Psychosocial Crisis Management: The Unexplored Intersection of Crisis Leadership and Psychosocial Support

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ABSTRACT

Epidemiological research has documented the serious health issues that can affect the victims of disasters and major crises. Yet, the psychosocial dimension of crisis has received little attention in crisis management literature. This paper integrates psychosocial principles with a model of strategic crisis management. The resulting model of psychosocial crisis management (PCM) describes how the tasks of strategic crisis managers can be guided by psychosocial support principles. This PCM-model helps public leaders, at society and local community level, to better understand typical psychosocial dynamics and obstacles as the crisis life cycle evolves. Although crisis management insights and psychosocial support principles stem from different disciplines and research traditions, integrating them helps to reduce foreseeable problems in the response and recovery phases.

INTRODUCTION: THE FORGOTTEN DIMENSION OF CRISIS MANAGEMENT
Communities everywhere can be confronted with crises and disasters, events that disturb the normal order of everyday life. A crisis often entails undesirable circumstances, which are characterized by a widely perceived threat to core values,

deep uncertainty, and time pressure (Boin, 't Hart, Stern, & Sundelius, 2016; Brecher, 1993; Rosenthal, Charles, & 't Hart, 1989; Rosenthal, Boin, & Comfort, 2001; Stern & Sundelius, 2002). We define crisis management as the set of efforts aimed to deal with the consequences of crises, "before, during and after they have occurred" (Shrivastava, Mitroff, Miller, & Miglani, 1988, p. 287; also see Boin et al., 2016). Crises can have substantial consequences for the well-being, functioning, and health of those affected by them (this also applies to complex emergencies in conflict areas; Salama et al., 2004). Typical effects include stress, fear, uncertainty, physical symptoms, and trauma-related mental health problems. Disaster health effects have been studied extensively, and in recent decades with an emphasis on mental health and post-traumatic stress disorder (PTSD) (e.g., Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonde et al., 2016; Galea, Nandi, & Vlahov, 2005; Herbert et al., 2006; Moline, Herbert, & Nguyen, 2006; Norris et al., 2002; Yzermans, Van Der Berg, & Dirkzwager, 2009).

Although such effects yield psychological dynamics and influence social interactions within affected communities (Dückers, 2017), and thus demand a response from public leaders, the psychosocial dimension of crises has received little attention in crisis management literature. The aim of this paper, therefore, is to integrate psychosocial principles, relevant to anticipating the well-being, functioning, and health of people confronted with potentially impactful events, into crisis leadership theory. We focus on public leaders and crisis managers at national or local level: public officials at the strategic apex of public organizations with a formal responsibility to manage the disaster response and recovery network. In the context of crisis management, these leaders will have to deal with a set of strategic crisis management challenges and tasks. After briefly discussing the crisis leadership tasks, we explore the degree of integration between the tasks and psychosocial support principles as described in the literature. As a final step, we present a model of effective psychosocial crisis management (PCM).

STRATEGIC CRISIS MANAGEMENT CHALLENGES AND TASKS

The challenges of strategic crisis management are daunting (for detailed overviews see Boin et al., 2016; Boin & 't Hart, 2011). To overcome these challenges, strategic crisis managers must focus on a set of tasks (Boin et al., 2016). Research suggests that the effective organization and implementation of these tasks helps strategic crisis managers to impose order in the network that is charged with responding to disaster. The following six tasks are distinguished: The *sense-making* task requires crisis managers to diagnose unfolding crisis situations adequately, often making use of scarce and ambiguous information. The core of the *decision-making* task is to identify critical decisions that can and should only be made at strategic level. The *coordination* task refers to the alignment of key actors in a response network, during and after the crisis (Boin & Bynander, 2015; Dückers, Rooze, & Alexander, 2014; Heller, 2010). Coordination is about allocating capacity and limited resources to facilitate the cooperation between particular organizations and groups. *Meaning making* is about providing a convincing narrative, an explanation of a crisis and its causes, its implications, the response, and the envisioned roles of different actors. *Account giving* refers to the democratic duty to clarify and accept responsibilities, without engaging in scapegoating. *Learning* requires crisis management actors to critically assess their own functioning and to draw lessons from it to enhance their

future performance, both during and after a crisis (Alexander, 2012; Smith & Elliott, 2007; Stern, 1997).

EXPLORATORY LITERATURE REVIEW

To get an impression of how PCM has been discussed in recent literature, we carried out an electronic search in Medline, PsycINFO, Cochrane, ProQuest (combined search of PILOTS and Sociological Abstracts), and Web of Science. These databases contain publications from broad fields such as sociology, psychology, public health, political science, and public management. The search was conducted on May 20 2016 using the following string of search terms: (psychosocial OR "psycho-social" OR psychologic*) AND ("crisis management" OR "disaster management" OR "emergency management" OR "crisis leadership"). We did not use a date restriction and selected relevant publications written in English, German, and Dutch based on an assessment of titles and abstracts. After removing duplicates, our search resulted in 436 publications, which we then reviewed. As our interest is primarily restricted to public crises and disasters, we excluded studies about the workplace, corporate crises, medical crisis interventions, suicide, and health disorders. We mostly found guidelines, discussion papers, and reflections, presenting primarily qualitative findings, which meant the material did not allow for formal meta-analysis.

Our literature study shows that crisis leadership and psychosocial support generally form two distinctive streams with limited unification or integration, despite their evidently shared area of interest. The study of crisis management is only moderately concerned with the psychosocial dimension of crises. Studies of crisis-related psychosocial support focus more on the impact on affected individuals—particularly the development of trauma-related mental health problems—than on crisis management dilemmas and problems. Numerous publications are devoted to particular models, interventions, or approaches that are suggested to be helpful in addressing trauma-related problems in individuals and groups (e.g., Clark & Volmann, 2005; Everly, 2000; Hammond & Brooks, 2002; Mitchell & Everly, 2006). However, because of a lack of evidence contemporary international evidence-based guidelines do not recommend early preventive measures that go further than the strengthening of social support, provision of information, and timely detection of serious health problems (Australian Centre for Posttraumatic Mental Health [ACPMH], 2013; Bisson et al., 2010; Juen et al., 2015; Te Brake & Dückers, 2013; World Health Organization [WHO], 2013).

The studies differ in their timeframe orientation. Several authors focus on the early phase of the crisis (Burkle, 1996; Van Loon, 2008), others take a longer term view (Buckle, Brown & Dickinson, 1998; Weaver, 1995). The few publications that explicitly speak of PCM use it as a synonym for psychosocial support in crisis situations (e.g., Beerlage & Helmerichs, 2011; Bering, Elklit, Schedlich, & Zurek, 2009; Hannig & Harks, 2009; Uhle & Haubner, 2005). Van Loon (2008) views PCM as "primarily aimed at 'normalizing' and gaining control over more or less increased levels of commotion during and after a calamity" (p. 115).

We found many topics that are relevant from a PCM-perspective, but we did not find an integrated model combining principles from crisis leadership and psychosocial support. Before we can produce such a model, we first need to describe the main building blocks. The crisis management tasks grounded in the work by Boin and 't Hart have already been discussed. In the next section, we integrate the findings from

the exploratory review into an overview of psychosocial support principles. Subsequently, we make a synthesis between the principles and the set of general crisis management tasks.

PRINCIPLES OF PSYCHOSOCIAL SUPPORT

The literature describes a variety of psychosocial support principles. We clustered them into three categories:
- consideration of needs, problems, risks, and existing capacities;
- provide a supportive context;
- evaluate and implement lessons.

Consideration of Needs, Problems, Risks, and Existing Capacities

Assess Needs and Problems

The needs and problems of affected populations, which response and recovery planners should consider, can cover a variety of issues such as: shelter, safety, food, drinking water, first aid, and medication (*basic aid*); information about what has happened, about the fate of loved ones, and about possible stress reactions (*information*); comfort, a listening ear, recognition of grief, compassion (*social and emotional support*); legal and financial problems, establishing a household again (*practical help*); and mental and physical health problems (*health care*) (Dückers & Thormar, 2015). The psychosocial needs and problems of people affected by disasters tend to change over time. These changes in psychosocial needs are related to the deterioration of social support (Amaratunga, 2006; see "consider risk and protective factors"). Rao (2006) states that support efforts should be "modulated according to the phase of recovery following the event occurrence because each phase will highlight different needs. (…). In the initial phases, the emphasis is placed on social intervention that can be delivered by community-level workers. In the later phases, the psychological issues that emerge necessitate the services of trained professionals" (p. 501).
The large range of problems mentioned demonstrates the need for flexibility and improvisation skills among psychosocial care providers (Van Loon, 2008). Stress is considered a normal reaction after a potentially shocking event. According to Van Loon (2008), psychosocial care providers involved in the provision of immediate psychosocial help to affected people, should not (only) focus on the possible development of event-related mental health problems (like PTSD) among victims. Putting emphasis on the treatment of psychological problems is considered too narrow given the extent of the needs and problems associated with the psychosocial well-being of affected people (Van der Velden, Van Loon, Kleber, Van Uhlenbroek, & Smit, 2009).

Consider Risk and Protective Factors

Effective psychosocial support requires an understanding of who is at risk within an affected population (e.g., vulnerable groups such as people displaced, children, and the elderly, but also first responders and other helpers). Typical risk factors linked to the prevalence of mental health complaints and a limited capacity for self-recovery should guide psychosocial support. Studies refer to risk factors such as lower socio-

economic status, female gender, lack of social support, exposure to death and loss, and existing mental health problems (Bonanno et al., 2010; Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). Additional stress is caused by actual or potential "resource loss," the loss of anything that matters to a person (Hobfoll, 1998), for instance, in terms of relations, possessions, work, someone's role in society and status. A risk reduction approach should incorporate addressing additional sources of stress linked to resource loss and other stress factors (Van der Velden et al., 2009).

Social support is a key component of community resilience (Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008) and—if absent—a well-known risk factor for the development of trauma-related mental health problems and, possibly, the attribution of physical symptoms from experiencing the event. Social support can vary if a person's life circumstances change, for instance, if someone moves to a new location, or if circumstances are altered by the disaster itself. Levels of social support, as perceived by affected citizens, tend to deteriorate in a disaster's aftermath (Kaniasty & Norris, 2004; Kaniasty, Norris, & Murrell, 1990). Collective emergencies can dramatically impact interpersonal social dynamics and the availability of community resources (Bonanno et al., 2010). The disaster stages model (Raphael, 1986; Yzermans & Gersons, 2002) illustrates the psychosocial impact of crises as an "emotional timeline." The "impact" phase is followed by a "honeymoon" phase with extensive levels of social support (sympathy, compassion, and attention from family members, friends, coworkers, community actors, governments, and media). In the "disillusionment" phase, in the weeks or months after a crisis, social support diminishes as the survivors and the bereaved pick up the thread of normal life. Raphael (1986) speaks of a "second disaster" when individual and community adaptive capacities reach a minimum. Gradually, the amount of social support is expected to regrow, with likely fall-backs, as an affected person overcomes the impact and enters a phase of "reintegration."

Strengthen and Utilize Existing Capacities

A core principle in the psychosocial support literature in disaster settings refers to strengthening and utilizing resilience, that is, adaptation or recovery capacity and resources available to individuals, communities, and societies (Bonanno et al., 2010; Dückers, 2017; Norris et al., 2008). Well before the current popularity of resilience theory in disaster mental health research, Omer and Alon (1994) noted that "the continuity principle stipulates that through all stages of disaster, management and treatment should aim at preserving and restoring functional, historical, and interpersonal continuities" at the level of "individual, family, organization, and community" (p. 273). The dominant perspective in the international literature is that the vast majority of people confronted with a potentially shocking event are capable of dealing with the psychological impact and capable of self-recovery (Bonanno et al., 2010). Some individuals will develop problems they cannot overcome themselves. While some authors focus on the capacity to adapt and interventions at individual level, others stress the importance of community-level resources/capacities, interventions, and programs (Basu et al., 2013; Comfort, Siciliano, & Okada, 2011; Dudley-Grant, Mendez, & Zinn, 2000; Dückers, 2017; Kapucu, Hawkins, & Rivera, 2013; Norris et al., 2006, 2008; Vernberg, 2002; Vymetal, 2006).

Provide a Supportive Context

Experts agree upon the importance of providing affected people with a "supportive context," which may include offering a listening ear, support and comfort, and being sensitive to immediate practical needs; offering practical and up-to-date information about the event; mobilizing support from one's own social environment; facilitating reunions with family and keeping them together; and reassuring people who are displaying stress reactions that their reactions are normal (Te Brake & Dückers, 2013). The notion of such a supportive context—which can be realized nationally or locally by government, businesses, and civil society actors—is reflected in three psychosocial principles:

- provision of information and basic aid;
- promote a sense of safety, calmness, self- and community efficacy, connectedness to others, and hope;
- social acknowledgment.

Provision of Information and Basic Aid

Information about the crisis, causes, and consequences, especially those killed, missing, or relocated, but also information on the status of response and recovery processes, practical guidance, and possible health reactions, is highly valuable for people confronted by a disaster. The same applies to direct basic needs such as safety, emergency first aid, shelter, water, and food, and reunification with loved ones, friends, and family members (Bisson et al., 2010; Te Brake & Dückers, 2013).

Promote a Sense of Safety, Calmness, Self- and Community Efficacy, Connectedness to Others, and Hope

Hobfoll et al. (2007) identified five essential psychosocial support principles, relevant for anyone who interacts with people exposed to crises. It is necessary to promote a sense of safety, calmness, self- and community efficacy, connectedness to others, and hope.

Social Acknowledgment

Maercker and Müller (2004) defined social acknowledgment as "a victim's experience of positive reactions from society that show appreciation for the victim's unique state and acknowledge the victim's current difficult situation. The term social here not only includes the (…) victim's [closest social network] (e.g., family, friends), but also significant persons (e.g., local authorities, clergy), groups (e.g., at the workplace, fellow citizens), and impersonal expression of opinions (e.g., media) about the experiences of the victims or survivors" (p. 345). Social acknowledgment is low if people affected experience societal disapproval, misunderstanding, criticism, rejection, or a lack of support. This can be problematic because it is social support that they are seeking.

Evaluate and Implement Lessons

The psychosocial support principles described above under "consideration of needs, problems, risks, and existing capacities" and "provide a supportive context" can be seen as assignments for the many different actors that are involved in the different stages of planning and the delivery of services to affected individuals and communities. In the principles under the third category, they can contribute to

closing the learning loop and service optimization. From a quality improvement perspective, the challenge is to approach each unique disaster context with the same series of quality improvement steps (plan–do–study–act) and to integrate (mental) health research into post-disaster management planning (Dückers & Thormar, 2015; Greenberg, Rubin, & Wessely, 2009; Reifels et al., 2013). First, collect information, rigorously and rapidly, about the needs, problems, risks, and (a lack of) adaptive capacities of the people exposed, also to verify whether expectations and assumptions are correct. Ideally, the psychosocial needs of the public, first response team, support staff, and volunteers will be assessed before advancing to the next stage of the disaster timeline (Amaratunga, 2006). Second, prioritize the issues that must be addressed and design a practical approach with clear roles and tasks for the actors involved, as well as required conditions ("plan"). Third, carry out the activities as planned ("do"). Fourth, evaluate the result in relation to the original plan and check whether principles are being put into practice ("study"). The final step, closing the loop, is to adjust the plan if necessary, to proceed with the plan or to end it ("act"). These steps increase the chance that affected populations will be served in an effective, efficient, need-centered, safe, and appropriate way (Dückers & Thormar, 2015). Basic "quality" criteria like these can be used to evaluate psychosocial support (including the performance of distinctive partners or networks) in positive or negative terms and, when appropriate, to implement lessons to improve the support of affected people in the present and the future.

PSYCHOSOCIAL CRISIS MANAGEMENT: A CONCEPTUAL MODEL

Bringing Crisis Leadership Challenges and Psychosocial Support Together
The next step is to bring crisis leadership and psychosocial support principles together in one PCM-model. The strategic crisis management model is thus enriched with insights from psychosocial literature. The six leadership tasks are used as the main platform for the development of a PCM-model to better understand typical challenges related to the psychosocial dimension of crises. In Figure 1 the crisis leadership challenges and psychosocial support principles are shown in different rings, linked to each other and centered around the well-being, functioning, and health of citizens exposed to potentially traumatic events. While psychosocial support principles are particularly relevant to professionals and trained volunteers, from a PCM-perspective they also provide meaningful guidance to public leaders with a responsibility for the well-being, functioning and health of citizens at national or local community level. Crisis leadership tasks and psychosocial support principles are structured anti-clockwise along the stages in the plan–do–study–act cycle in Figure 1.

[FIGURE 1.]

Sense Making
From a psychosocial perspective, sense making is needed to make an assessment of the event and its potential effects on the exposed population. This assessment should identify psychosocial risks, needs and problems, risk factors (insufficient) capacity to adapt, preferably guided by lessons learned from earlier situations. In the early phase of a crisis, the PCM-response is hindered by a lack of information. Public leaders have to access different channels to obtain necessary information. At individual level

this can be done based on informal conversations with the affected (Jong, Dückers, & Van der Velden, 2016a), or more formally through an investigation or professional diagnosis. At community or country level it is possible to perform a rapid health and needs assessment (Korteweg, Van Bokhoven, Yzermans, & Grievink, 2010), a health monitor to follow the development in time of mental and physical health (Yzermans et al., 2009; Yzermans, Baliatsas, Van Dulmen, & Van Kamp, 2016), or an analysis of social media, newspaper, or television broadcasting to understand emotions and perceived PCM-outcomes within local communities (Back, Küfner, & Egloff, 2010; Griffin-Padgett & Allison, 2010; Jong & Dückers, 2016; Jong et al., 2016a). Although these activities are helpful there is always a risk that sense making intensifies the crisis (Weick, 1988). Asking people about possible health consequences, may make them believe they are suffering or are going to suffer from a physical ailment and therefore make them extra aware of symptoms, regardless of whether these symptoms are linked to exposure.

Decision Making

Crisis leaders must make critical choices, also in relation to the psychosocial impact and necessary aftercare in the short-term as well as in the long-term. To ensure that the right principles are reflected in strategic crisis decision making, crisis leaders must be informed about particular characteristics and challenges surrounding the psychosocial dimension of crises, including the lessons learned from earlier disasters and major events (see "learning"). In disaster settings, (mental) health experts can highlight specific but critical crisis management aspects. Education and advice on psychosocial principles is also relevant to other partners, such as disaster personnel and emergency workers, primary caregivers (e.g., family physicians), welfare workers, clergy and other community actors (McFarlane, 1984; Powell & Penick, 1983; Raphael, 1984; Van Loon, 2008).

Including psychosocial support knowledge in decision-making processes enhances the possibility that coordination and meaning making are shaped and conducted in line with the right principles, strengthening and utilizing resilience, and anticipating the deterioration of social support.

Coordination

Crisis management and post-disaster psychosocial support have in common that both are conducted by actors with different tasks, interests, and responsibilities at different levels in a multidisciplinary inter-organizational network (Bisson et al., 2010; Boin & 't Hart, 2011; Dückers, Witteveen, Bisson, & Olff, 2015). The realization of services to affected populations after a disaster requires the involvement of a variety of government, business and civil society actors (Dückers, 2017). These actors will then be enrolled in what we can call a psychosocial support program: "a community intervention that can differ in length (weeks, months, years), scope (variation in themes) and organization (number of partner organizations at different levels)" (Dückers & Thormar, 2015).

Rescue workers, response team, families, volunteers, community workers, clergy, primary health care-givers, and therapists play a role in providing a supportive context. The PCM-challenge is to pursue cooperation across social groups (including groups of survivors and the bereaved), professional disciplines, organizations, jurisdictions, policy domains, and governmental layers. Without the alignment of activities and interventions and without the deliberate allocation of resources

(including information), adjusted to different circumstances through time, PCM is bound to fail in its aim to be responsive to needs, problems, risks and stress factors, (a lack of) resilience, and to establish a supportive context reflecting essential principles. Finally, providing information remains a vital element of PCM. News media must be regularly and appropriately briefed, in order to use their potential for disseminating information to the survivors, bereaved families, and the public (Kroon & Overdijk, 1993; Vasterman, Yzermans, & Dirkzwager, 2005).

Meaning Making

Giving meaning to something can have a positive effect on people's resilience and recovery from stressful events (Park, 2016). Benedek and Fullerton (2007) underlined the relevance of the "essential principles" (Hobfoll et al., 2007; see "provide a supportive context" in the previous section), but emphasized something was missing, namely a "vehicle" to bring the principles into practice. In a reaction, Hobfoll stated that the "passageways and obstacles" for the essential principles need to be elaborated (Dückers, 2013). Public leaders can serve as the necessary vehicle. In their meaning-making behavior, crisis managers can provide social acknowledgment and contribute to a sense of connectedness and hope, for example, just by being there and by using well-chosen words.

The meaning-making task is prone to being amplified by (social) media and becomes harder when public discussions are dominated by frustration about unmet expectations, disillusionment and a perceived lack of social support (the second obstacle in Figure 1). After the earthquake at L'Aquila, Italy, in 2009, the public was positive about the initial response and provision of temporary housing by the government, but then unrealistic promises were made. The government promised that permission for evacuees to return to their homes would be granted within a month of the disaster, but the actual repair of homes became a slow, disorganized process that was dependent on funds that were in very short supply (Alexander, 2010). When government involvement becomes a problem in itself, it will become harder for leaders to provide a convincing narrative with explanations and implications.

Psychosocially speaking, meaning making requires crisis leaders to consider the potential impact of rituals that are routinely employed in the wake of a disaster. Leaders are expected to play a role in "remembering" the disaster, its impact on people involved, including responders and communities as a whole. Nowadays, societies do not easily allow a disaster to be forgotten. Years after an event there is still a need—political or not—for commemoration ceremonies and monuments (Boin & 't Hart, 2011; Eyre, 2007; 't Hart, 1993). While this may be functional in terms of the legitimacy of leaders and institutions, and in terms of connectedness and social support, it could have the opposite impact on survivors and bereaved families who may feel pressured to share their grief in the public arena (Jong, 2013).

Account Giving

Investigations and inquiries play a role in aiding or inhibiting recovery (Eyre, 2004). In the accountability phase of PCM, social acknowledgment and evaluation of leadership come together. To what degree were psychosocial support principles followed in the response and recovery phase? In practice, PCM can be judged using a broad range of evaluation terms (see "learning"). Crisis managers must render an account of their decisions and handling of response and recovery. This account giving should be broadened to include how PCM was organized. If that is not done,

or not done properly, the legitimacy of responsible leaders and public institutions may well suffer as a consequence. The effective implementation of psychosocial principles enhances the fate of leaders in the wake of crisis. For instance, 6 years after the Bijlmermeer plane crash disaster in Amsterdam, health complaints escalated, ending in a highly contentious parliamentary investigation procedure, which threatened the ruling coalition (Boin, Van Duin, & Heyse 2001; Yzermans & Gersons, 2002).

Learning
During a crisis, we expect public leaders and crisis managers to take into account feedback that suggests the proposed course of action is not working as envisioned— they can optimize PCM by applying the plan–do–study–act quality improvement model. Learning from a crisis implies that lessons are remembered in the management of the psychosocial impact of a new crisis (this type of plan–do–study– act cycle is shown in Figure 1). Evaluation of PCM can be complicated because of the potential variation in normative viewpoints among stakeholders with respect to needs, problems and capacities of individuals and communities (with in-group and between-group differences), the multi-faceted composition of community programs, and relevant contextual differences (possibly connected to community or society-level characteristics) that justify another approach.

Moreover, as changes through time matter psychosocially, the evaluation strategy should be responsive to the different challenges crisis leaders have to solve at different time stages. If the response is too passive or too active, the evaluation will be negative (Dückers & Thormar, 2015). Negative-passive PCM-evaluations are expressed in terms of neglect, disregard, and a lack of insight, involvement, capacity, or opportunity. People can feel abandoned or ignored. The aftermath of the earthquake at L'Aquila (Alexander, 2010) and the Bijlmermeer plane crash disaster in Amsterdam (Boin et al., 2001; Yzermans & Gersons, 2002) can be seen as examples. Negative-active PCM-evaluations reflect over-attention and wasted resources. Things were done, but probably not the right things. After the Bijlmermeer disaster the mental health interventions made available to many victims were much too short to achieve any lasting result, did not follow an explicit protocol and, in many cases, did not prove to be effective even in the short-term. These and other experiences from the Bijlmermeer plane crash were used to implement an improved program after the Enschede fireworks disaster, almost 10 years later (Yzermans & Gersons, 2002). This example illustrates how lessons can be implemented in a new cycle of sense making, decision making, etc.

PCM AND HEALTH

A Two-Way Relation
Although psychosocial support and crisis management insights stem from different disciplines and traditions, integrating them can reduce foreseeable problems in the response and recovery phases. A key assumption in this line of reasoning, present in the body of knowledge brought together in this article, is that a relation exists between PCM on the one hand, and the well-being, functioning and the health of those affected on the other. This relation works in two directions and this is where the two research disciplines differ in their emphasis.

Psychosocial support literature is mostly interested in how PCM influences the health of affected people. Norris et al. (2008) describe this type of relation explicitly at community level: "[if] management systems (…) function effectively to protect lives, reduce injuries, minimize damage to public utilities, and connect community members to necessary services, it is reasonable to expect the population to remain well" (p. 133). Psychosocial support literature contains descriptions of interventions and programs, but so far provides little evidence on the health effects of such interventions and programs, nor on the health effects of leadership behavior. Literature on crisis management stresses the implications of disaster health issues for the leader's position. The general well-being of citizens is not an explicit crisis management objective. Authors emphasize the emotional well-being of society primarily with regard to the accountability and responsibility of public leaders ('t Hart, 1993), and the impact on their support from constituencies (Boin & 't Hart, 2003; Fairhurst & Cooren, 2009; Griffin-Padgett & Allison, 2010; Jong, Dückers, & Van der Velden, 2016b). In the end, the care for "victims and survivors" tends to be instrumental: a lack of well-being results in declining support from voters and political and institutional turmoil. At the same time, in order to politically survive the crisis, public leaders are more or less obliged to serve the interests of their citizens and to be responsive to their needs. In an ideal situation this shared interest functions as an institutionalized PCM-"safety valve," that is, the self-interest of the leader stimulates to take good care of the interest of disadvantaged citizens. What makes matters complicated is that, post-disaster, public leaders will have to deal with different groups and differing interests within those groups.

Causal Attribution Problem
The term disaster health effects implies causality between a person's condition and an external source of exposure. Methodologically, verifying a causal relation between the two is vastly complex as actual exposure levels are difficult to ascertain retrospectively while controlling other relevant factors. Causal attribution is a typical problem in disaster health research (Yzermans et al., 2009). Even in case of personal doubts concerning the plausibility of a causal relation, effective PCM requires public leaders to deliver a trustworthy and supportive meaning-making performance. Whether causality can be verified or not, when it is real in the subjective perceptions of affected individuals and they define it as such, it is real in its consequences, and demands serious attention from crisis managers while shaping the various PCM-tasks. This classical Thomas theorem (Thomas & Thomas, 1928) confronts public leaders with the challenge of finding a balance between social acknowledgment (meaning making) and confirming responsibility or entitlement to compensation (account giving).

CONCLUSION
Crises are disruptions with a potential psychosocial impact. In this paper, we explored the intersection between crisis leadership and psychosocial support. We identified a lack of integration of the two disciplines in the literature, and presented a PCM-model linking typical crisis leadership challenges to the well-being, functioning, and health of individuals in relation to their social environment. By combining insights from both knowledge domains, the scope of PCM can be better delineated as a distinctive crisis management theme. PCM stretches out over different time stages, from sense making, decision making, coordination, meaning

making, account giving to learning, confronting public leaders with predictable obstacles in their challenge to integrate the psychosocial support principles into crisis leadership. Clearly, PCM should not disappear from the radar of political-administrative elites when the operational phase of the crisis is over. The PCM-model can assist crisis leaders and researchers to better understand and to evaluate the psychosocial dimension of crisis management. PCM can only be effective if it is integrated into every stage of crisis management.

This paper offers a study model and several angles to formulate and test hypotheses. We encourage more empirical research on the realization of PCM-principles by leaders in different phases of a crisis, and under different circumstances. Particularly interesting topics are: the extent to which PCM-principles are recognized and translated in practice; relevant characteristics and factors explaining the success or failure of PCM (e.g., individual, role, governmental, societal and external sources; Wittkopf, Jones, & Kegley, 2007); and the nature of the two-way relation between PCM and well-being, and how it can be influenced. Systematic assessments of topics like these have the potential to enhance the forgotten psychosocial dimension of crisis management, and can therefore strengthen crisis management in general.

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FIGURE AND TABLES

Figure 1: Psychosocial Crisis Management: Crisis Leadership Guided by Psychosocial Principles.

Note. Crisis leadership challenges and psychosocial support principles are shown here in different rings, centered around the well-being, functioning, and health of citizens exposed to potentially traumatic events. General leadership challenges, originating from crisis management studies, are linked to post-disaster psychosocial support principles identified in the literature. While psychosocial support principles are particularly relevant to professionals and trained volunteers (e.g., rescue workers, family physicians, mental health professionals, social workers, and clergy), from a PCM-perspective they also provide meaningful guidance to public leaders with a responsibility for the well-being, functioning, and health of citizens at national or local community level. The crisis leadership tasks and the psychosocial support principles are structured anti-clockwise along the stages in the plan–do–study–act cycle. PCM encompasses different time phases in which public leaders must overcome several obstacles while shaping sense making, decision making, coordination, meaning making, account giving, and learning tasks.

Obstacles:
1. Lack of information
2. Social support deterioration / compassion fatigue
3. Critical public appraisal

Psychosocial support categories:
* Consideration of needs, problems, risks and existing capacities
** Provide a supportive context
*** Evaluate and implement lessons