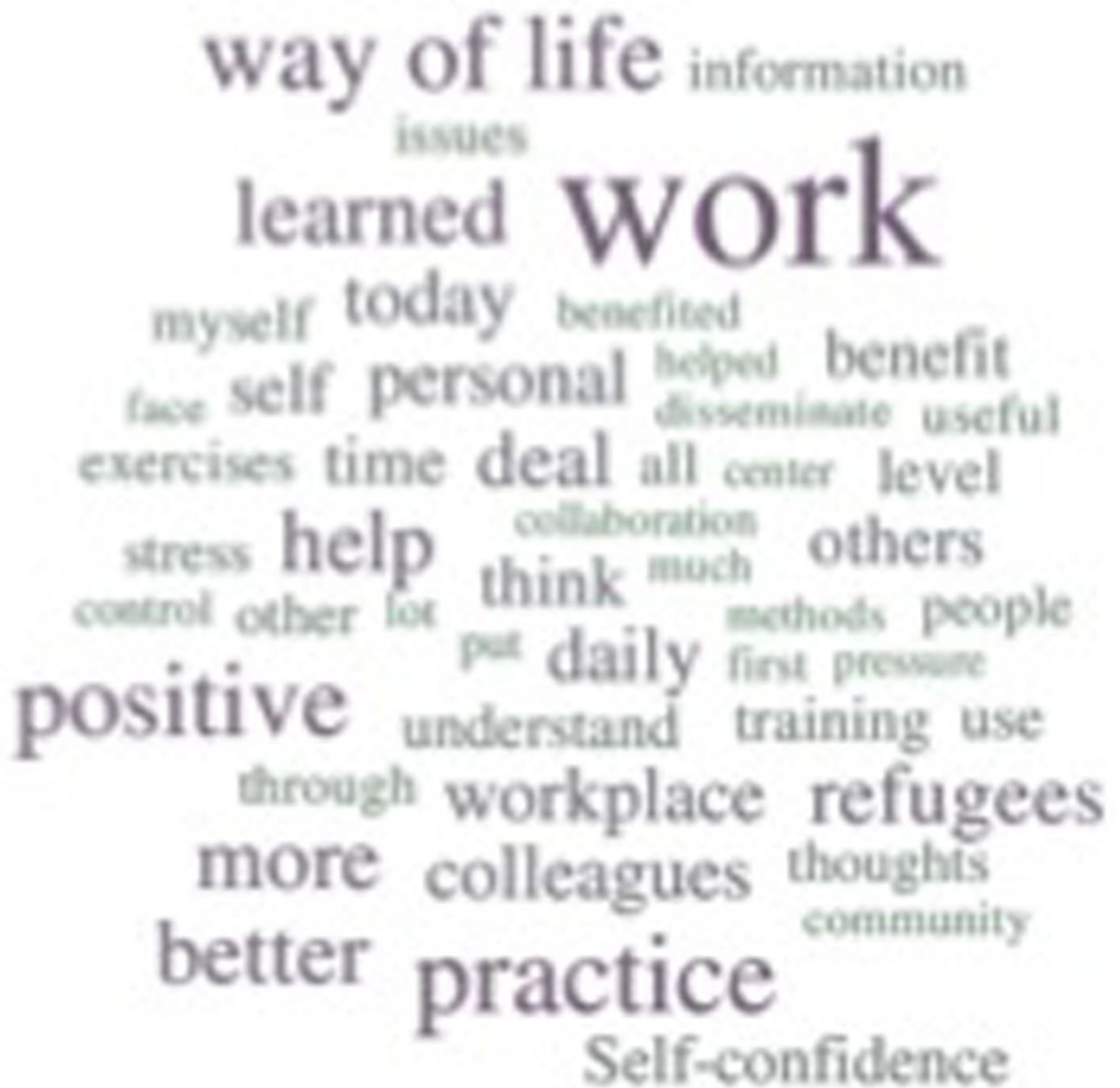


Figure 2.
Fifty most commonly used words in participant responses regarding 'Interpersonal vs. Personal Benefits'.

Table 1

Outline of topics and exercises for each session of the SMART-3RP programme.

Session	Topic	Exercises
Session I	Understanding Top/Down Regulation; Stress Awareness; Relaxation Response and Resilience Training	10 min: Breath Awareness Meditation and Mindfulness/Mindful Awareness (Eating Raisin)
Session II	Discussing and Reflecting on Trauma and Loss; Teaching Empathy	15 min: Body Scan; List 3 things you are grateful for; Reflect and Practice: Good, Bad and Routine
Session III	Learning Self-Care; Keeping Connected; Feeling and Elaborating on Positive Thoughts and Emotions	20 min: Insight Imagery (The Meadow).
Session IV	Negative Automatic Thoughts, Thought Distortion, Understanding and Practicing the Coping Log	Stop, Breathe, Reflect, Choose and 20 min of yoga

Table 2

Demographics intake table by region (mean \pm SD or *N*).

Region	Akkar	Akkar-Zghor	Beirut	Bekaa-Arsal	Chouf/Beirut	Racha Marj	South	Zahle	Overall
Avg. Age	34.85 \pm 9.20	34.67 \pm 4.51	41.67 \pm 12.90	33.00 \pm 0	34.53 \pm 10.45	32.06 \pm 9.17	34.23 \pm 8.76	42.25 \pm 10.19	35.06 \pm 9.56
Female	16	3	4	0	10	5	4	9	51
Male	4	0	0	1	5	12	9	0	31
Unknown	0	15	0	0	0	0	0	3	18
Total	20	18	4	1	15	17	13	12	100

Table 3

Participant characteristics at baseline ($N = 100$)^{*} and among those who remained for the duration of the four sessions.

Variable	Baseline	Time 4
	Mean \pm SD or N (%)	Mean \pm SD or N (%)
	$N = 100$	$N = 52$
<i>Age</i> ($p = 0.4803$)		
–	35.1 \pm 9.6	35.8 \pm 9.2
<i>Gender</i> ($p = 0.2829$)		
Female	51 (62.2)	25 (56.8)
Male	31 (37.8)	19 (43.2)
<i>Region</i> ($p < 0.0001$)		
Akkar	20 (20)	2 (3.9)
Akkar-Zghorta	18 (18)	9 (17.3)
South	13 (13)	4 (7.7)
Beirut	4 (4)	3 (5.8)
Zahle	12 (12)	8 (15.4)
Bekaa-Arsal	1 (1)	1 (1.9)
Rachal-Marj	17 (17)	13 (25.0)
Chouf-Beirut	15 (15)	12 (23.1)

* Ranges from 80 to 100 on demographic characteristics due to missing data.

Table 4

Participant scores on psychosocial and biological measures at the four time points (n = 50–52).

Variable	Change from Time 1 to Time 4			
	Time 1	Time 2	Time 3	Time 4
	Mean \pm SD or N (%)	Mean \pm SD or N (%)	Mean \pm SD or N (%)	Mean \pm SD or N (%)
SCL-90	57.5 \pm 27.3 19 (36.5)	59.6 \pm 33.0 17 (34.0)	54.78 \pm 34.9 15 (30.0)	42.8 \pm 29.2 12 (23.1)
SCL-90 64 (Clinically significant)				-14.7 \pm 29.8 ($p < 0.00001$)
Systolic blood pressure	132.4 \pm 16.7	122.5 \pm 15.8	116.8 \pm 16.5	120.5 \pm 23.9
Diastolic blood pressure	83.4 \pm 8.9	78.6 \pm 9.8	74.4 \pm 10.3	77.0 \pm 10.9
Pulse	76.8 \pm 12.0	73.6 \pm 14.9	70.2 \pm 11.1	68.5 \pm 10.1
				-11.9 \pm 18.4 ($p < 0.00001$)
				-6.4 \pm 10.1 ($p < 0.00001$)
				-8.3 \pm 15.9 ($p = 0.0016$)

Note: *P*-values obtained from repeated measures ANOVA s comparing scores over the four times.

Table 5

frequency with which participants practiced 3rP between sessions.

	Practicing 3RP	Never	1-2 X/ month	Once/15 days	1-2 X/ week	Daily	Other
Time 1-2	61	3	7	9	19	3	20
Time 3-4	48	2	10	13	15	1	7