ACF - INTERNATIONAL

THE PSYCHOSOCIAL IMPACT OF HUMANITARIAN CRISES

A BETTER UNDERSTANDING FOR BETTER INTERVENTIONS

ACTION CONTRE LA FAIM
ACF INTERNATIONAL

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INTRODUCTION

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WHY SUCH A DOCUMENT?

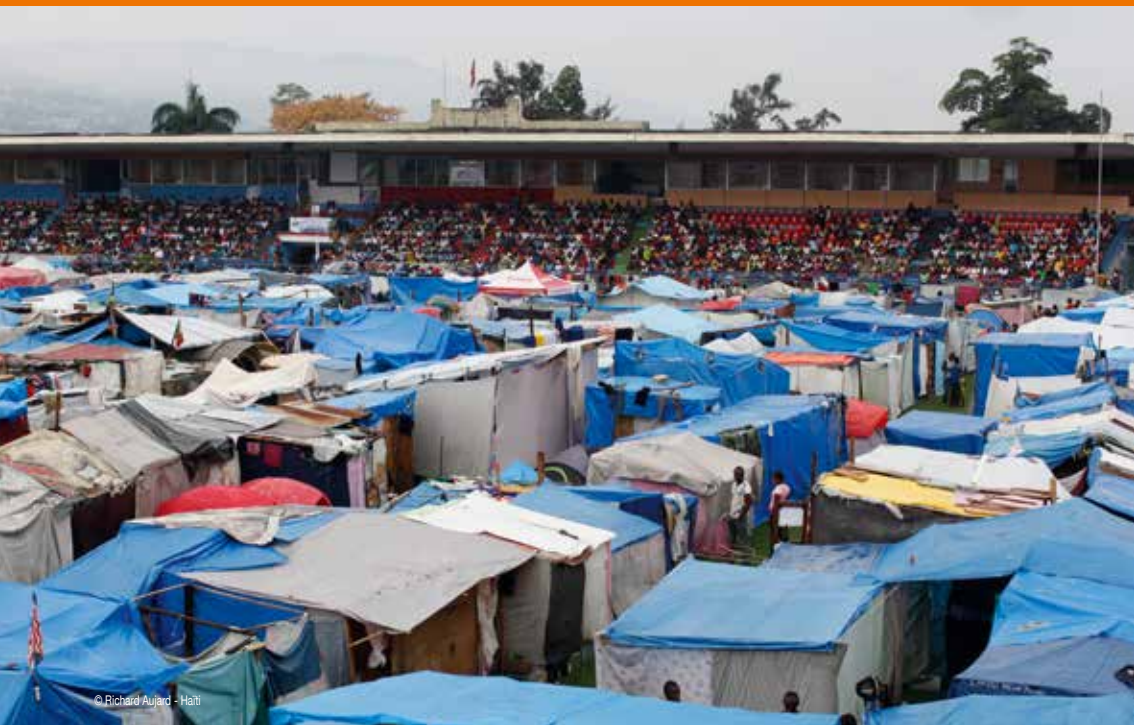
ACF's first strategic priority is to «increase ACF's action in the areas of prevention and treatment of malnutrition».
ACF's second strategic priority is to «respond and prevent humanitarian crisis, combat vulnerability and reinforce long-term resilience of populations in crisis».
Each year, ACF responds, through its emergency operations, to the vital needs of thousands of people facing humanitarian crises. These crises have many different causes, both natural and human: natural disasters, droughts, conflicts, totalitarianism, extremism, epidemics, etc.
These humanitarian crises, often highly complex from a material point of view, also cause profound changes on social and psychological aspects of individuals, within the families and communities.
Responding to such crises situations therefore involves a complex operational response, addressing psychosocial dimension. For this reason, and to increase the effectiveness of our humanitarian programmes and responses, it is essential that field workers understand the social and psychological impact of different types of humanitarian crisis on populations. An understanding of this aspect can thus support that such a component be integrated into ACF operational responses.

In this document, we describe the different crises situations in which ACF intervenes: natural disasters, conflicts, totalitarianism and extremism. We introduce the specific psychosocial impact on communities, families and children for each crisis situation.
We also clarify the difference between establishing psychosocial programmes to support the community and / or a victim (which involves specific expertise) and integrating the psychosocial dimension into ACF's different humanitarian programmes.

WHO IS THIS DOCUMENT FOR?

This guide is for those who, in the field as well as at headquarters, develop and / or intervene in ACF programming in humanitarian crisis situations.
Many will not have had training in the field of psychology, but need to understand the psychosocial challenges of a crisis situation, in order to make interventions more appropriate and meaningful. We hope that this guide will help build more respectful, appropriate programmes that respond to the psychosocial needs of populations.

UNDERSTANDING THE PSYCHOSOCIAL IMPACT OF HUMANITARIAN CRISIS ON POPULATIONS



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WHAT IS A HUMANITARIAN CRISIS?

«A crisis is an acute situation, difficult to manage, with severe and long-term consequences, which are generally harmful. A crisis should not be understood in relation to a stable condition, a stable state, a system or by universal references, but must be seen as a process. In fact, it constitutes a change in state, from one moment or type of organisation to another, for example from a stable or critical situation to a catastrophic situation. A crisis is therefore a disastrous upheaval from a previous situation.» (Josse and Dubois, 2009).
According to Josse and Dubois (2009), the criteria used to define a humanitarian crisis are the following:

- A rapid and serious deterioration in a situation,
- Numerous victims or numerous people whose lives are in danger,
- The unique nature and the extent of the crisis plunges the population into a situation of great distress,
- Substantial material destruction,
- Institutional management undergoing great difficulty or incapable of managing the situation.

Today humanitarian crises (or emergencies) are both multidimensional and complex. They are the result of sudden natural disasters (such as an earthquake), on-going natural catastrophes (such as drought) or man intentionally provoked situations (conflicts, dictatorship, for example). These emergency situations lead to a series of - sometimes rapid- psychological and social changes. These changes affect the individual, the family, and/or the community. They endanger the lives of the civilian population and / or make them unable to meet their vital needs. Emergency situations often involve standardised interventions based on meeting basic needs. These responses already contribute, at least partially, to the improvement of the psychosocial well-being of populations (a first stage, for example, is to ensure the safety and protection of people). **But, in order to promote a holistic approach in response to the complexity of humanitarian crises, a deeper consideration of the psychosocial dimension is crucial in all ACF programmes.**

GLOSSARY

The term **«psychosocial»** highlights the permanent relationships and interactions between psychological and social processes.

«Psychosocial support» describes the care and support provided to an individual (or family), with the aim of protecting and / or developing psychological well-being and / or preventing or treating mental disorders[1].

The expression **«mental health»** refers to the state of mental well-being of a person and not only to the absence of mental illness or addictive behaviours (WHO). Rightly, it concerns all human beings.

PFA – Psychological First Aid refers, according to SPHERE (2011) and the CPI (2007), to aid given to an individual who is suffering and may need support. PFA is intended for people who have recently been confronted by a serious crisis situation[2]

1 For more details on the cited words and concepts, please refer to the ACF International – Policy on mental health and care practices.
2 For more details please refer to the document «The psychological first aid» (WHO, 2012).

WHAT DO WE MEAN BY «PSYCHOSOCIAL IMPACT»?

The psychosocial impact of humanitarian crises includes psychological and social problems, at both the individual and community levels, following an emergency, as well as the impact on the existing psychological resources.
In crises situations, an increase in social problems (social breakdown, increase in gender-based violence, etc.), psychological distress (such as grief, , etc.) , mental health issues (such as depression, anxiety, post-traumatic stress disorder, psychosis, etc.) and individual difficulties in conducting daily activities is often noticed.
It is important to highlight that the psychosocial impact does not only affect the individual and his or her mental health. When psychosocial impact is treated, the different levels (individuals, families and communities) and types (emotional, psychological and social) of impact of the crisis are dealt with.

Individual psychosocial impact

Nobody comes out of humanitarian tragedies unharmed. Psychological reactions to such events are often dramatic. In addition, in such situations, individuals often have a reduced capacity to meet their vital needs, to concentrate, to find solutions to daily problems, to contribute to reconstruction and to interact with others.
Despite this serious impact, research shows that the majority of the affected population react quickly and positively, which enables them to cope and return to daily activities after the initial shock. The existing previous situation , culture, individual resources, social links and the type of crisis explains the difference in reactions experienced by individuals in emergency situations.

Collective psychosocial impact

Humanitarian crises do not only affect people individually, but also communities as a whole. Reference systems, habits, community and social links often change due to the emergency itself, but also, at times, as a result of humanitarian interventions. Interventions do not always take into account, for example, the original community hierarchy, risk groups and/or local representatives involved in the emergency, as community structures or traditional support mechanisms may be made weak and fragile.
Social disrupt can also keep the community capacity from relying on their own leaders and social links to organise themselves, support each other and begin reconstruction. The absence of places of worship and religious leaders may result in delay or cancellation of religious rituals or funerals, which contributes to the advancement of personal and collective grieving processes. Alcoholism and violence may spread as a reaction to the individual and collective inability to find a answersto their basic needs. Anxiety may be expressed through destructive actions.
Moreover, community resources may be negatively affected, further limiting the individual and collective ability to meet basic needs.

IS THE PSYCHOSOCIAL IMPACT THE SAME FOR ALL TYPES OF HUMANITARIAN CRISES?

Social and psychological reactions may differ according to national or regional context, culture, background to the disaster, degree of country development , crisis severity (and eventual repetition), timing and in particular availability of internal resources (e.g.: functioning services) and external resources (e.g.: humanitarian aid).
The psychological impact depends especially on the type of emergency. A natural disaster is often perceived as coming from an impersonal destructive force or from a divine origin and this can help the population to find motivation together to start again. A conflict or totalitarian regime, on the

contrary, will confront people with murder, which may cause more endemic terror, suspicion, impotence, guilt and depression.
The social impact may also differ according to the type of crisis. For example, in the aftermath of a natural catastrophe, there is mutual solidarity and support. In the case of conflict, due to arising suspicion in such a context, there is a stronger process of withdrawal within a group (less contact and fewer exchanges, reinforcement of the beliefs of one's own group) that may lead to fundamentalism. During a slow advancement of drought a community may be more prone to preparing to the crisis and finding better strategies that may be challenging to find during a sudden disaster[3].

SHOULD ALL PEOPLE AFFECTED BY A HUMANITARIAN CRISIS CONSIDERED VICTIMS?

Yes and no.
Yes, in the sense that all people affected by a crisis have been victims of the event and feel overcome by its unforeseeable and massive nature. We may speak in this case of individual or collective vulnerability.
No, in the sense that people affected by a crisis will rediscover – more or less quickly- something that enables them to cope with the situation and fight to survive This is the case of individual or collective resilience. Even so, it is often necessary, in post-emergency and rehabilitation phases, to assist affected people in the process of readjusting back to their normal lives and to support them, strengthening their resilience.
Psychosocial support requires interventions support the resilience of communities and individuals, avoiding actions that discourages autonomy.

In public health, the concept of **vulnerability** is closely related to the idea of danger. An individual or a group is vulnerable if it is predisposed to suffer a negative result from a given situation or problem. Vulnerability is determined both by the potential risk and by its impact. It may be related to the age of the subject, the gender, the health conditions, etc. (Josse, Dubois, 2009).

Resilience: from the Latin verb resilio, ire, literally 'to jump back', thus 'rebound, resist'. Resilience is, originally, a term used in physics that characterises the capacity of a material subject to an impact to recover its initial state. In psychology, resilience is the psychological capacity to rebound after one or more potentially traumatic events and to function well despite stress, adversity and unfavourable situations (Josse, Dubois 2009). It is an individual and/or collective process which makes it possible to face up to intense stress levels by developing (and using) one's own social and psychological resources.

3 For more detail, please refer to the chapter related to Natural Disasters

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DISTRESS AND PSYCHOPATHOLOGY: A DIFFERENCE TO BE CLARIFIED

Distress caused by natural disasters, wars and totalitarian regimes affects the world, from the earliest days. Often, cultural differences in expressing emotions and distress limits the understanding of certain attitudes, behaviours and practices related to the suffering of persons; this can be seen in under or over interpretation of its severity, for example.
In general, it may be said that people, in a crisis situation, may have normal reactions in situations that are abnormal". The majority of people affected recover relatively quickly from the initial shock and become concerned with their own and relatives' survival. However, the fundamental psychological distress may remain for a long time and slow rehabilitation and the reconstruction efforts or, in some cases, may lead to symptoms which require specific clinical treatment in psychopathological terms (mental troubles or disorders).

According to the WHO, in a crisis situation:

- 35–50% of the population manifests light to moderate distress that may be remedied through psychosocial intervention and may be resolved in the first weeks;
- 15–20% of the population present lasting light to moderate distress (psychosomatic issues, post-traumatic stress disorder, etc.). Specific mental health support intervention is necessary in this case;
- 3–4% of the population suffer from a major psychiatric disorder (psychosis, severe depression, major anxiety disorder) and need psychiatric treatment.

It is important to distinguish between **psychological time** and **chronological time**. These do not always correspond, which may give rise to errors in comprehension or interpretation. The signing of a truce (chronological time), for example, does not necessarily mean the end of their symptoms for the people (psychological time). Frequently, there is also a time during which symptoms do not manifest: the person's functions and acts in accordance with a survival mode. However, once the situation is stabilised and security is once again assured, symptoms may appear which had been somehow 'frozen' during the acute phase (the symptoms come out several weeks after the event). Finally, there are post-traumatic disorders which may be triggered by a new traumatic event. This was the case, for example, in Sri Lanka after the tsunami, where post-traumatic disorders related to the conflict appeared following the natural disaster (a new traumatic episode flares up the pain again from an previous episode).

SHOULD WE ONLY INTERVENE IN THE CASES OF TRAUMATISED INDIVIDUALS? CLINICAL VERSUS PSYCHOSOCIAL INTERVENTIONS

Over the years, humanitarian 'psychosocial' programmes have mainly targeted so-called traumatised people[4], requiring specific clinical treatment. The people who need psychological care are only a small percentage of the total population, whatever the type of disaster.
Since the 2000s, it's clear that we should not be exclusively focusing on psychological trauma (clinical intervention). The overall psychosocial context analysis and approach has made it possible to highlight the important of these interventions at different levels: community, family and individual, with adapted and complementary approaches.

Psychosocial interventions: actions with the priority goal of creating, restoring and maintaining the social functioning of the population affected as well as the affective and emotional balance of individuals at the level of their social environment.
Clinical interventions: actions focused on the most vulnerable individuals, specifically targeting psychological or psychiatric effects. (Josse, Dubois, 2009)

The IASC (Inter-Agency Standing Committee) pyramid for psychosocial support and mental health in emergency situations[5] proposes a system of intervention in stages, in order to increasingly meet specific needs. The base of the pyramid relates to the psychosocial needs of the whole population and the top of the pyramid relates to the needs of a limited number of people.

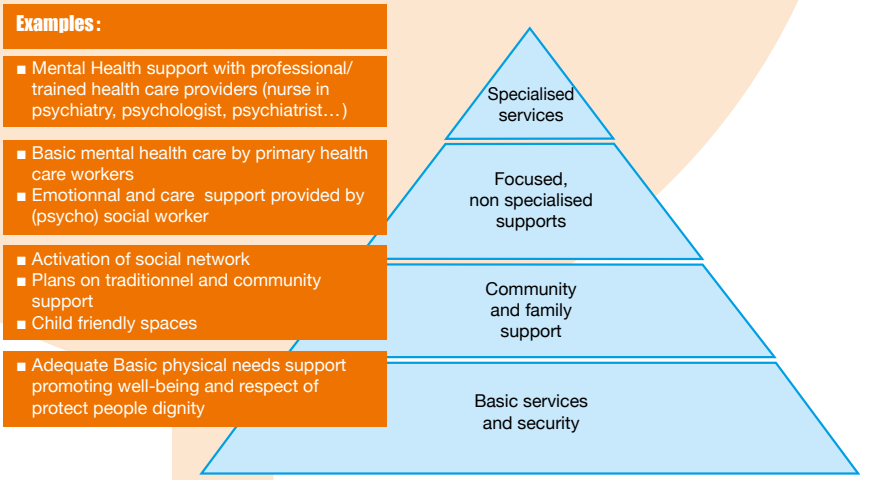


Figure 1. Pyramid of interventions for mental health and psychosocial support in emergency situations.

4 We refer here to the definition of Psychological Trauma in the Grand Dictionary of Psychology (LaRousse, 2000): an event experienced by a subject who experiences a very intense affective and emotional illness, putting at risk his/her psychological equilibrium and often bringing about a psychotic or neurotic type of decompensation or various psychosomatic problems.
5 IASC Guidelines on Mental health and Psychosocial support in emergency settings

CAN THE VULNERABILITY OF POPULATIONS IN DISTRESS BE MEASURED?

This is an important challenge for achieving more effective interventions and programmes.
To make this measurement, risk and protections factors (resources) must be determined, qualitatively and quantitatively, in the context of a given crisis, by using a certain number of indicators, such as the type of crisis (conflict, prolonged or not, natural disaster, etc.), the degree of exposure of the population (direct impact, indirect, etc.), the frequency of exposure, the level of impact and the degree of political economic, social and cultural awareness of the context.

Vulnerability may be social or psychological.

Social vulnerability relates to the capacity of a society, its institutions and the different communities that are part of it, to face up to multiple stress factors, because of reasons which are inherent and which have generally preceded the crisis.

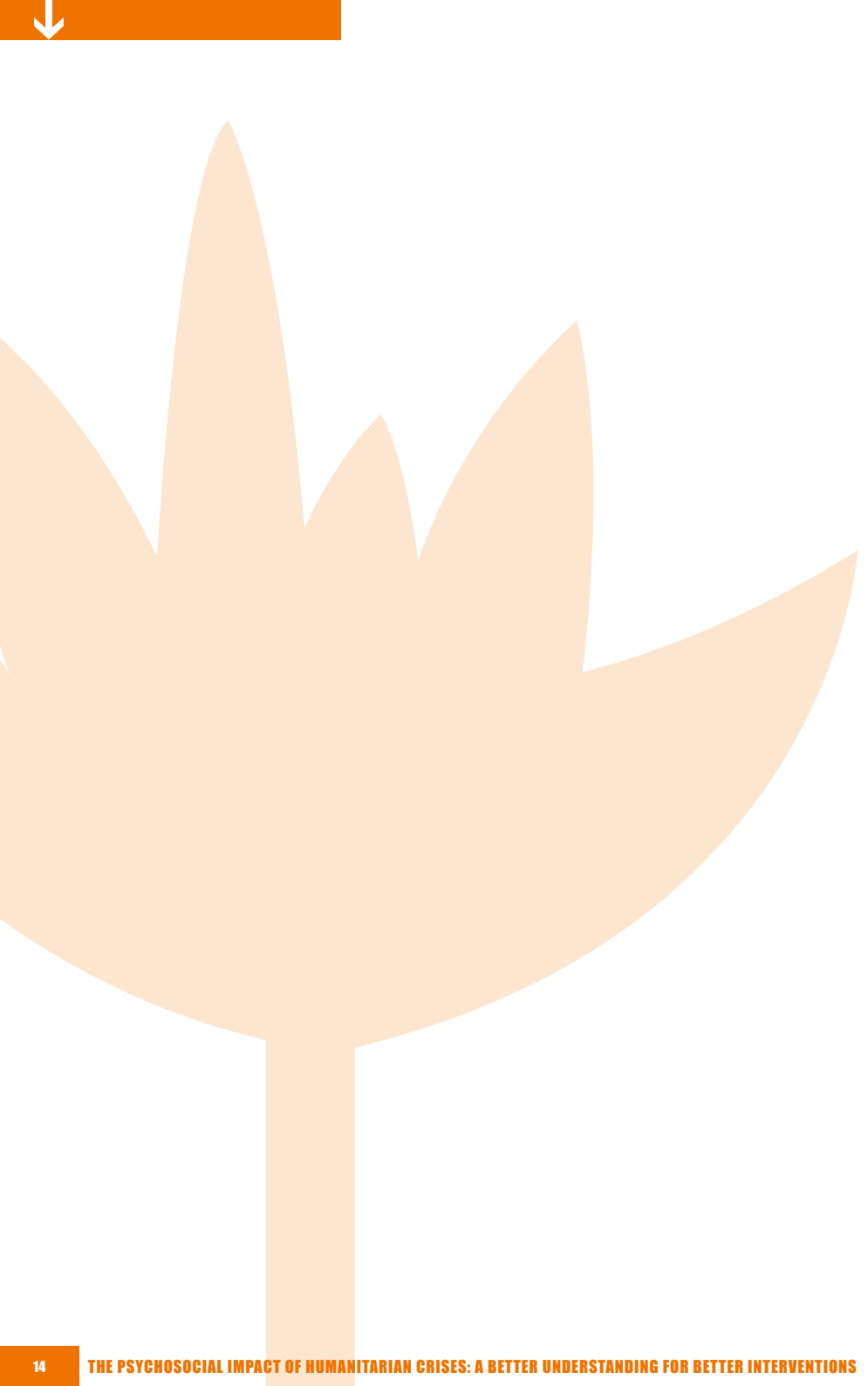
Psychological vulnerability refers to the situation when a severe crisis will have a impact on the psychological and behavioural functioning of a person, based on his/her initial environment, degree of exposure to the critical event and susceptibility to trauma.
Groups with a particular vulnerability must also be taken into account including: women, children, the elderly,the sick, the physically and mentally handicapped, refugees, minorities.

CAN PSYCHOSOCIAL RESILIENCE BE MEASURED?

Psychosocial resilience is defined as the psychological capacity to rebound after one or more potentially traumatising events and to function well despite stress, adversity and unfavourable situations. It depends on the risk factors and protection factors of the individual and the situation (internal and external resources)[6]. The more significant risk factors there are, the fewer people may pull through easily. Humanitarian interventions must have an emphasis on all protection factors at economic, social and psychological levels, by strengthening or creating resources.

Vulnerability and resilience are difficult to measure with quantitative variables only, given their multidimensionality and development over time. A qualitative analysis is essential to enrich and refine the analysis.

6 Examples of internal resources: self-esteem or sociability. Examples of external resources: social support network, good operation of a school, tradition that respects women, etc.



NATURAL DISASTERS: THEIR SOCIAL AND PSYCHOLOGICAL IMPACT

The word catastrophe is derived from the Greek work katastrophê which means 'reversal'. Etymologically, this word indicates 'upheaval' and designates an unfortunate event which occurs suddenly (Josse and Dubois, 2009).

FIRST SOME FIGURES...

In the world, the number of natural disasters related to climate has more than tripled since the 1960s. The total number of people exposed to such risks has now reached two billion.
Between 1975 and 2008, natural disasters caused more than 2.28 million death[7], mainly in developing countries. A major debate is underway to assess the impact of climate change on the psychosocial equilibrium and welfare of populations at risk.

WHAT KIND OF DISASTERS?

It is important to identify different types of natural disaster when developing a programme, as they have different individual and collective implications, according to whether they involve mass movements or not, and whether the people are more or less prepared for the disaster.
Among different natural disasters, there are sudden disasters (such as a tsunami) and disasters with a long or seasonal process (such as drought). This distinction is important, as reaction and response times are different, as are psychosocial dynamics, challenges, and type of interventions. Capacities and perception of anticipation, the effect of habit, existing livelihood coping mechanisms, beliefs and social representations of types of disasters are all important elements.

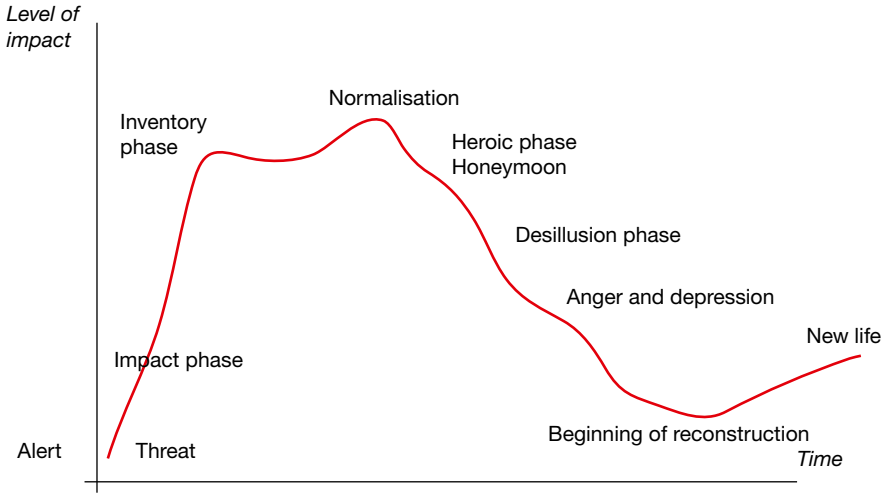
WHAT ARE THE PSYCHOSOCIAL REACTIONS AFTER A NATURAL DISASTER?

The psychosocial reaction of the affected population generally goes through a number of phases:

- **the alert and the threat** (for example, in the case of cyclones, volcanic eruptions or floods) cause great anxiety and stress, but also cause behaviours aimed at protecting the family and the community and preserving material goods (personal and social commitment/movement);
- **the impact phase** is the most destructive part of the event. It causes a wave of shock (fear and despair) to the whole population and activates survival mechanisms;
- then there is the **inventory** of damage;
- then follows the **'heroic' phase**, usually short, where there is assistance in a huge spirit of national and international solidarity, a so-called 'honeymoon' phase, during which the hope is born that all will quickly return to normal;
- then comes the often long phase of **disillusionment**, followed by anger and depression, which leads eventually to;
- the **reconstruction phase**, often chaotic in its development, and which takes years.

Humanitarian interventions must adapt activities and approached to these phases. In addition, each phase will prompt the humanitarian organisation to modify the programme based on the new needs and resources which emerge at each stage. The progress of the stages is illustrated in the figure below.

7 Cf. ACF-IN strategic document, 'Risk management in disasters for communities', 2011



HOW IS THE SOCIAL STRUCTURE AFFECTED?

During natural catastrophes, communities face material destruction and crushing losses in terms of family members, friends, homes, jobs, social networks, wealth, social status, and entire benchmark systems. This often yields a great sense of solidarity (heroic phase) above all in cases involving sudden natural catastrophes. The community is the first to provide aid before external aid arrives, for example, in searching for missing persons. The survivors' search for information and organization takes precedence over everything else, and contributes to reassuring and ensuring the safety of the population.

Often people must migrate into less dangerous territory, changing community interactions and linkages. Sometimes these linkages are stretched. Family, neighbors, and friends are no longer an available resource. A certain proportion of the affected population must live in IDPs camps. This is usually a temporary situation, can also be a prolonged situation: in Haiti, camps are still in place two years after the 2010 earthquake. Daily life redefines community ties and neighborhoods as new community representatives emerge (often coming from the outside (for example people who are not originally part of the community). Life in camps involves often promiscuity, which raises the risk of violence for certain vulnerable groups, in particular young women.

The temporary situation becomes an enduring one. The ability to adapt, which emerges right away, can eventually wear down and/or transform into anger against authority, which, in the eyes of the population, is not proving efficient but rather helpless.

The impact that catastrophes have upon communities and their functioning depends on the characteristics of the catastrophe (sudden/unexpected, the level of destruction) but also, as we have seen, on the internal and external resources of the community.

DO COMMUNITIES IN DISTRESS HAVE THE SOCIAL, PSYCHOLOGICAL, CULTURAL AND RELIGIOUS RESOURCES TO REBUILD?

Collective and social resilience depends on risk and protective factors that allow a group or community to respond postively or negatively to stress and adversity. However, internal as well as external protection mechanisms can be spontaneously activated in affected populations. As in the following cases, for example:

- Stress factors linked to the disaster diminishing over time (flood waters lowering, waves receding after a tsunami, volcanic eruptions calming; the population sees that there is no longer danger even if fear lingers on) and the population can thus aim for new beginnings
- The ties between families and individuals are reinforced suddenly due to danger and need for solidarity
- Communities seek a return to normalcy, as well as the establishment of new benchmarks. A common goal, such as reconstruction, is vital at this stage moment in order to "give a sense" to the disaster and to allow community members to comprehend that they are still living
- This normalcy allows schools and other institutions to reopen. When it is possible to assess the damage community members must then act to find water and food, to reunite families and to rebuild the social network. Recent research has shown that the most important protective factor in this context is the reactivation of social networks, which tend to be very damaged.
- Health care becomes available again as institutions reopen
- Religious authorities conduct religious ceremonies and traditional rituals, which contribute to "giving sense" of the tragedy. They also offer a space in which the deceased can be remembered, and mourning and forgiveness processes are initiated. Religious comfort is a precious, fundamental resource in time of catastrophe in that it supports anger management and identifies a superior protective force to tame fear.

The first anniversary of the catastrophe is a very important moment for communal recovery process, as well as for families. An almost palpable psychological improvement can be seen after the first anniversary, and this helps rehabilitation.

WHAT IS THE IMPACT OF NATURAL CATASTROPHES ON FAMILIES?

Initially, means of communication are damaged or destroyed and families lack information about their disappeared loved ones. They are left to themselves and often far from a help center or hospital. A few months later, this unfortunately sustains the provisional nature of their lives. The nuclear family is often an essential resource for the individual, but the functioning of the family can be seriously damaged by death or the handicapping of several of its members, even more strongly if the mother of the family has been the victim. As a result, fathers become lonely and start to search - according to the culture - to remarry, mostly in order to have support in caring for the children and the home. A psychological trauma that is too great can also, in some cases, create problems within family dynamics, reinforcing members on their specific helplessness and distress, since expression and emotions cannot be freely explored.

This can also lead to a reorganization of social roles. For example, as men encounter difficulties in finding employment and supporting their home, they progressively lose a sense of legitimacy and their place in society. In certain social groups this can drive a sense of emptiness as they lose self-esteem and become at risk of alcoholism and other addictions. They are also at risk conflicts and/or violence within their families.

"Baby booms" are also frequently observed after natural catastrophes, in the attempt to cling to life. But these babies are often born under unstable conditions which can lead to malnutrition and illness, overpopulation and insufficient harvests.

Furthermore, the arrival of an infant can reactivate the mourning of children that were lost, or other losses within the family. The birth can become a difficult moment for the family, who then will require more attention and support.

WHAT IS THE IMPACT ON INDIVIDUALS?

Individuals search to understand a catastrophe and a reason for such a destructive force. The difficulty in understanding the senselessness of the catastrophe can engender anxiety and depression. In some cases, stress linked to managing a changed and troubled daily life leads to more complicated symptoms, such as post-traumatic stress or psychosomatic symptoms.
Mourning (of people, but also of pre-catastrophe life) is clearly a major phase which affects all individuals after the catastrophe, breaking and fracturing their relationship to pre-catastrophe life, which must be mourned. Without established processes, individuals face hardships in reinvesting themselves in new lives, finding new directions and rebuilding relationships.
The post-catastrophe period is also marked by a range of very strong emotions: fear of another catastrophe, pain of facing the future and reconstruction, and shame and guilt for having survived. These strong feelings can manifest in serious symptoms if the individual does not find a safe space to express them.
Stress, strong emotions, and sweeping changes also have a strong effect on cognitive capacity. It becomes more difficult to concentrate, learn, assimilate information and develop solutions.

HOW ARE THE CHILDREN AFFECTED?

In natural catastrophes, children are some of the most vulnerable victims. They are more susceptible to illness and death from lack of food, poor water and hygiene as well as inadequate shelter and healthcare. Psychosocial difficulties linked to the emergency can have an impact on their parents' abilities and resources (material, emotional, and social). These difficulties place the child's health in danger due to a deterioration of childcare practices. Moreover, affected children risk exposure to exploitation, abuse, and human trafficking. The most vulnerable are those who have lost one or both parents, whose parents are undergoing grave physical or psychological suffering and/or children who have been separated from their family. Their psychological distress is expressed in different ways depending on their age and is generally observed as insomnia, restlessness, ,tears, lack of play or repetitive games, phobias, anxiety, bedwetting, and nightmares. Children react better and more quickly if they are surrounded by a protective and loving environment.

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Six months after the 2004 tsunami in Sri Lanka, young Balan (6 years old) could not stop having nightmares, waking up terrified and wetting his bed. He started to sleepwalk - his father would find him on the street. He went back to school but was unable to concentrate, and found it difficult to express himself to others. He spent the day in a corner, looking straight ahead and crying. He was aggressive toward his classmates and didn't want them to bother him. When the teacher asked him questions, he became anxious and agitated. The anxiety, fear, and stress that the unpredictable catastrophe brought upon Balan is revealed in his personality: a heightening irritability, continuing problems sleeping, and increased difficulty concentrating.

CONFLICTS AND THE POST-CONFLICT PHASE: THEIR SOCIAL AND PSYCHOLOGICAL IMPACTS

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SOME GENERAL REMARKS:

Post-modern conflicts are characterized by political, ethnic or religious struggle perpetrated by governments, militaries, or rebel factions. The destruction strategies (massacres, guerrilla war, genocide, terrorist attacks) vary greatly. Every year, these conflicts cause millions of men, women and children to be threatened, wounded, killed, raped, displaced, recruited by force, deprived of potable water, stable shelter, and nourishment.

DO DIFFERENT KINDS OF CONFLICTS HAVE DIFFERENT KINDS OF IMPACT UPON THE AFFECTED POPULATION?

Conflicts can stem from various origins: ethnic conflict, territorial invasion, religious war, competition for resources, etc.
The origin of a conflict determines the particular psychosocial impact upon a population: territorial invasion can be more violent as it is based upon the principle of domination. Ethnic or religious conflict can strongly affect inter-group relations and lead to an isolation of each group within their values and traditions.
The duration of a conflict, as with its intensity, has an evident impact on the population's resilience and their available resources. Moreover, conflicts can be characterised by varying levels of violence and destruction: some involve atrocities upon a population (torture and attacks upon vital social linkages) while others are characterised by destruction of assets (burned homes and villages), causing large-scale displacement of populations.
Despite these differences, violence remains associated with the endemic insecurity felt in these communities, as well as in families and individuals, to differing degrees.

HOW CONFLICTS WILL CHANGE COMMUNAL TIES...

One example among many...

After a four-year blockade and the Isreali « Operation Cast Lead », 1.5 million residents of Gaza live in a closed environment of not more than 360 km2, where the movement of goods and people is subject to severe restrictions. In 2011, nothing changed, and attacks against the civilian population continued daily, maintaining a climate of terror, frustration and despair. Assuredly, material conditions remaine quite rough 2012: drastic restrictions on the import of construction materials makes the reconstruction of homes, schools, universities, hospitals and other infrastructures, such as sanitary facilities, impossible, and keeps the population in a subsistence economy. But the impact of the blockade has been even greater on the social and psychological balance of the communities. Even though there seems to be some cohesion based on hatred of Israelis and daily religious practice, the social structure has deteriorated under endemic violence, in particular within families, a failing healthcare system (according to WHO), a 45.2%[8] rate of unemployment, and the absence of a future for the youth. Society has regressed to a traditional way of life where women remain at home and are often subject to polygamous unions, domestic violence has increased and excessive births are registered. Unfortunately, children are also victims of the conflict. They are experiencing major health and educational problems and are increasingly involved in acts of delinquency.

8 www.emro.who.int/palestine

It is known that, in situations of war, the deterioration of the social structure is first and foremost tied to the number of dead, wounded and abuses committed against the civilian population. The effects of violence and insecurity alter human relationships profoundly as:

- feelings of injustice and helplessness pervade;
- the proliferation of militant groups may cause a degree of confusion and breed distrust. This then decreases ties with those outside of the community and strengthens gestures of solidarity between individuals of the same group;
- identity closure may also have consequences on the structure of traditional society, strengthening values specific to the group and a stiffening of group characteristics (religious values for example). There is also, in certain cases, the phenomenon of endogamy: families prefer to marry their daughters to men belonging to the same clan, or even to the same family. This identity closure may also lead to certain levels of fundamentalism.

In addition, conflicts can often lead people to travel for significant distances, undermining community ties. Families are often at risk of losing touch with their social values, and therefore losing significant external resources when confronted with the emergency situation.

... AND DESTABILIZE FAMILIES?

Men, who did not die in conflict or are fighting at war, are often required to hide or stay in the camps to avoid being killed or enlisted. As such, women become responsible for all tasks related to the household and children, as well as bread-winning. Men may sometimes struggle with this reversal of roles and the stress is causes on the livelihood. In fact, the women do everything. The omnipresent tension and feeling of helplessness sometimes take the form of arguments and conjugal and/or parental violence. Misunderstanding, conflict and tension are no longer expressed verbally but through violent acts or abuse.

Moreover, sometimes mothers are no longer at home to watch over the youngest children over long periods of time. The older children, themselves very young, may therefore take on that responsibility. These situations may be particularly conducive to malnutrition. For example, the older children may not feed the youngest properly (incorrect choice of foods, insufficient quantities, limited practice of good hygiene) and may not eat properly themselves.
Finally, distrust due to frequent misunderstandings, evolving roles or conflict-related political differences, may happen in the family.

THE SPECIFIC CASE OF THE CAMPS: HOW WILL SOCIAL LIFE AND THE REORGANIZATION OF THE COMMUNITIES AND FAMILIES TAKE PLACE?

Fatma has just arrived with her seven children to the Al Salaam camp in Darfour. She is completely desperate. She explains that a heavily armed militia attacked her village three days ago in the early morning hours. Several people were killed before her eyes, including her neighbors' two children, before the houses were pillaged and burned. A truck picked them up, along with 100 other people, and drove them 300 km along byroads. They were attacked once again yesterday. In the confusion, she was separated from her husband. She also does not know what has happened to her elderly mother, who may very well have been killed in the attack. They are starving and exhausted.

During the *first phase*, in addition to having fled the violence and insecurity, refugees and/or IDPs are unprepared for the dehumanising situations of camp life, where everything must be learned: obtaining a refugee card, fighting for access to shelter (competition sets in), having access to food, learning to share latrines with strangers and bearing with unhygienic conditions. Not only have these people suffered ill-treatment, in the camp they must cope with insufficient food, great changes to their daily routine (location and weather change as well as interactions and activities), shifts in their reference systems (social roles, dynamics, shared values, group identities, beliefs), and contact with humanitarian workers. There may also be tensions between camp authorities and traditional group leaders (community representatives) of the displaced, who often lose their power and authority over the population.
All of this is a source of great stress for families and individuals, and violence may be a direct consequence.
In the *second phase*, these refugees or displaced people slowly realise that their living conditions are deteriorating: overcrowding, closure of camps to new arrivals (which can stand in the way of family reunification), daily frustrations, juvenile delinquency, alcohol and drug consumption, and an increased lack of solidarity linked to food competition... And this will not change quickly. [9]

Expectation, desperation and anxiety for the future may set in and reduce the family's capacity for resilience in the face of the emergency as well as their ability to begin the rebuilding process.

Often in the camps, the entire family (sometimes the extended family) must share a small tent: the parents no longer have privacy. Several adults exercise authority under the same roof: each one feels that they do not have enough control over events; some feel short-changed while others feel unwanted. Often good intentions are not enough to prevent disputes among adults. Each additional sacrifice decreases the stability of camp life. The tents are close to one another: there is no room for small vegetable gardens. Each new wave of arrivals makes it more difficult to stock up on supplies: the families cannot live on food rations. In addition, the people are also suffering the effects of epidemics.

WHAT RESOURCES WILL BE MOBILISED BY THESE FAMILIES AND COMMUNITIES IN ORDER TO SURVIVE AND ADAPT?

Following the early days of the conflict, material and intellectual resources will depend primarily on humanitarian aid given by responders, who are expected to be both respectful and attentive. On average and in the long-term, the traditions and spiritual as educative practices will generally provide social and psychological support, as well as identity support, creating a sense of calm in the midst of the chaos.
The need to protect and educate the children, and give them a brighter future may also strengthen the determination of the parents and families to survive, and help them cherish the hope of a better future.
Humanitarian aid, protection and safety of the people, as well as good information about the situation and on available aid, are all factors that make it possible to substantially improve the psychosocial well-being of the population. This can be further strengthened by the role played by a return to a specific routine, such as the return to work, schooling for the children, etc…

9 For more details, refer to the works of Michel Agier, who describes the life in refugee camps from an ethnological and anthropological standpoint. Aux bords du monde, les réfugiés. Paris, Flammarion, 2002.

WHAT PSYCHOLOGICAL IMPACT DOES WAR HAVE ON INDIVIDUALS?

Although for the last decade, humanitarian aid has exported the Western concept of *post-traumatic stress disorder*[10] following a crisis, the majority of the population does not suffer from this syndrome (in the psychopathological sense of the term). The trouble may be expressed in a less serious manner or take on a psychopathological form[11] that differs from this stress-related condition.
There are, for example, more widespread and less serious psychological consequences to take into consideration that are generally classified as "*psychological distress/suffering*". This malaise can encompass different problems, such as the feeling of increased vulnerability, fear, and low self-esteem. In this type of situation, reactions are often the consequence of both the conflict and the conflict's impact on interpersonal relationships.
But there are also psychopathological manifestations other than post-traumatic stress disorder.
For example, people frequently experience "physical manifestations[12]» of certain problems and consult the doctor for physical symptoms. This means that people transform their despair into a medically (either general or traditional medicine) admissible physical complaint (headaches, difficulty sleeping, stomach aches, weight loss, etc.).
It can also be said that depression conveys despair: an uncertain future or lack of future and a situation of powerlessness with regard to a life that has become unmanageable. Often this is caused by impossible, never-ending mourning (bodies that are never found, unaccomplished funeral rites, lost property, obligation to flee, etc.). We see signs of depression, for example, when a mother no longer cares for her children because she is physically and emotionally exhausted. Symptoms often include a loss of appetite, troubled sleep and, sometimes, trouble breast-feeding. This is notices as women with these symptoms may tend to isolate themselves and not attend supply distributions, for example. Depression often leads to the inability to carry out routine activities, a feeling of extreme fatigue and helplessness, lowered self-esteem and/or profound melancholy.
Finally, *Anxiety*[13], ranging from simple worries and/or fears to more serious forms of anxiety disorders, is also a frequent response in conflict-related emergencies.

WHAT IS THE IMPACT OF CONFLICTS ON THE MOST VULNERABLE GROUPS?

In the context of conflicts, the gender issue is significant. UNHCR considers that those women who are isolated, who are head of their family, and/or widows, are amongst the most vulnerable, ranking them above children in foster homes, people with a physical or mental handicap, and older people.

Indeed biological factors, as well as the role of these women in their own society, make them more susceptible to war violence. In particular, adolescent girls are most often the target of sexual abuse and violence, leading to complications in their pregnancies and in the development of their children.

10 Post-traumatic stress disorder (PTSD) : a condition that arises following an exceptionally violent event (being attacked, being the victim of an accident or catastrophe, witnessing one's life or that of loved ones being threatened), which induces distress. It should be noted that there is often a period between the stressful event and the advent of PTSD: the «latent period» (APA).
11 Refer also to the paragraph on page 9, which distinguishes between psychopathological and psychological distress.
12 Expression of a mental health problem through physical pain.
13 Anxiety: psychological and physiological state characterized by somatic, emotional, cognitive and behavioral components (Seligman et Al.).

RAPE: A WEAPON OF WAR, IMPACT ON THE FAMILIES AND PSYCHOLOGICAL DISTRESS FOR THE INDIVIDUAL RAPED.

Sexual violence in armed conflicts has always existed. Rape in times of war is a way of reaching and attacking the enemy by "polluting" its descendants. The vagina becomes a strategic, military weapon, and it is in causing offence to other males that the "pleasure" derived from wartime rape apparently lies. Violence linked to women.during armed conflicts cannot be viewed as "collateral damage", but is in fact an intrinsic part of war.

Teresa, a 19 year old Congolese, tells us:

"At the beginning of 2006, I have met bandits not far from Bukavu. I have the face of a Rwandan Tutsi and that is probably why I was attacked. Six men jumped on me and raped me. I got pregnant with my first child. Because I had nowhere to go with the baby, a volunteer took pity on me and took the child. My daughter lives in Bukavu and she is now 2 years old. Now I am married and mother again. My husband is present, but we live separately. My husband's family found out the event of rape and now we are almost separated, though my husband is really making an effort. But he is pushed and harassed by his family because of me. So we live this way, putting up a front, but inside I am unhappy. When someone asks me about this problem with my husband's family, it makes me feel worse… I was going to leave and live alone, but what made me decide to become a psychosocial counsellor was that at the beginning I was helped and comforted by other people and by the leaders of the association. I saw how the lives of others were improved by counselling and that encouraged me to take on this role, and face up to the situation. However, this trauma is still in me even though we are taught how to cope with it. I try to stay calm, even if persecution continues in my husband's family. But when I hear the others, I feel my strength coming back."

The reactions of families to rape can be quite different according to culture. Very often, shame is quite an important element (if the rape case is discovered and reported) and it can translate into rejection, physical or psychological, of the individual (girl, young woman, man[14]) who is considered unworthy, impure and guilty. The child born as a result of rape is looked upon with mistrust and often rejected. However, a certain amount of solidarity can also be found in the treatment of the individual, who is seen as a victim to be protected and supported.

Psychologically speaking, these individuals feel powerless about what has happened to them and are full of self-disgust (often feeling dirty and guilty) which makes them conceal the truth. Moreover, rape can create depression, anxiety and even a post-traumatic stress disorder. Some women often become incapable of looking after or breastfeeding their child, unable to show affection or play with "the baby of the enemy". Indeed, they may completely reject or abandon the child. It is also not unusual for them to commit suicide, as these women see no way out of this living hell.

14 Very often, rape victims are women, but men or children may also be victims of rape or sexual abuse.

TOTALITARIAN AND EXTREMIST REGIMES: THEIR SOCIAL AND PSYCHOLOGICAL IMPACT

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UNDERSTANDING THE BACKGROUND...

In the 21st century, totalitarian regimes seem to have taken new forms to persecute their people, different from the Communist and Nazi regimes of the past. But a closer look shows that they are in essence the same and that the psychosocial impact on populations is just as devastating.

The X regime[15] has become one of the most repressive in the world, as well as one of the latest military dictatorships. Its government is totally illegal and anti-democratic. Any congressman who expresses criticism of the government risks up to 20 years in prison. The political and social situation is appalling: forced work and displacements, torture, executions and arbitrary imprisonment… Detention conditions are inhumane in the regime's prisons, where torture is considered as "state policy".

According to multiple sources, the number of forced workers (men, women and children) rises up to hundreds of thousands of people over the whole country. They are employed without payment, and in the worst conditions, on construction sites managed by the military (roads, dams, railroads, bridges, barracks, mines or forests…). Sexual aggression perpetrated by soldiers on civilians, women, and girls are also current practices.

Massive displacements deeply change the demographic and socio-economic balance of the country in the longer term. Severe malnutrition is chronic and the infantile death rate extremely high, and in some areas, the rate of maternal deaths is alarming. In such an explosive context, the army continually increases its power. It becomes a "State within the State". A high number of children are forcibly recruited, making the number of child-soldiers in this country the highest in the world. Some of these children are regularly tortured (causing accidental death in certain cases) or forced to commit severe human rights violations against civilians or other children.

WHAT ARE THE MEANS USED BY A TOTALITARIAN STATE TO CONTROL ITS POPULATION?

- Omnipresent administration and propaganda, where the army plays a central role;
- Control of the population through an arbitrary division of territory in geostrategic zones, preventing free circulation of citizens;
- Control of media and Internet censorship;
- Pervading surveillance and repression, with highly efficient intelligence services, using widespread arbitrary imprisonment, with or without summary executions;
- Strong discrimination against ethnic minority groups;
- "Spies" recruited from the civilian population;
- Deliberate continuation of poverty, poor access to education, resources and the outside world.

15 Fictional example.

In order to reinforce national unity, indoctrination starts very early with education in the State official language: minority languages are banned. The aim is to discourage children who only speak the local language; they do not understand what the teacher says and give up. So they have no chance to develop. The State invests very little in education and textbooks offer a version of history "revised and corrected" by the government. The handing down of history and the collective memory is a key issue for national unity, for highlighting the greatness of the nation and for preserving the ideology of the regime in power, based on a hatred of minorities, neighbouring countries or those in the West.

Totalitarian states often have the monopoly of mining, industrial and oil activities. Consequently, they need a workforce and resort to forced labour. They send the army to commandeer villagers, provoking mass population displacement, burning down their houses to prevent them from coming back. When displaced populations arrive in resettlement zones, there is no infrastructure: no houses, no sanitary facilities, no schools, and no hospitals. Agricultural resources are insufficient so the most vulnerable – the women and children – are very quickly exposed to malnutrition and epidemics.

The state forces people to sell a significant and unpredictable part of their agricultural production at reduced price, which often obliges the farmers to borrow in order to eat.

WHAT ARE THE CONSEQUENCES OF STATE VIOLENCE ON COMMUNITIES AND FAMILIES?

In the small towns and countryside of country X[16], living conditions are often quite dramatic. One may see factories that have been abandoned for lack of energy resources or spare parts, steam locomotives fuelled by old tyres, huge concrete highways on which no vehicle ever travels, inefficient agriculture using ox-drawn carts more often than machines, frozen fishermen waiting near an ice hole on a river, women searching in the mud for something to light the fire, frozen bodies of fugitives lying on river banks near the border, columns of prisoners using picks and shovels under the unpitying eye of their guards. While stunted children stare blankly, their mothers prepare soup with roots and other unidentifiable ingredients.
Chronic malnutrition weakens the immune system, disrupts the young ones' development and encourages the spread of epidemics. Though the health system officially ensures free public health care for everyone, in fact, doctors ask to be paid in cigarettes, alcohol or just basic foods. Amputations are carried out without anaesthetic and operations conducted by candlelight because of power failures.

At this stage, are communities or families still there? Through deliberately enforced famines, arbitrary imprisonments, with or without summary executions, families of prisoners are locked in terror and forced to remain silent. Solidarity networks are destroyed and a climate of distrust pervades what is left of society. These systematic abuses clearly have a massive social and psychological impact on a whole country or area. The totalitarian society slows down and loses its impetus, functioning in an endless chronic collective depression. This is one of the ways in which totalitarian regimes maintain their power: they systematically destroy community ties, by creating mistrust between people and through fear. The deliberate continuation of poverty, lack of education and propaganda are an integral part of their strategic policies.

16 The example described is fictitious.

WHAT ARE THE DISTINCTIVE CHARACTERISTIC AND CONSEQUENCES OF STATE OPPRESSION ON AN INDIVIDUAL'S PSYCHE?

Mental manipulation, psychological suggestion, impact of daily terror, threats of imprisonment and torture, humiliations… all these conditions create a feeling of powerlessness and mental confinement, which may result in chronic anxiety and depression. Any rebellion can only be expressed through silence or flight. Traumatic events and grief are experienced in isolation, with the constant fear of betraying oneself. There is no hope in the future. Independence and planning for the future are impossible. Loss of control over their life is inevitable; each surge of hope is destroyed. As a result, mental functions are reduced, freedom of thought and creativity are limited. There is a reduction in empathy which affects the emotional bonds between individuals [17]

17 For further reading, cf. Carnets d'un psy dans l'humanitaire, by Francis Maquéda

HOW IS IT POSSIBLE TO INTEGRATE A PSYCHOSOCIAL DIMENSION INTO ACF INTERVENTIONS AND PROGRAMMES?

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WHY DOES A PSYCHOSOCIAL DIMENSION NEED TO BE INTEGRATED INTO ACF PROGRAMMES AND INTERVENTIONS?

Humanitarian emergencies, regardless of their origins, have a strong psychosocial impact on communities, families and individuals. Not taking this into account means limiting analysis, understanding of the emergency and needs, and the deployment of adequate/adapted aid and support.
Knowing the psychosocial changes, dynamics and needs related to emergencies can allow for better integration of this analysis into interventions and therefore to propose more effective and sustainable actions.
This corpus of knowledge has now been synthesised by the Inter-Agency Standing Committee (IASC) in the form of *Guidelines on Mental Health and Psychosocial Support in Emergency Situations*, which brings together current internationally accepted good practices. They describe, in particular, how to ensure, in the first few hours of an emergency operation, the inter-sectoral and cross-disciplinary coordination of interventions by including the psychosocial element. This includes all sectors, whether it is nutrition, food security and means of existence, water, hygiene and sanitation, etc.
Since 2002, Action Against Hunger (AAH) has adopted the approach of integrating the psychosocial dimension into its emergency and development programmes in order to improve quality and propose interventions increasingly adapted to and respectful of the sociocultural context. This has allowed strengthening population adaptation mechanisms while not further dismantling the social and familial environment. AAH, as of 2002, began considering, for example, that malnutrition is due not only to a lack of food, drinking water and to diseases, but also due to the absence of adequate care for children in accordance with their age and appropriate bonding between the children and their care givers or families. This consideration was also about recognising that care practices dimensions are even more in difficutl in the context of humanitarian emergencies (see the AAH policy on mental health and care practices). That is the reason why ACF provides response to psychological needs in case of emergency to support people in distress.

Guidelines, section 9.1[18]

[Unofficial translation] In many emergency situations, hunger and food security cause serious stress and undermine the psychosocial well-being of the population affected. Conversely, the psychosocial effects of an emergency situation could endanger food security and nutritional status of a population. An understanding of the reciprocal links between psychosocial well-being and food/nutritional security (see the following table) allows for an improvement in the quality and effectiveness of food-aid and nutritional-support programmes while protecting human dignity. Misunderstanding these links is harmful and translates into, for example, programmes that require people to wait in line for many hours to receive food, thus treating them like dehumanised and passive consumers or creating tense conditions at foodstuff distribution points.

18 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Situations. IASC, 2007

HOW IS IT BEST TO INTEGRATE A PSYCHOSOCIAL DIMENSION INTO ACF'S INTERVENTION CONTEXT UNDERSTANDING?

- The concept "humanitarian" encompasses humanity, human, person, women, child, sadness, anger, joy, love and laughter in link with statistics, operations, tons of rice, medical equipment, etc. Integration of the psychosocial aspect allows humanitarian workers to be more respectful, more attentive and focussed on understanding the human issues associated with their intervention and to promote ethics. This applies as much during responses to humanitarian crises as during post-crisis or development-support interventions. Thinking, above all, about the human aspect is a first step in integrating the psychosocial dimension: we support people, families and children first and foremost, not just 5,000 refugees or 500 beneficiaries. Let's start to think of them as people.

- No intervention is possible without taking into account the global system of an emergency situation. This implies including an understanding of what intangible aspects, which human sciences have addressing for nearly a century (i.e. distress, social destruction). The impact of our work risks being limited if activities are proposed following an emergency while neglecting the difficulties that some families may have in reorganising themselves and entering into a reconstruction dynamic.

- Integrating the psychosocial dimension also allows us to strengthen a key humanitarian principle: do no harm. This integration translates into participation in co-ordination groups in order to better understand the population and/or in information-gathering in order to propose an optimal action by limiting a potential negative impact of the humanitarian intervention, for example, on community organisation (economic activities not adapted to the context or that could create inter-group conflicts). We thus take care not to cause harm to the population that we are helping.

- Lastly, in the past decade it has been largely demonstrated, as much by the international community as by NGOs such as Action Against Hunger, that programmes are all the more effective when they integrate an understanding of the context and its psychosocial component. Taking into account the psychosocial component allows us to favour and promote the autonomy, recognition and rehabilitation of populations and people in crises' contexts because it allows focus on the specificities (such as suffering and difficulties but also loss of resources) of each community and to restore their dignity and autonomy.

- By taking the above into account, we can adapt our interventions to the real needs (material, social and psychological) and to the characteristics of communities to avoid negative consequences of our intervention, such as disruption of roles and social dynamics, additional trauma and cultural incompatibilities with the practices and information proposed, which generates much frustration or miscomprehension.

- Integrating the psychosocial dimension into the various areas of ACF interventions will allow ACF to better understand the changing context by integrating the social and psychological impact into the context analysis, to assess the impact of our interventions on families, groups and communities and thus to better adapt the interventions. For example, the effect that infrastructure, such as a well, could have on interactions between families and individuals, on their daily activities and rhythms, on the roles of people in the community, are all crucial pieces of information when determining the relevance and feasibility of a well. Such considerations are necessary when determining the approach and terms of intervention and promoting its sustainability.

ARE THERE BROAD INTERVENTION PRINCIPLES TO BE FOLLOWED AND WHAT ATTITUDES SHOULD BE ADOPTED IN ORDER TO TAKE INTO ACCOUNT AND RESPECT THE PSYCHOSOCIAL DIMENSION OF THE BENEFICIARIES IN ALL HUMANITARIAN INTERVENTIONS?

- The first principle is **equality** which is based on human rights. This means, during an intervention, promoting impartiality in the availability and accessibility of packages, regardless of gender, age group or linguistic or ethnic group membership. Particular attention must be paid to *groups in greater difficulty* and their specific needs, such as handicapped persons, the elderly, pregnant women, unaccompanied children, etc. Respecting the principle of equity means respecting the singularity of each individual and his or her personal difficulties and resources and adapting response as required (*adapting work procedures or putting in place referencing systems if needed if direct support is not possible within the framework of the organisation*).

- Humanitarian action must **maximise the participation** and involvement of the local affected populations in the humanitarian intervention. In most emergency situations, a significant percentage of the population is resilient enough to be able to participate in the efforts deployed during the emergency and reconstruction phases. This avoids a hierarchical relationship between those who provide aid and those who receive aid and gives a voice and an active role in reconstruction to the people while respecting their values and way of life. Regular consultation with beneficiaries and their involvement in the development of our intervention procedures is one example.

- One of the key principles—even at the very beginning of an emergency—is to identify **local capacities and/or resources**, support teamwork and strengthen existing resources. Programmes designed and piloted in different contexts often lead to inappropriate, largely ineffective or even harmful interventions that cannot last over the long term[19]. Forward-looking reflection about the consequences of each of our actions on the equilibrium and way of life of communities, families and individuals is crucial: some activities can, for example, upset the balance of social roles or the daily rhythm of families or even create stress by creating competition for resources between people.

- **Open-mindedness to diversity** is also an important and indispensable principle in humanitarian interventions. Humanitarian action sometimes risks being idealist and thus prone to myths,. This can be a risk to understanding of and open-mindedness toward others. Choosing to understand and include others with their differences and complementarity allows for an intervention closer to the beneficiaries' real needs and thus for the increased effectiveness of the action. It involves trying to understand the complexity of others in order to avoid haphazard identification and compassion clouded by one's own narcissistic need[20]. However, open-mindedness toward others can be difficult, sometimes even painful, although always enriching. This open-mindedness requires not imposing one's Western values (ethnocentrism) and not confining the beneficiaries to a role of victim or traumatised persons. It is important for them, as for us, that their existing values are identified and their individual and collective dynamic of repairing, respected.

19 The principles listed are part of the basic principles also cited in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Situations, to which are added the principles of causing no harm, integrated support systems and polymorphous support packages.

20 Needs very centred on oneself and one's own experience.

- Lastly, we cannot forget our **open-minded attitude to national employees** and their possible difficulties, as staff have often been directly very affected by humanitarian emergencies. This can involve challenges concentrating on work, trouble remaining neutral on the job and a heavy emotional burden during each action. These emotions and difficulties need to be acknowledged sensitively and specific procedures need to be thought of and put in place to help these employees to continue to work in such conditions (adapted work pace, roles and responsibilities chosen according to the person, debriefing exercises, etc.).

CONCLUSION

In order to help staff on the ground to better understand the issues encountered in emergency interventions, this guide is intended to show how to integrate a more in-depth understanding of the psychological and social dimension of the populations affected by different types of humanitarian crises. This approach helps to improve the programmes, from design to documentation on experiences, but also to further professionalise aid workers not familiar with the "psychology" field.

It is indispensable to understand the nature of the psychosocial dimension and distress in emergencies and to understand the added value of integrating the considerations presented during an intervention. It is equally important to understand that the populations affected are not just victims. They have within their cultures psychological and social resources for reacting and rebuilding. The attitude of the aid workers is therefore crucial in terms of recognition, respect and support for remobilising these resources.

We hope that this guide has helped to increase understanding that these different types of crisis contexts can provoke different reactions of distress—and therefore different responses from the humanitarian community are required. The victims of natural disasters, conflicts and totalitarian and extremist regimes have different psychosocial needs. AAH's responses must therefore be nuanced and extended to ensure that programming adapted and sustainable, thus more effective.

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KEY POINTS

- Humanitarian crises transform the social and emotional links/interactions inside communities and families, destabilising the relationship between mother (or care giver) and child and thus threatening the future of the entire society through its young victims/new generation.
- The psychological distress of the victims of humanitarian crises should not be always considered as psychopathological disorder. It is usually a "normal response to an abnormal situation."
- Often the victims, with appropriate psychosocial support, can reconnect with their psychological resources and survival abilities and can develop collective and individual psychosocial resilience.
- Humanitarian assistance should strengthen the resilience of communities and individuals without aiming to replace the repair processes of the culture, which are generally not known by external organisations.
- Before intervening, there should be an assessment of the psychosocial risk factors inherent to the population, especially for the most vulnerable, as well as protection factors, which the programme will need to help develop and sustain.
- Participation by communities in their own reconstruction is a major element of an emergency intervention, which contributes to affirming their confidence in life and their self-esteem.
- The importance of taking into account the psychosocial dimension at the beginning of a crisis, and to assist the populations in their psychological and social needs is crucial to ensure a quality intervention. Integrating the psychosocial dimension in all of our emergency interventions goes beyond the presence of a team of psychologists. It represents a necessary cross-disciplinary and holistic approach. On the other hand, the presence of prepared and technically supervised teams is necessary for the development of psychosocial support programmes for groups that in distress.

The following table summarises the main psychosocial risks that can be found in each type of humanitarian emergency and indicates how teams can consider such impact when proposing responses that are more sensitive and better adapted to the needs of the populations.

The table highlights the main elements, without being exhaustive and representing the complexity and specific features of each humanitarian emergency. This complexity cannot be summarized in a table!

EMERGENCY TYPOLOGY	PSYCHOSOCIAL IMPACT **Main points**	HOW TO TAKE THE MAIN POINTS INTO ACCOUNT IN OUR RESPONSE **Focus on ...**
NATURAL DISASTER	■ Fear ■ Distress ■ Anger ■ Stress ■ Reduction in cognitive abilities (attention, concentration) ■ Separation of families ■ Displacements: changes in locations and times of life ■ Initial phase of solidarity followed by the risk of individualism (due to competition)	■ Protection of individuals ■ Support for rituals/religion, if present ■ Support for group solidarity and commitment ■ Isolated families/individuals or those with particular difficulties (weakness, mobility challenges)
CONFLICT	■ Insecurity ■ Powerlessness ■ Depression ■ Anxiety ■ Violence and gender-based violence ■ Distrust ■ Inter-group conflicts ■ Fundamentalism	■ Protection of women and children ■ Building on group strength ■ Helping with planning and projections for the future ■ Neutrality ■ Minimizing risk of additional group conflicts through resources competition
TOTALITARIANISM	■ Stress ■ Anxiety, anguish and victimising thoughts ■ Feeling of being manipulated ■ Loss of control and autonomy ■ Distrust and social disruption ■ Limited intellectual freedom	■ Recreating social links (based on family nucleus) ■ Avoiding establishing inter-group competition ■ Promoting empowerment but with specific support ■ Ongoing and predictable confidence-building work

TO FIND OUT MORE...

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