TRAUMA

Guidelines for Psychosocial Care

© Médecins sans Frontières Belgium
Evelyne Josse

Medical Department
Operational Centre of Brussels
January 2004

In collaboration with: Laetitia Schul-Martin, Benoît Deneys, Patrick Maldague, Barbara Laumont
Index

PART I: THEORETICAL FACTORS

Chapter 1: Definitions with regard to a traumatism

Chapter 2: Reactions to a traumatic event

Chapter 3: Factors implicated in traumatic reactions

Chapter 4: Vulnerable groups and individuals

Chapter 5: Factors favouring the psychosocial recovery process

PART II: OPERATIONAL ASPECTS

Chapter 6: Framework for an emergency intervention

Chapter 7: Strategies

Encouraging the community's own resources for providing support and its own strategies for coping

Work with local leaders and professionals
Chapter 8: Entering an emergency: the acute phase .................................................................................................................. 39
  Making contact with the community ................................................................. Error! Bookmark not defined.
  Disseminating information .................................................................................. 40
  Providing security ............................................................................................... 40
  Collecting data ..................................................................................................... 40
  Collective deriefing ......................................................................................... Error! Bookmark not defined.
  Detecting vulnerable people ............................................................................. Error! Bookmark not defined.

Chapter 9: The post-emergency phase ................................................................................................................................. 46
  Stress management ......................................................................................... Error! Bookmark not defined.
  Education ......................................................................................................... 47
  Individual counselling ..................................................................................... Error! Bookmark not defined.
  Reference system ............................................................................................. Error! Bookmark not defined.
  Social activities ................................................................................................. Error! Bookmark not defined.
  Useful and productive activities ....................................................................... 52
  Cultural and festive activities .......................................................................... 52
  Recreational and sports activities ..................................................................... 53
  Training counsellors ....................................................................................... 54

Chapter 10: Support for children .......................................................................................................................................... 55
  Assist the prents .............................................................................................. 55
  Children's needs: security, stability and reliability in their lives ................. 55
  Support for parents ......................................................................................... 56
  Support for depressed mothers ....................................................................... Error! Bookmark not defined.
  Activities for child.......................................................................................... Error! Bookmark not defined.
  Education ......................................................................................................... 57
  Play ..................................................................................................................... Error! Bookmark not defined.
  Recreative and sports activities ...................................................................... 58
  Education ......................................................................................................... 58
  Expression ....................................................................................................... 58
  Identification of children in difficulty ............................................................. 59

Chapter 11: Support for adolescents .................................................................................................................................... 60
  Activities .......................................................................................................... Error! Bookmark not defined.

Chapter 12: Support for the elderly ...................................................................................................................................... 62

Chapter 13: Psychopharmacology ......................................................................................................................................... 63

Appendix: Humanitarian personnel ...................................................................................................................................... 65
  Difficulties encountered by humanitarian workers and the psychological support team .... Error! Bookmark not defined.
  Professional stress factors ............................................................................... 65
  Structural factors related to the organisation ................................................. Error! Bookmark not defined.
  Living conditions ............................................................................................ Error! Bookmark not defined.
  Additional complications that may occur ..................................................... Error! Bookmark not defined.
  Feelings that can overtake support personnel ............................................. 68
  Alarm signals among support personnel ....................................................... 69

List of the worksheets included in the Toolbox .................................................................................................................. 71

Bibliography ................................................................................................................. 74
Preface

Armed conflicts and natural disasters are at the origin of a large number of
refugee and displaced person situations. Until recently, in emergencies, Médecins Sans
Frontières concentrated mainly on medical care and basic needs (food, water, shelter, etc.).
However, disasters and violence also have consequences for the mental health of the
individuals forced to experience them.

Mental health care has the following objectives:

- To reduce the state of stress during the acute phase;
- To prevent post-traumatic problems in the long term within beneficiary populations.

The aim of these guidelines is to suggest a general framework for intervention in order to
develop psychosocial programmes and mental health care in emergencies.

The principle of emergency intervention is common to numerous programmes, but the
response varies according to the specific situation. The groups targeted and the
circumstances in which interventions take place are always unique and complex. Thus,
these guidelines do not provide uniform responses for each context, nor do they
describe in a definitive fashion all the activities required in order to reach a given
objective. The implementation of psychosocial care therefore always requires knowledge
of the environment at several levels (cultural, social, familial, political; education and
health systems, civil society networks, etc.)

What kind of information do these guidelines provide?

- They make it easier to reach an understanding of how people are reacting
  psychologically to a traumatic event;
- They suggest possible actions within the framework of a psychosocial assistance
  programme among population groups affected by a natural disaster or armed
  conflict.

To whom are they addressed?

- To the psychosocial team intervening in such emergencies;
- To any professional humanitarian worker intervening in them.
Introduction

There is no universal definition of 'mental health'. Nevertheless, people with sound mental health have in common the ability to understand and respond to the challenges of daily life, to feel and express a whole range of emotions and to maintain good relationships with members of their family and community.

Mental health problems encompass a wide spectrum of mental and social problems ranging from relatively minor stress symptoms to major psychosocial and psychiatric problems.

Wars and natural disasters are factors external to individuals, which, by their very nature, create unfavourable conditions for maintaining psychological equilibrium.

There is a well-founded and accepted belief that a response is required to the mental health needs of affected populations in emergency situations. Nonetheless, this type of intervention is still in its early stages, although it was conceived and developed progressively in so-called 'long-term' projects (street-children and psychiatric hospitals).

Medical personnel have little preparation for facing mental health problems. There is often a very high percentage of psychosomatic problems in the contexts in which MSF works, but the responses provided are rarely adequate. In order to optimise care in regard to a population's mental health needs, it is essential that:

- Humanitarian personnel are aware that the health of individuals includes their mental health and that a psychosocial intervention forms part of a medical intervention;
- They should also be aware that there are tools available, such as these Guidelines.

The different emergency contexts

Acute crises can be of different natures: of natural or human origin. Each emergency has its own profile and its own specific logic with regard to the response selected. Some measures will be common to any emergency, but the choice of activities to be implemented will depend on factors specific to the context.

In order to speak of a 'disaster', whether natural or manmade, the following criteria must be present:

- The event must have caused a large number of victims (dead, wounded, victims, survivors, etc.).
- It must have resulted in a notable amount of material destruction (houses destroyed, roads and bridges cut off, etc.) or have altered the human geography (for example, crops and arable land inundated without any other material destruction). The concept of a human geography is important because an earthquake in an uninhabited region is not a disaster.

- It must have resulted in social disorganisation through the destruction or alteration of functioning networks (such as the networks for 'production-distribution-consumption', energy, food, drinking water and medical care, the circulation of people and goods, communications-information, education, forces of order and the disposal of dead bodies).

This last criterion underlines the social dimension of the disaster: the event is a destroyer and bearer of ill luck for a specific community.

**Natural disasters**

It is important to realise just how many people are the victims of natural disasters. According to the UN, three million people have perished in such disasters over the past 25 years and over a billion people were otherwise affected (Audet, 1999).

Natural disasters can be very diverse in nature: earthquakes, floods, typhoons, tidal waves, droughts, fires, snowstorms, volcanic eruptions, etc.

So-called 'natural' disasters are only natural up to a point. Many of them affect people already vulnerable because of the precarious living and housing conditions with which they are forced to live.

**Armed conflicts**

At the end of 2002, 20.5 million people throughout the world (including refugees, asylum-seekers and the displaced, as well as people returning to their own countries during the year) came under the UNHCR's mandate. Recent population displacements have mainly been due to conflicts, but natural disasters, such as drought, only serve to exacerbate a situation.

Refugee movements often imply that political, religious or ethnic tensions are exported with them to host or neighbouring countries and frequently become the source of problems there. Thus, refugees and the displaced (IDPs) increasingly find themselves in insecure regions where their installation is compromised by chronic instability. They are then forced to find a new place of asylum on several consecutive occasions (for example, Liberia, DRC, etc.).

Population movements occur at an increasing tempo and on an increasingly large scale leading to states of acute crisis.

---

1 Number of refugees: 10.3 million; asylum-seekers: 1 million; refugees returning to their country of origin during the year: 2.4 million; displaced persons: 4.3 million; displaced persons returning to their country of origin during the year: 1.1 million; others (forced migrants, residents at risk, etc.): 1 million.

2 United Nation's High Commissioner for Refugees
SECTION I: THEORETICAL FACTORS

The objectives of this section are:

- To define what is meant by a victim;
- To define what is meant by a traumatism;
- To discuss the psychological reactions of adults, adolescents and children to traumatic events;
- To indicate the factors likely to favour the recovery process from a traumatic event.

The requirements:

- An ability to recognise mental problems caused by a traumatism;
- To identify vulnerable people.
Chapter 1: Definitions with regard to a traumatism

Powerless in the face of the irreversible consequences of natural disasters, human beings, no matter their cultural background, generally allot responsibility to deities whose anger has been aroused. In contexts of war, the traumatic experience leads to an interrogation on the subject of the nature of human beings, which must be taken into consideration when offering psychological support.

Defining a victim

By 'victim' we infer any person suffering injury or damage that is recognised as such by others (or would be if they were aware of it), even if the person concerned is not always aware of the injury and/or damage.

Recognition by the victim is neither necessary nor sufficient; that of other people is essential. Some victims are not capable of recognising that they have suffered an injury (young children, mental patients, etc.).

We speak of 'direct' and 'indirect' victims according to the extent to which they are implicated in the traumatic event.

- **Direct victims** have been confronted with chaos, a feeling of imminent death or of horror. They may have been subjects (on whom injury has been imposed), actors (who have involuntarily provoked injury) or witnesses (who have personally been present when injury was inflicted) in the traumatic event.

- **Indirect victims** have not been witnesses to the event, but are affected by it – or by its consequences – due to their:
  - Family connection to the direct victims;
  - Social connection to the direct victims (friends, acquaintances);
  - Professional activities (medical personnel, rescue workers, etc.).
Definition of a traumatism

For more detailed information, see Worksheet 101 "The traumatic event of natural disaster"; Worksheet 102 "The traumatic event of armed conflict"; Worksheet 103 "The female victims of sexual violence"; Worksheet 104 "The male victims of sexual violence" and Worksheet 208 "Child victims of sexual violence", all from the Toolbox.

The traumatic event constitutes a critical and urgent threat to life, the physical and/or mental integrity of an individual or a group of individuals.

The event can be:

⇒ Either large-scale and sudden;
⇒ or,
⇒ A small incident appended to a progressive accumulation of factors that are potentially traumatising, which pushes the individual beyond his/her level of tolerance.

A traumatising event is distinguished by the fact that it is unusual, exceptional and pulls those affected into a whirlwind of violence. It is experienced both as a rupture and a challenge:

⇒ A rupture in that it signals a break with the continuity of the past;
⇒ A challenge in that it indicates potentially important changes.

It should be noted that an event that may prove traumatising for one person will not necessarily have the same effect on another, and what may be traumatic for somebody at any specific time might not have had that effect in the past.

It is important to differentiate between emergency situations resulting from armed conflicts and those initiated by natural disasters, and to understand what, in each of these two contexts, is intrinsically traumatic (see Worksheets 101 and 102 from the Toolbox).
In addition, sexual violence is frequently a form of violence seen in the context of armed conflicts (see Worksheets 103, 104 and 208 from the Toolbox).

**SUMMARY TABLE**

**A traumatic event:**
- Constitutes a threat to life, the physical and/or mental integrity of an individual or a group of individuals;
- Generates a feeling of intense fear, impotence and horror;
- Provokes an acute disruption to the framework of people's lives (basic beliefs).

**The traumatising factors are:**
- Threat of death;
- Wounds;
- Suffering, pain;
- Period of anxious waiting;
- The sight of other people dying;
- The spectacle of destruction;
- Torture and violence (in armed conflicts).
Chapter 2: Reactions to a traumatic event

It has been observed that in crisis situations (natural disasters, war situations) the majority of the population concerned present particularly intense stress symptoms. In order to understand why and how these reactions develop we first need to define stress.

The first observations about post-traumatic stress date back two thousand years before Jesus Christ when the Sumerians in Lower Mesopotamia described the anguish and suffering of their people following the destruction of Nippur³. However, the suffering experienced by traumatised people was only 'officially' recognised in 1980, with the introduction in the DSMIII⁴, of the psychiatric problem named 'Post-traumatic Stress Disorder' or PTSD.

Wounded people were given little or no psychological care for centuries. The two world wars gradually drew attention to the psychological consequences of the violence of war. This interest was first aimed at finding a way of avoiding long convalescent periods by soldiers and returning them to the front as quickly as possible. The attention paid to the after-effects experienced by American soldiers fighting in Vietnam raised greater awareness of psycho-traumatic damage.

In the face of a traumatic situation, two reactive moments can be pinpointed:

- The moment when the event takes place produces immediate reactions;
- After the event, we can distinguish post-immediate reactions and long-term reactions.

Immediate reactions

By immediate reactions we mean that symptoms appear at the moment of the traumatising event and last for a few days.

---


⁴ DSM III is the third edition of the Diagnostic and Statistical Manual of Mental Disorder, American Psychiatric Association, 1980.
Normal stress

Crocq\(^5\) defines normal stress as "the immediate biological, physiological and psychological reaction of alarm, of a mobilisation of resources and of the individual's response faced with an attack or a threat."

These reactions by the organism under attack are mainly a positive phenomenon aimed at effectively dealing with exceptional situations.

Stress:

- Focuses attention on the threatening situation;
- Mobilises the energy required for evaluating the situation and making a decision about it;
- Prepares for an appropriate action in response to the aggression.

While it lasts, the stress is accompanied by troubling symptoms. This is the price that has to be paid. These symptoms manifest themselves at three levels:

  - Physiological: tachycardia, sweating, gastric hypersecretion;
  - Motor: hyperactivity, feverish activity;
  - Cognitive: feeling of distress, groaning, aggressiveness.

Severe stress

For reasons that may just as well be due to the violence of the situation (external factors) as to the individual's vulnerability (internal factors), severe, pathological and inappropriate stress reactions may become evident. These reactions are:

  - Paralysis (the individual is incapable of acting or thinking);
  - Disorganized restlessness, panic flight;
  - Emotional crises (anxiety crises, tears, crying);
  - Psychotic reactions (confusion, episodes of delirium).

Traumatic stress

Despite the fact that the stress reaction varies according to the individual, some events exceed the coping ability of most people.

According to DSM IV\(^6\), we can speak of traumatic stress when the subject has been exposed to an event in which the two following elements were present:


\(^6\) Guidelines for psychosocial care of TRAUMA – Evelyne Josse – Medical department– MSF- OCB
The subject experienced, witnessed or was confronted by an event or events during which people may have died or been seriously injured, or was threatened with death or serious injury, or during which his/her psychological integrity, or that of others, may have been threatened;

- The subject's reaction to the event takes the form of an intense fear, a feeling of impotence or of horror.

**Post-immediate reactions**

Symptoms appearing between a few days and a month after the traumatising event are called post-immediate reactions.

**State of acute stress or acute stress disorder**

For more detailed information, see Worksheet 201 'States of acute stress' from the Toolbox

We will base our explanation of traumatic reactions on the model proposed by DSM IV because it is a universally recognised psychiatric reference tool.

The following symptoms, taken together, may justify fear of longer-term post-traumatic syndrome.

- **Dissociative** symptoms (at the moment of or immediately after the traumatic impact): feeling of detachment, paralysis, absence of emotional reactions, derealization, inability to remember an important aspect of the traumatic event, etc.

- **Re-experiencing** the traumatic event. This kind of symptom, which occurs independently of the subject's volition, is very realistic and produces a very intense anguish or distress. It takes the form of repetitive memories (flash-backs, repetitive images), nightmares, an impression that the aggression could be repeated (state of alert), repetitive behaviour (repeating the behaviour at the time of the event), etc.

- **Avoidance behaviour** triggered by any stimulus recalling the traumatising situation. The victim avoids thoughts, feelings, activities, places and people that recall the traumatic event. This can be evidenced also in a low level of general reactivity expressed by a disinterest in important activities, emotional withdrawal, etc.

- **Persistent neuro-vegetative activity (arousal symptoms):** The patient demonstrates a state of hypervigilance, disturbed sleep, difficulty in concentrating, is easily startled, etc.

---


7 The two principal models of psychiatric classifications: CIM-10 (Classification Internationale des Maladies Mentales, tenth edition, 1992) and DSM IV (Diagnostic and Statistical Manual of Mental Disorder, fourth edition, 1994) agree theoretically in regard to the definition of traumatic reactions, but differ in regard to their forms.
Anxiety reactions manifested as much in their somatic version (feeling of suffocation, vomiting, sleep problems, motor agitation, etc.) as in their psychological version (expectation of imminent death, irritability, aggressiveness, etc.).

The expression of these reactions is regarded as normal given what the individual has had to confront, even if they may seem 'inappropriate' or 'abnormal', but this does not mean they are easy for the victim to cope with.

In the month after the event, the stress remains acute, but should gradually wear off. After this point, a continuation of the symptoms observed, or the appearance of additional or more intense symptoms, should raise suspicion that the stress is evolving to a chronic level. We then speak of a post-traumatic stress disorder.

Long-term reactions

Symptoms that appear or continue for at least a month after the traumatising event are called long-term reactions.

Post-traumatic stress disorder (PTSD)

For more detailed information, see Worksheet 202 'The state of post-traumatic stress'; Worksheet 103 'The women victims of sexual violence'; Worksheet 104 'The male victims of sexual violence' and Worksheet 208 'Child victims of sexual violence', all from the Toolbox.

Post-traumatic stress disorder always occurs after a latent phase that can vary from a few weeks to several months.

- When the symptoms last for less than three months, we speak of an acute form.
- If they last for more than three months, the form is described as chronic.
- If the symptoms first occur at least six months after the traumatic event, this is described as a delayed appearance.

PTSD covers a vast range of states extending from moderate to severe cases. The gravity is evaluated as much by the number of symptoms as by their intensity. In fact, a subject can present many symptoms of a low intensity or present only a few, but very intense, symptoms.

Just as with a state of acute stress, PTSD is characterised by three different categories of symptom:

- Re-experiencing the traumatic event
- Avoidance
- Persistent neuro-vegetative activity.
Associated disorders or non-specific symptoms

This covers non-specific symptoms to the extent that these are found in mental troubles other than psycho-traumatic syndromes. These non-specific symptoms are sometimes in the forefront among the traumatic pathologies, even going so far as to eclipse the rest of the more discreet clinical table. Humanitarian teams providing psychological assistance report meeting more psycho-traumatic syndromes with predominantly somatic symptoms in non-Western cultures. These problems can also be the expression of the suffering resulting from new living conditions.

Depressive disorders

For more detailed information, see Toolbox Worksheet 203 'Mood disorders'.

A large number of people subjected to very stressful or traumatic events present depressive symptoms. Nevertheless, despite their living conditions, the majority of people will not develop a real depression.

The depressive symptoms are:

- Feelings of sadness, hopelessness;
- Concern, anxiety;
- Lack of energy, constant and high level of fatigue;
- Physical problems such as headaches;
- Sleep problems (difficulty in falling asleep and premature awakening);
- Eating problems (lack of appetite, weight loss);
- Loss of interest in sex;
- Profound feeling of uselessness, guilt;
- Suicidal tendencies.

These symptoms are found in association with a state of post-traumatic stress or can give rise to a diagnosis entirely separate from problems of depression. In this case, there is reason for treating the depression specifically.

Anxiety

For more detailed information, see Toolbox, Worksheet 204 'Anxiety disorders'.

The majority of people who have experienced a traumatism become anxious, although most of them were not so beforehand. This anxiety can take the form of an anxiety crisis or a

---

8 In 'Psychosocial Effects of Complex Emergencies', symposium report, Washington, 1999

9 According to DSM IV, in order to speak of depressive disorder, the subject must have presented a certain number of symptoms for a period of at least two weeks.
diffused state of anxiety (with internal tension, wariness of the outside world, permanent feeling of fear).

The difficulties facing victims (particularly the lack of food, shelter, basic necessities, etc.), as well as their various concerns (about people who have disappeared, the short-term future, the future of their children, etc.) reinforce this anxiety.

**Behavioural disorders**

See Toolbox Worksheet 205 'Problems linked with substance abuse'.

Subjects who have experienced a traumatic event frequently present various behavioural problems. These become habitual, are harmful to health and affect family and social life. Such behavioural problems can take the following forms:

- Fits of anger, aggressive acts, antisocial or criminal behaviour;
- Suicidal behaviour;
- Withdrawal;
- Eating problems;
- Alcohol or drug abuse, misuse of medication. The victim can develop such behaviour in order to:
  - Attempt to self-medicate against intrusive symptoms (nightmares, repetitive memories, flash-backs, etc.) or neuro-vegetative hyperactivity due to stress (palpitations, cramps, etc.)
  - Escape reality
  - 'Kill' boredom.

In very precarious situations, the regulatory role influencing the behaviour of individuals played by families and the community is often less effective. Adolescents and young adults are the groups most likely to develop behaviour problems.

**Somatic disorders**

It is acknowledged that stress has an effect on the organism. It may be at the origins of a somatic illness or may aggravate the development of an existing pathology. It may affect:

- The cardio-vascular system (hypertension);
- The respiratory system (asthma and hyperventilation);
- The digestive system (ulcers, colic, spasms);
- The skin (eczema, urticaria, psoriasis).

---

10 Antisocial behaviour will be less restricted, due partly to a limited social opprobrium, which encourages their emergence.
**Functional troubles**

Individual presenting with functional complaints constitutes 20 to 30% of the adult population consulting the health structures. In stressful situations (for example, a refugee camp in an insecure setting), this percentage may increase considerably.

We speak of functional troubles when an individual presents with:

- A physical problem for which it is difficult or impossible to identify a medical cause;
- Several vague symptoms (for example, 'hurting all over', 'feeling weak all the time');
- A minor illness that cannot justify the number of symptoms present.

These somatization disorders are described as 'functional' because they seem to be useful:

- For people with a problem that they do not dare to talk about through fear of being regarded as mentally ill or of not being understood, etc. It is easier to summon up physical problems.
- Some people may think that the doctors in the health centres are only there to care for purely physical complaints.
- In some culture, it is not appropriate to express personal feelings. For such people, it is generally more acceptable to express their complaint through their body.
- Some people do not realise that they have a personal problem and that the stress of the situation is affecting their bodies.

However, we observe that the troubles raised may also be symptoms of depression, anxiety, alcohol abuse or the result of torture, rape or other violent acts.

**Psychotic disorders**

For more detailed information, see Toolbox, Worksheet 206 'Psychotic disorders'.

Psychotic reactions may appear in subjects who are fragile or have psychiatric antecedents.

They are characterised by a loss of contact with reality (a confused state, episodes of delirium, auditory or visual hallucinations, agitation, aggressiveness). People presenting with a psychotic episode during an emergency situation generally have symptoms that relate to what they have just experienced. For example, they hear screams and see blood everywhere although they are now safe.

When these reactions are analysed, the cultural context must always be taken into account. In fact, delirious ideas may be influenced by the individual's values and beliefs (for example, somebody who lives in a group defined by a religious ideology may develop a mystical delusion).
Children's reactions to a traumatic event

For more detailed information, see Worksheet 207 'Children's reactions to a traumatic event (by age)' and Worksheet 208 'Child victims of sexual violence', both from the Toolbox.

Generally speaking, a child's universe gravitates around predictable events occurring in a stable environment inhabited by reliable people. Children can rely on reassuring habits: waking up in the morning as part of a family, getting ready for school or for customary work, meeting the same teacher, the same companions, etc.

Disaster and armed conflict bring in their wake consequences that upset this secure world:

- Family members or friends may have perished.
- Their own lives may have been put in danger.
- Their homes may have been destroyed.
- Temporary shelter may force them to live in an area that is not familiar to them.
- The family, occupied by its own fears, may be less effective in comforting children.

Sometimes, such situations, combined with the pressures and requirements of new living conditions, push the family to a point where dependent children are not taken into account.

These sudden upsets in family habits, as well as the fears and anxieties related to their own experience of the traumatic event, may modify children's behaviour.

Confronted with a sudden and violent event, children experience intense emotions, including anguish and fear, which are normal reactions to danger. In addition, they are afraid of:

- Dying;
- Being wounded;
- Hurting;
- Being separated from their family;
- Finding themselves alone;
- Seeing the event reproduced.

These reactions, although normal and transitory, may overwhelm the adults with responsibility for these traumatised children.

We observe that an event that may traumatise a child may not have the same effect on an adult and vice versa.

The symptoms previously described for adults (repetition, avoidance and emotional numbness, neuro-physiological arousal) also apply to children. Nonetheless, the symptoms turn out to differ according to the age group.
Children's reactions to a traumatism are strongly determined by the reactions of those around them, their parents in particular.

Adults, themselves disturbed by the traumatic event, very often acquire a specific behaviour that does not at first allow them to assume their normal functions as parents. Yet the children require their parents' support, as early as possible, in order to regain their psychological equilibrium.

As adult attitudes are a determining factor in the genesis of children's problems, this should incite us to intervene with the parents in order to help them to help their children. It is therefore advisable to simultaneously implement psychosocial programmes for both adults and children.

Emergency situations are likely to favour the emergence of sexual violence against children. Interested readers can refer to Toolbox Worksheet 208 'Child victims of sexual violence'.

**Adolescents' reactions to a traumatic event**

A traumatic event may have numerous repercussions on adolescents depending on the extent to which the family and the community are overwhelmed and their functioning affected.

It may have the following effects:

- Arouse fear for the family;
- Increase adolescent anxieties about their physical being and their vulnerability;
- Reactivate fears connected with previous stages of their development;
- Compromise their emancipation from the family, thereby precipitating a premature entry into the adult world.

Adolescent reactions resemble those of adults. However, we observe some particularities, which, although they may also be found among adults, are exacerbated among adolescents, including:

- Feelings of anger and guilt;
- Antisocial and criminal behaviour, rebellious attitudes, showing off, self-destructive acts;
- Addictive behaviour (smoking, alcoholism, drug abuse);
- An affective discomfort (depression, sadness, weariness, solitude, suicidal ideas, confusion, feeling of uselessness, blocking out emotions);
- Modifications of cognitive development (difficulty in making decisions, lack of discernment, reduction in the ability to reason);
- Somatic troubles (headaches, stomach aches, etc.);
- Behavioural problems related to eating (anorexia, bulimia);
⇒ Low estimate of personal worth and poor self-esteem;
⇒ Feelings about the future blocked off with an expressed wish never to marry or have children;
⇒ Difficulty in committing to a professional activity or to social life.

Elderly people’s reactions to a traumatic event

For more detailed information, see Toolbox Worksheet 401 'Vulnerable elderly people'.

Contrary to received ideas, the elderly are not usually fragile, ill, inactive, dependent or disoriented. In reality, they constitute an autonomous and resourceful group. Most of them demonstrate resistance and courage in the face of traumatic situations because their life experience has given them a capacity for recovery. In addition, they are not a homogenous group (for example, a very handicapped 80-year-old cannot be compared with a 60-year-old in good health).

Some elderly people may present emotional and stress reactions.

⇒ Anxiety, depression, fear, guilt and grief are normal, even appropriate, feelings. They can be a way of expressing their concern for the future, the loss of their physical health, family roles, social contacts, etc.
⇒ Anger is also a normal reaction when it serves as retaliation against what has injured them and helps them face up to what they have lost. This anger may be directed towards the children, the adults or the services offering assistance (rescue or humanitarian teams, etc.).
⇒ Feelings of despair and impotence, accompanied by a lack of organisation and state of confusion, may result in a feeling of desolation in the face of the huge task of rebuilding their lives.
⇒ The traumatism may reactivate memories of traumatic experiences or previous painful events.
### SUMMARY TABLE

People who have experienced traumatic events often present a series of symptoms. These are regarded as normal in the light of what they have been through. The modifications to their psychological equilibrium affect their family, professional and social lives. Furthermore, these survivors must continue to live in a precarious state (collective housing, poverty, etc.). In such a context, other psychosocial problems often arise (presence of drugs, alcohol, violence, ill-treatment, etc.).

- **Physical symptoms**: insomnia, easily startled, agitation, gastro-intestinal problems, muscular pain, vertigo and permanent tiredness.

- **Cognitive symptoms**: phenomenon of dissociation (impression of unreality), amnesia (partial or total) with regard to the traumatic event and difficulty in concentrating.

- **Behavioural symptoms**: reduced or excess level of activity, anger directed against oneself (suicidal tendencies, self-destructive behaviour such as alcoholism) or others (physical and/or verbal violence) and changes in sexual behaviour.

- **Affective symptoms**: loss of confidence in both human and divine beings, loss of faith in basic beliefs ("the world is fair and logical"), a prolonged depressive state (apathy, feeling of guilt and despair) and an affective withdrawal.

- **Relational symptoms**: difficulty in establishing social relationships, reduced contact with others and fewer affects.
| **Immediate reactions**  
| (within a few minutes to a few days) | **Post-immediate reactions**  
| (within two days to one month) | **Chronic reactions**  
| (occurring after the first month) |

**Normal stress**

**Severe stress / Traumatic stress**

- Sideration
- Uncoordinated restlessness
- Emotional crises
- Psychotic reactions

**Acute stress disorder**

- Symptoms of dissociation
- Re-experiencing events
- Avoidance
- Anxiety reactions

**Post-traumatic stress disorder**

- Acute form (not lasting more than three months)
- Chronic form (lasting more than three months)
- Differed form (occurring after six months)
  - Re-experiencing events
  - Avoidance
  - Neuro-vegetative arousal

**Associated disorders**

- Depressive symptoms
- Anxiety
- Behavioural disorders
- Somatic disorders
- Functional complaints
- Psychotic disorders

---

11 DSMIV; F43.0: 300.02; A.P.A. 1994

12 DSMIV; F43.1: 300.981; A.P.A. 1994
Grieving

For more detailed information, see Worksheet 209 'Stages of grieving' and Worksheet 230 'Children's grief', both from the Toolbox.

Experiencing grief because of all that has been lost is a fundamental aspect of survivors' reactions after a traumatising event.

Grieving is the usual demonstration of the emotional process triggered by the loss of somebody important to an individual's affective life. However, grief felt after a traumatism may not only be expressed in reaction to a death, but also to the loss of material possessions (home, land, belongings), of a way of life (activities, a neighbourhood, a social role, etc.) or of other elements necessary for emotional well-being (security, souvenirs, photographs, animals, etc.).

SUMMARY

Almost all survivors experience grief, to various degrees, in the face of what they have lost.

Demonstrations of grief cover a wide range of reactions from a state of shock to acceptance, passing through anger, denial, sadness, guilt and depression.
Chapter 3: Factors involved in traumatic reactions

It is important to take into consideration the various aggravating factors that influence the frequency and intensity of post-traumatic reactions.

These factors can be divided into three categories: variables related to the event and those related to the individual, and the characteristics of the recovery environment. A large number of survivors accumulate factors that increase the potential risk of developing a psycho-traumatic syndrome.

Variables related to the event

- Intensity of the event: death of loved ones, death threats, wounds, torture, rape, irreversible sequela;
- Duration and frequency of exposure to the traumatising factor(s);
- Accumulation of traumatising factors (for example: losing loved ones, being raped and/or receiving death threats, and having fled when wounded);
- Physical proximity (the closer to the site of the traumatic event, the more the individual is at risk of developing a psycho-traumatic syndrome) and emotional proximity (the closer the people implicated in the traumatic event – family members, friends, acquaintances – the greater the risk of presenting a PTSD);
- Impossible to predict the future;
- In the case of human conflict, the intentionality of those responsible for the event;
- Etc.

Variables related to the individual

- Sex (for various reasons, probably linked to social and cultural factors, women are more at risk than men);
- Age (children and the elderly are more vulnerable);
- Personality (anxious, introverted people or those suffering from previous psychological fragility or psychopathological problems will be more at risk);

- Coping strategies\(^{13}\) adopted by the individual (subjects who have a tendency to avoid issues more often develop a psycho-traumatic syndrome that those who take an active stance);

- Perception and personal evaluation (for example: stressful events that took place in the name of an ideology that approves of violence may have no psycho-traumatic repercussions; religious faith may reduce the traumatogenic impact of an experience);

- Etc.

**Characteristics of the recovery environment**

- State of acute stress or post-traumatic stress syndrome in the immediate family/social circle;

- Family support;

- Social support (for example: individualism versus collectivism);

- Society's attitude towards the victims (for example: hostile attitude of the host community);

- Etc.

**SUMMARY**

People will be at greater risk of developing a psycho-traumatic syndrome when:

- The traumatic event is on a large scale;
- They have fragile personalities;
- Family support is poor;
- Social support is insufficient or non-existent.

\(^{13}\) Coping strategies represent the cognitive and behavioural attempt by a person to deal with (reduce, tolerate, control) the demands (internal and external) of a stressful transaction. (Lazarus, 1984)
Chapter 4: Vulnerable groups and individuals

Even if, as we have seen above, the whole of a population is affected, certain groups and certain people are more vulnerable and at greater risk of developing chronic problems.

Vulnerable groups

For more detailed information, see Toolbox Worksheet 401 'Vulnerable elderly people'.

The vulnerable groups are composed of:

⇒ The elderly (especially when they are separated from their families);
⇒ Children;
⇒ Unaccompanied children (orphans, children accidentally separated from their families during population movements or deliberately abandoned);
⇒ Women (for example, in camps, where they are more vulnerable to sexual abuse and rape and may suffer discrimination so that their access to resources, such as food, is restricted);
⇒ Widows;
⇒ The physically/mentally handicapped and sick people;
⇒ Ethnic, political or religious minorities.

Vulnerable families

In emergency situations, some families are also particularly vulnerable, especially families who are:

⇒ In mourning;
⇒ Have lost all their roots;
⇒ Have responsibility for children who are not their own;
Were already in a precarious situation before the traumatic event;
Single-parent families, especially those with very young children;
Large families.

**Vulnerable individuals**

The people for whom we should exercise greater vigilance are those who:

- Have suffered directly in violent situations;
- Have lost family members;
- Have had previous psychological or psychiatric problems;
- Have experienced repeated, extended or extremely intense (rape, torture, etc.) traumatising events;
- Have experienced significant material losses;
- Have inadequate social support (especially widows);
- Have come from towns and are now living as refugees in a rural area, and vice versa.

In each situation encountered, these vulnerable groups and individuals need to be identified.

**SUMMARY**

The most vulnerable individuals in the face of a traumatic event are:

- Children;
- Women;
- People in a personal situation (handicapped, ill, badly traumatised, etc.) or family situation (isolated, in mourning, etc.) or social situation (impoverished, etc.) that was precarious before the event or has become so as a result of it.
Chapter 5: Factors favouring the psychosocial recovery process

It is possible to intervene rapidly in regard to some factors that favour the recovery process and to do so from the start of the emergency. The related activities are carried out by the psychosocial team in collaboration with doctors, logisticians and other actors present in the emergency.

In exploring the elements that have a positive influence on the psychological recovery process, concrete and effective approaches for a psychosocial intervention in emergency situations begin to emerge. A series of factors influences the prognosis.

Immediate intervention

An important factor for improving the prognosis is to intervene as early as possible.

Good information

Where a person finds it impossible to exercise control, at least mental control, over the situation, this may indicate a traumatic stress experience. Somebody who is capable of understanding a situation does not give in to it completely, but a subject who is unable to understand it will passively submit to it and become submerged. Reliable information about the events that have taken place and about those still likely to occur help to reduce the state of stress very quickly and prevent it from having a traumatic impact.

Acknowledging the victim status

It is important that all concerned (fellow citizens, the authorities, the international community, etc.) can respond to the survivors' fundamental – although only temporary – need to be 'taken care of' and to have their needs and their painful experiences recognised. Acknowledgement of this victim status and the emotions and suffering related to it, is basic to the recovery process.

Social and family support

When the social and family support systems are efficient, they provide adequate resources for recovering a feeling that life has meaning and for regenerating self-esteem.

Adaptive Behaviour

If survivors are able to discover efficient ways of adapting in the wake of a traumatic event, they should be able to recover a feeling of control over their own lives and over events. For example, where it is possible for them to make choices for themselves or to take an active stance in regard to their new refugee status, the risks of presenting long-term psycho-traumatic sequelae will be reduced.
Returning to a daily routine

The sooner people have the possibility of recovering a daily routine, the less risk they run of developing mental problems.

-around
- School and cultural activities can revive a feeling of normality, even in a refugee camp.
- Any kind of games can help children to get over their fears.
- For women, the opportunity to talk with other women can be a comfort, even within a displaced population.
- Work may help men to recover their role as husbands and fathers, even far from their own homes.

Helping a displaced community to return to its habitual round of activities in a new locality, such as a camp, can help prevent the appearance of psychological problems.

SUMMARY

The factors favouring the recovery process after a traumatism are:

- Provision of rapid psychological support and acknowledgement of the suffering of the survivors;
- Reliable information that helps survivors to understand the events that have taken place, as well as the present situation, and to anticipate the near future;
- Efficient family and social support;
- A rapid return to a life that is as normal as possible (daily routine and the opportunity to make choices about one's own life).
PART II: OPERATIONAL ASPECTS

The objectives of this section are:

- To discuss the place and the role of psychological support teams;
- To understand the community approach;
- To put in place appropriate strategies and activities.
Chapter 6: Framework for an emergency intervention

Before approaching the activities to set up in an emergency context, certain principles and some prerequisites should be kept in mind. The list that follows does not claim to be exhaustive.

The length of the psychosocial component must be determined from the start of the intervention. Ideally, it should last from three to six months\(^\text{14}\). As far as MSF’s mental health programmes in emergencies are concerned, we opt for a psychosocial approach. Psychosocial interventions are not directed towards a specific group of psycho-pathological cases, but towards the whole community in difficulty and use both preventive and curative activities.

The psychosocial programmes are directed towards:

- Reducing, even eliminating, conditions that produce psychological problems by the detection, prevention and management of psychosocial problems;
- Stimulating and supporting coping strategies emerging from within the community itself.

It is through working on the social fabric (‘talking groups’, facilitating mutual support in daily life, etc.) that we’ll achieve the most appropriate and the most rapid results at the psychological level; in this instance, a reduction in the state of general stress and longer-term prevention of mental disorders linked to the traumatic event.

**Prerequisites for psychosocial interventions**

**Rapid intervention**

In emergency situations, we are confronted with a massive influx of people, not necessarily with pathological symptoms, but in crisis after having recently been subjected to a traumatic or stress-producing environment. Early intervention makes it possible to:

- Prevent the appearance of numerous psychological problems;
- Reverse the symptoms of acute stress among a large number of survivors;
- Detect people who require specific care.

\(^{14}\) Beyond this period, the requirement for psychosocial care is greater than that for problems related to the emergency situation
In addition, although it is difficult to confirm that the rapidity of an intervention prevents psychological problems from occurring at a later date, this initial contact helps to facilitate the future approach to care.

**Continuity of care**

Survivors may present psycho-traumatic problems many years after an emergency. A lot of people continue to suffer well after MSF has withdrawn; the effects can even be felt in succeeding generations. However, there are only limited resources for promoting mental health care. It is therefore important that:

- Projects should not be too ambitious;
- Planners must develop affordable ways of completing the programme by working with local resources (mental health services connected with the ministry of health, associations, etc.).
- In brief, an emergency plan has to be put in place, but from the perspective of ensuring continuity.

**Place and role of psychological support personnel within the MSF team**

Psychological support programmes must become an integral part of the emergency plan and must be developed together with doctors and logisticians.

In fact, the psychological support teams will be fully effective if their activities are realistically integrated into the overall plan for an intervention.

- The psychologists must work in direct collaboration with the doctors. The medical post is often the first, or even the only, service available. Contact with the population there is easy and direct. People arrive with multiple and varied requests because they feel they are being reassured and taken care of. The doctors are often powerless in the face of the psychological suffering and medication soon proves inadequate. The integration of a psychological care component prevents us from an excessive medicalisation of the situation and relieves the medical consultations.

- The psychological support team will collaborate with the logisticians over matters that concern them, for example, the organisation of camp life, distributions, the preparation of meals.
Presuppositions regarding an intervention

The whole community is affected

During massive and rapid population displacements, there is a collective feeling of crisis and consequently a considerable risk of sequelae in the population. The social and family fabric is profoundly weakened.

Changes in the social structure may force new forms of social organisation on to the population. For example, camp life may involve a change of lifestyle for refugees who may have to submit to a new form of authority or to cohabit, not out of choice, with other ethnic groups. All this may affect the equilibrium of the group’s mental health.

Apart from the subject experiencing it, an individual traumatism also affects the family, but it also affects the community. The most striking example is that of rape, which produces feelings of humiliation and shame, not only for the woman raped, but also for all those around her. Stigmatised socially, these women have difficulty in their relationships with the members of the group overall.

The community has resources

The psychosocial approach is based on the idea that human beings possess, both within themselves and within their community, the resources required for dealing with exceptional events. It stresses the importance of the social milieu and social processes in individual psychological recovery in the wake of a dramatic event.

As a general rule, the survivors of a conflict or a natural disaster are normal people: they were autonomous and competent prior to the traumatic event and will be so afterwards. Most of them do not fall apart, but remain ordinary individuals who have had an extraordinary experience.

It is important not to regard survivors as people without resources, totally dependent on humanitarian aid. You only have to think of the fact that those who are unharmed or only slightly injured do not wait for the humanitarian organisations to arrive, but immediately focus on helping the wounded and the most vulnerable.

Survivors have lost their homes, their work, their material possessions and loved ones, but they have not lost their knowledge or their skills. They may have been forced to abandon their way of life and their traditional roles, but they have the capacity to define alternatives, whether similar or different, within their new community.

If most of these people accept aid over a certain period, they nevertheless want to recover their autonomy as quickly as possible. It is therefore important to encourage beneficiaries to build a new life as soon as they can.
A strong community to support the most vulnerable

Encouraging and supporting the resources of a community of survivors strengthens the mechanisms that are operating to look after the most dependent and the most vulnerable. The mental health of these groups depends on the social support provided. The objectives will be:

- To implement a culturally appropriate programme;
- To identify and restore the natural community networks, as well as the coping strategies;
- To seek information about how vulnerable groups are traditionally treated;
- To contribute to the continuity of care.

Advantages of a psychosocial approach

It makes it possible to reach a large number of people in a short period of time. The cover is very wide.

It is culturally appropriate. It helps to develop a therapeutic tool related to the culture and the needs of the population by supporting the reconstruction efforts emanating from the community.

It stimulates a pro-active attitude on the part of the population (taking initiatives and taking on responsibility in the face of the problems), increases the social support and thus encourages the natural re-building process.

It stimulates the communication and sharing of emotions between the members of the community, which is itself therapeutic.

It avoids the trap of falling into an approach centred on the traumatism and based on a clinical diagnosis (such as that of PTSD). In fact, it is not efficient to relegate individuals to the status of ‘sick persons’, especially when by so doing there is a risk of missing the needs expressed by the beneficiaries.

It encourages beneficiaries and those helping them to be creative.

Reasons for failure

Mental health programmes may experience failure for two reasons: cultural differences and the belated active involvement of the population.
Cultural differences between beneficiaries and expatriates

The expatriate staff, even when they are motivated by the best intentions, do not always understand either the way of life or the culture of the beneficiaries. It is therefore difficult to know how best to help the local population with the resources available. A humanitarian programme will have a better chance of meeting the needs of the survivors, of being relevant and of ensuring continuity if it takes the context into account.

Knowledge of the human sciences, developed in the West, particularly in the US, must always be put into the historical, social and cultural context. Psychology and work on trauma are not excluded from this need for relativity. For the first time, the DSM IV handbook mentions cultural characteristics, highlighting the danger of using a classification simply as it stands to evaluate another ethnic or cultural group. In fact, a clinician who ignores the nuances of the reference culture of an individual may, wrongly, regard behaviour, beliefs or the common experiences of this community as abnormal.

In order to avoid falling into this trap, it is necessary to keep in mind that there are strong variations between one culture and another with regard to how suffering is expressed, in the symbols, the communication styles and the coping mechanisms.

Thus there may be ‘cultural’ hysterical reactions (falling into trances, possession by spirits, etc.) that correspond to a traditional manner of expression that is accepted, or even encouraged. Other cultures will repress such emotional demonstrations, which will favour the appearance of more ‘acceptable’ psychosomatic problems (headaches, eczema, etc).

Belated involvement of the local population

In order to create a programme that adjusts to the local culture, local groups and community leaders must be implicated from the first stages and provide their input to the preparation of programmes. If this is not done from the start, it will be more difficult to get their involvement afterwards.
The psychosocial intervention method is flexible, adapted to the situation and directed towards the overall community. It has the following goals:

- To recognise that the community overall has the capacity to help itself through natural support networks (family, clan) and coping strategies that existed prior to the traumatic event.
- To prevent dependence on the humanitarian organisations and the cycle of victimisation by validating and encouraging traditional methods of healing and support.
- To restore and promote the natural support networks that may have been weakened by the situation.
- To encourage individuals and groups to help themselves and to show that we have confidence in their capacity to do so. By allowing the survivors to take back control over what happens to them, they will recover their self-esteem. People in refugee camps testify to the improvement in their psychological state when they can begin to help other people.
- To support the local associations that look after survivors. These associations understand the daily problems that faced the members of the community overall before the traumatic events, as well as the resources available for coming to their aid.
- To train community leaders with regard to psychosocial problems in order to make them able to assist their own community to deal with the stress.
- To collaborate with the local professionals capable of providing quality care in order to ensure the continuity of programmes.
SUMMARY

In psychosocial interventions in emergencies, the emphasis is on:

- The prevention of psycho-traumatic problems;
- The natural psycho-sociological healing processes based on cultural belief systems;
- Routine and facing up to the difficulties of everyday life. The best support for overcoming a traumatic event seems to be to relaunch daily activities based on the needs and resources of the community;
- The priorities identified by the community itself;
- Social activities. Many people believe that if we refer to their mental health, this means that they are being regarded as 'crazy', 'abnormal' or 'weak'. Some will refuse to accept help if the support offered is in some way labelled as mental health support. It is therefore essential to avoid using terms and methods that suggest the idea of psychological problems. For example, in a culture such as Turkey where 'honour' is important, the men especially are unable to openly express a need for psychological assistance. Proposing activities of a 'social' character is a good cover and opens the doors in a non-intrusive manner;
- Acknowledging that the sources of stress reside in the traumatic events and the social environment (for example, the daily problems linked with the new way of life) rather than within the individuals themselves.
In order to prevent the appearance of psychological and social problems as the result of a traumatic event, we should propose strategies that promote the community’s coping strategies and its own resources for providing support, and we should also work with local partners. For people who have developed severe problems, we have to ensure that they receive clinical care.

**Encouraging the community’s own resources for providing support and its own strategies for coping**

- Encourage the community to express its needs and own resources.
- Support community initiatives in response to the problems caused by the disaster.
- Actively encourage the personal resources of each person through a community approach.

The emergency provides an occasion for rebuilding a community assistance network because this situation generates strong motivation. This is a matter of supporting people in looking for their resources as a group. The consequences of this will be to:

- Reinforce the feeling of belonging to the group;
- Take back control over what happens to them;
- Recovering their human dignity.

**Working with local leaders and professionals**

By intervening at the psychosocial level in an emergency, we can straightaway start to think about the continuity of the action because every intervention creates needs that will have to be taken into consideration. In addition, people may suffer from longer-term psychological disorders and thus require aid well after the intervention is completed. From the start of our intervention, we must consider who will take over afterwards and thus collaborate with the
existing support networks in the country, the region and the community itself. By working with local partners we can:

- Gain the collaboration of community leaders and, consequently, of the community itself (which will feel more confident about a humanitarian programme when it is supported by people within the community in whom they have confidence);
- Facilitate decision-making and the allocation of community resources within a minimal period of time;
- Increase the possibility of being able to train community health workers in mental health care;
- More easily overcome any misunderstandings, or lack of understanding, on the part of the local community with regard to humanitarian psychosocial programmes;
- Promote culturally appropriate interventions.

### SUMMARY

The strategies for preventing the appearance of psychological problems are:
- Promoting individual and community resources;
- Offering individual assistance to people presenting with an acute stress or post-traumatic syndrome.
Chapter 8: Entering an emergency: The acute phase

A psychosocial programme in an emergency situation is characterised by an approach that responds to the two phases of an emergency: the acute emergency phase and the post-emergency phase. This chapter proposes what should be done from the first hours of an intervention.

During the acute emergency phase, humanitarian aid is mainly concentrated on the basic needs, such as food, water, sanitary installations, health care and shelters. Because these needs lie at the forefront of the concerns of the survivors, the mental health programmes may not seem to be a priority. Nonetheless, measures can be taken that will help to prevent the long-term psychological consequences of traumatisms:

- Reintroduce a daily routine;
- Encourage the population to form community groups;
- Put vulnerable people in contact with existing services and/or with community resources.

The stages of the acute emergency phase are:

1. Making contact with the affected community;
2. Disseminating information;
3. Providing security: participating in activities aimed at ensuring that basic needs are met; reintroducing a daily routine and personal, family and social rituals;
4. Gathering data;
5. Collective debriefing;
6. Detecting vulnerable people.
Making contact with the community

The programme begins by making contact with the people we hope to help. The priority of the expatriates will be to identify and consult community leaders, seek their advice and their opinions and ensure their participation for the duration of the project.

Disseminating information

For more detailed information, see Worksheet 801 'Some hints for an information centre', Worksheet 802 'Information in cartoon form: What is an earthquake?' and Worksheet 901 'Causes and symptoms of stress. Text to be distributed.', all from the Toolbox.

Once the basic needs have been met, the next essential is to meet the vital need for information. During a crisis, people submit to what is happening to them without understanding it. By disseminating information as quickly as possible, we achieve a directly positive effect on the stress caused by the traumatic event because this reintroduces a feeling of certainty and of control. This information must be complete, varied and correct, and must really meet the requirements of the beneficiaries.

Anguish and false rumours risk provoking panic attacks at any moment and these are difficult to channel and likely to hamper rescue activities. It is essential to provide information (about the event, the risks, the immediate future, rescue centres), as well as instructions about how to behave (for example, for evacuating the affected area, for organising shelters and alternative housing) in an attempt to prevent such phenomena.

Providing security

At the start of the intervention, we have to act quickly in order to save lives and assist the survivors. The priority is therefore on the vital needs. Nevertheless, the survivors have been and remain submerged by stress, panic, despair and exhaustion. Most mental health problems arising from a traumatic event can be reduced if simple measures aimed at the whole community are taken from the beginning of the intervention.

There are a number of activities that can be set up.

Saving victims

For more detailed information, see Worksheet 810 'Immediate psychological support'; Worksheet 811 'Basic attitude of those assisting with saving victims'; Worksheet 812 'How to behave with people in distress'; Worksheet 814 'Active listening'; Worksheet 815 'How to break the news of a death' and Worksheet 957 'Helping the bereaved ', all from the Toolbox.

The first intervention consists of saving the victims. The psychological support team can play a role alongside the medical tem by offering emotional support to the survivors.
Ensuring basic needs

For more detailed information, see 'Toolbox Worksheet 820 'Some ideas for the organisation of a camp'.

In the first phase of an emergency, the humanitarian actors mobilise in order to ensure that the primary needs are met and to set up reception structures.

This phase must be organised in a coordinated manner with logisticians, doctors and psychologists discussing together about how the camps should be organised.

It should be noted that it is important to involve the beneficiaries from the start of an emergency intervention. For example, by taking an active part in aid activities (distribution of clothes, food, blankets, etc.), they regain control over their situation, as well as recovering a sense of their own competence and personal resources. In addition, the regularity of such activities reintroduces a spatial-temporal structure meeting the need to rediscover a secure and predictable world.

Helping to ensure the primary needs of the community thus encourages the psychological recovery process.

However, it is unthinkable to begin actual psychological work with the survivors when the latter are still searching for bodies under the ruins and are hungry, cold and do not know where they are going to sleep.

Psychological help and reception centre

As the distribution centres and the medical tent are usually the first places survivors go to, that is where the psychosocial workers will be present. They can mingle with the survivors, answer their questions and come to the assistance of any who are affected by major emotional reactions or personal problems (aggravated by the traumatic event or its consequences). The emotional support services must be offered in an informal fashion.

A tent for psychological support will be set up beside the medical tent.

Installing rituals

Each individual, each family and each social group has its own practises, habits and rituals. In emergency situations, these reference points are disturbed, or even lost altogether.

Some indicators, such as interpersonal conflicts, schooling problems, drug or alcohol use, indicate that a community has problems. However, the presence of positive rituals, such as commemoration ceremonies or traditional celebrations, is a sign that a community's identity and well-being are becoming stronger.

The organisers of mental health programmes, in agreement with the beneficiaries and their community leaders, will take care to reintroduce into daily life local habitual practises compatible with camp life. For many people affected by a traumatic event, this type of support is sufficient for helping them to cope with their psychological and emotional problems.
Personal rituals
Before the traumatic event, each person will have had personal habits that can be reinstated; for example: specific bedtime habits, some leisure activities, etc.

Family rituals
It is important, in as much as this is possible, to encourage family intimacy. For example, we take care that families are grouped together (rather than forming separate groups for men and for women), although this may mean improvising makeshift separations for dividing up a shelter.

Giving names to camp alleyways, numbering shelters and indicating the names of the families occupying them all help to humanise living conditions and encourage social relations by making it easier for people to meet one another.

Social rituals
A comforting living environment can be constructed by encouraging the practise of customs, beliefs and traditions, as these restore security, and the ability to reliably predict the future and exercise control.

⇒ Some people take great comfort in social activities. We have to give thought to how these can be encouraged. For example, by supplying coffeepots/teapots, coffee/tea, sugar and kettles as in many cultures coffee or tea ceremonies enable people to gather among friends and neighbours.
⇒ As far as possible, we encourage the introduction of traditional activities. For example, in some cultures, women get together to cook and the men play cards.
⇒ The sleep-waking pattern must relate to the day-night pattern. In agreement with the beneficiaries, we could institute hours of quiet during the night.

"Traumatisms are healed by a reassuring daily pattern."
(Prof. B. Rimé, Brussels, UCL)

Data gathering

For more detailed information, see Worksheet 831 'General data', Worksheet 832 'How to gather useful data with regard to mental health'; Worksheet 833 'Useful data with regard to mental health'; Worksheet 834 'Rapid assessment of the mental health needs of refugees, displaced and other populations affected by conflict and post-conflict situations' and Worksheet 835 'Impact of event scale', all from the Toolbox.

A rapid evaluation of the mental health needs, as well as of the available resources, must be carried out as quickly as possible during the emergency phase. This evaluation must be updated regularly, something that becomes even more important when the situation may evolve rapidly.

It must not take longer than seven to ten days to gather the data for preparing and launching a psychosocial programme.
A more detailed evaluation of the needs of the vulnerable groups must follow.

**Objectives of data gathering**

The information gathered must enable identification of:

- Immediate and subsequent problems, as well as the needs of the population;
- The community's priorities;
- The resources available within the community;
- The extent to which the psychological assistance programme is likely to be accepted, as well as the obstacles to it;
- The obstacles in terms of access to services for the potential beneficiaries;
- The vulnerable groups and their specific needs, as well as the programmes likely to meet these needs;
- The means of encouraging the individual and collective initiatives of the beneficiaries.

**The collective debriefing**

For more detailed information, see Toolbox Worksheet 841 'The debriefing'.

A preventive approach will include a phase in which emotions can be expressed, just as it includes a phase in which security is provided. In fact, the intention is to avoid the development of serious psychological problems in the post-immediate phase.

The best time for beginning to work on the expression and verbalisation of what has happened is during the first days following an event. Nevertheless, it is obvious that the possibility of this type of intervention will be strongly determined by the context and by the nature of the event itself. Thus it is inconceivable to proceed with a debriefing when certain minimal conditions are not met. The security of participants is an essential prerequisite. Equally, there can be no thought of bringing the survivors of a disaster together for a group debriefing while the search for survivors is still under way.

**Definition**

The psychological debriefing is a group meeting held shortly after the event during which those who escaped are invited to talk about their experiences. The debriefing represents a passage between the chaos caused by the emergency situation and the beginning of a period of reconstruction and return to daily activities.

**Objective of the collective debriefing**

The objective of the debriefing is to encourage the survivors to talk about their experiences of the event in order to:
Avoid a pathological evolution of the symptoms of acute stress;

Prevent or mitigate the surfacing of psycho-traumatic problems in the long term;

Accelerate the psychological recovery.

**Impact of the debriefing**

As regards the preventive value of the debriefing, we must not deceive ourselves and hold out ill-considered hopes. In the situations in which MSF intervenes, the problems are not only the traumatic incident and the initial losses, but also the large panoply of subsequent and cumulative difficulties. In addition, all individual deal with their own feelings in their own way and at their own rhythm, and some victims have experienced a more significant degree of hurt or are psychologically more vulnerable.

Due to its emergency character, it is difficult to conduct scientific research during interventions and we have little data about the impact of the debriefing. However, a study presented by P. Bouthillon on the victims of terrorist attacks examined three years after the event indicates encouraging and clearly significant results. Thus it was observed that 16% of a group participating in a debriefing suffered severe problems while in groups without a debriefing the percentage was 75% (Crocq, 1999). In Armenia, eighteen months after the earthquake, Pynoos (Meichenbaum, 1994) observed significant results regarding the severity of psycho-traumatic problems among children who had the advantage of a debriefing followed by three to four individual and collective sessions compared with children who received none.

Quite simply, we can say that in the present state of research, an early intervention proves effective for some and not for others, and in no case can it claim to be an effective treatment for complex and persistent problems resulting from the traumatic event itself, from previous individual vulnerabilities or from the variety of social conditions surrounding the critical incident.

**Detecting vulnerable people**

See Chapter 4 'Vulnerable groups and individuals'.

People presenting psychological problems after a traumatic event and requiring individual care must be identified. The debriefing groups and members of the community are useful sources of information.
SUMMARY

The first stages of an emergency psychosocial programme:

- Make contact with the affected population: this step enables data gathering with regard to the needs and particularities of the beneficiaries, to pinpoint the existing resources and to ensure the participation of the community leaders.
- Spread information for the beneficiaries about the events and the humanitarian activities taking place, as well as the psychological consequences of a traumatism.
- Save the victims and ensure their basic needs: these activities require the ability to empathise and to listen on the part of those intervening.
- Collect data that is relevant for the preparation of a mental health programmes.
- Set up immediate psychological support to be provided by all those intervening (defusing) and by the psychological team (defusing and debriefing).
- Reintroduce a reliable daily round of activities.
- Pinpoint people requiring individual care.
Chapter 9: the post-emergency phase

During the post-emergency phase, appropriate family and community support helps most people to recover from a traumatic event. However, some people, due to individual characteristics or because they have experienced particularly traumatising events, may present psychological problems that require specific care.

Once the conditions for ensuring security have been effectively installed, the chaos of the first phase brought under control and the population has moved beyond the first state of shock, the second phase of the intervention begins. In this post-immediate phase, the goals of the next actions are:

1. To offer preventive and social activities that strengthen the social fabric in order to reduce the risk of post-traumatic mental problems:
   - Stress management;
   - Mutual aid groups;
   - Social activities;
   - The expression of emotions within a group setting.

2. To train mental health professionals to be able to provide emotional support to the community:
   - Training counsellors.

3. To offer assistance to the people who present persistent psychological problems:
   - Individual counselling;
   - Referring people who have need of it.

Stress management

See Chapter 2 'Reactions to a traumatic event'.

When individuals are subjected to an attack or are under threat, they respond in an immediate manner: they mobilise their physical and psychological resources in order to deal with it. This reaction, almost a reflex, is accompanied by bothersome symptoms: muscular tension, rapid respiration, increased cardiac rhythm, etc. Normally, once the danger has passed, they relax and progressively recover their sense of well-being. But the survivors are in a state of permanent tension (families have disappeared, the future is uncertain, etc.). This chronic stress
may have somatic repercussions. These physical symptoms, because they upset the survivors, in turn become a source of stress and increase the tension. It is thus a vicious circle, but one in which it is possible to intervene.

How can we help these people to manage their stress and to reduce it?

**Information**

For more detailed information, see Toolbox Worksheet 901 'Causes and symptoms of stress. Text to be distributed.'

This information covers the causes and symptoms of stress. The causes are obvious, but the survivors often do not know that their symptoms are a consequence.

**Education**

The population can be encouraged to adopt behaviour likely to help them to manage their stress and its consequences.

- Restoration of sleeping capacities;
- Relaxation exercises;
- Breathing exercises;
- Exercises for bodily expression;
- Sports activities;
- Massages.

The above are all means of dealing with stress.

We should therefore allocate space for relaxation, for sport and for social interaction according to what the population needs and is capable of doing.

The activities will be selected in line with the cultural background of the beneficiaries.

**Recovering the ability to sleep**

See Toolbox Worksheet 910 'Sleeping problems'.

Sleep is essential for conserving or recovering equilibrium with regard to physical and mental health.

**Relaxation**

Relaxation techniques are effective for reducing a state of stress. Information can be sought about traditional methods (for example, meditation, yoga, dancing, etc.), as well as the personal habits of the beneficiaries (for example: reading, dancing, singing, story-telling, etc.). Such relaxation sessions can be led by members of the community.
Breathing

For more detailed information, see Worksheet 920 'The hyperventilation syndrome' and Worksheet 921 'Text for breathing exercises to stop hyperventilation', both from the Toolbox.

Breathing changes under the influence of stress, (more rapid rhythm and/or fuller respiratory movements). If this change continues beyond the period of the dangerous situation, people complain of various symptoms. In some cases, their number and/or their intensity is such that those concerned have the feeling they are going crazy or fear dying of a heart attack. The most frequent symptoms are:

- An impression of insufficient air, of weight on the chest;
- Dry mouth;
- Dizziness;
- Heart palpitations;
- Prickly feeling or loss of feeling ('falling asleep') in the extremities (foot, hand);
- Difficulty in concentration;
- Sensations of weakness, depression, irritability;
- Etc.

The presence of such symptoms should lead those assisting to pose deeper questions and teach appropriate breathing techniques (voluntary apnoea) so that those affected recover their sense of well-being (Worksheets 920 and 921).

Physical exercises

For more detailed information, see Toolbox Worksheet 930 'Bodily expressions'.

These physical exercises should encourage:

- Relaxation;
- Externalisation of emotions;
- Development of confidence in oneself and in other people;
- Links between participants;

In addition, by encouraging survivors to organise such activities, we also assist in:

- Strengthening the social organisation of the community;
- Promoting people's positive resources.
Sports activities

For more detailed information, see Toolbox Worksheet 931 'Physical training'.

Sports activities (gymnastics, ball games, walking, running, etc.) provide physical relaxation while momentarily lifting the spirits of those taking part in them.

Massage

Massage is well known in many cultures. It is a very good way of relieving tension and establishing a positive contact with the body.

Information should be sought about such methods that might fall within the traditions of the community concerned and people should be identified who might be able to provide massage or teach the techniques to others. People can massage themselves, other members of their family and their children.

'Talking groups' and mutual aid groups

For more detailed information, see Toolbox Worksheet 940 "Talking groups".

The objectives of these groups are to:

- Help people to find comfort, support and advice from people who have lived through a similar experience. The members of a group support one another and benefit from each other's experience. The group strengthens the social link thanks to the solidarity, mutual recognition, protection and tolerance.

- Allow participants to talk about their experience, their reactions, their difficulties, etc. These groups are based on the therapeutic benefits of sharing experiences and emotions.

- Encourage awareness that other members of the group are experiencing a large number of emotional reactions (guilt, fear, anger, solitude, impotency, etc.). This phase encourages acceptance of the feelings experienced.

- Research common projects ("What would we like to do together?").

- Develop joint activities for dealing with the problems ("How are we going to do this?").

Thanks to these groups, the psychological support team will acquire information about the cultural background of the survivors, particularly how they perceive and deal with problems. This will enable the team to adapt the responses proposed.

The group will preferably be comprised of six to ten people. It could include, for example, a nurse, a healer, a community leader or a local religious leader. If the culture allows it, the group will include both men and women because each sex often has a different approach to problems and solutions.
The basic rules are:

- Confidentiality: whatever is said in the group must remain within the group.
- Mutual respect: even if the people share the same cultural and/or historic past, and/or the same present living conditions, the participants and those leading the group must respect the differences and the integrity of each individual.

### Individual counselling

For more detailed information, see Worksheet 950 'The different stages of counselling'; Worksheet 951 'Patients' files'; Worksheet 952 'Fortnightly synoptic tables'; Worksheet 953 'Fortnightly summary sheet'; Worksheet 954 'Summary sheet'; Worksheet 955 'Home visits'; Worksheet 956 'Impact scale of the traumatic event'; Worksheet 957 'Helping the bereaved'; Worksheet 958 'Helping the male victims of sexual violence'; Worksheet 959 'Helping the female victims of sexual violence' and Worksheet 960 'Follow-up worksheet for female victims of sexual violence', all from the Toolbox.

Counselling is a task requiring an ability to provide active listening and emotional support, which is intended to help people express themselves and ventilate their feelings.

It includes a process by which individuals identify their own problems and clarify their own objectives. The role of the counsellor is to pose questions that will help them to:

- Define their own difficulties and the reasons why a decision is required. (What is the problem and what makes it a problem?).
- Set their own goals. (When things get better, what will change in the patient's life?).
- Reflect on the different options for reaching the objective, as well as the consequences of their decisions. (What must the patient change in order to reach what is wanted? Will these changes have repercussions other than what is wanted, for his/herself and/or the people immediately around him/her?).

The objectives of counselling are to:

- Help those who are having the greatest difficulty in dealing efficiently with the impact of the traumatic event. An individual approach aims first and foremost at the most vulnerable people (the victims of sexual violence or of torture, those who have lost a family member, witnessed atrocious scenes, etc.).
- Help people to help themselves.

The counselling service is offered by mental health professionals or by community members identified as being capable of filling this role. The latter will be trained and supervised by the MSF staff.

In some societies, the tradition is that the 'rehabilitation' of individuals takes place within the family framework, possibly with the help of a religious leader. It may be difficult for such
groups to accept the assistance of outside psychologists, especially if those concerned do not share the same view of the problems as the counsellors. For this reason, counselling provided by community actors will be more effective and better accepted. The healing dynamics natural to the group in question must also be respected. The role of the psychosocial team is to serve as the motor for the development of therapeutic dynamics.

**Referral system**

For more detailed information, see Worksheet 970 'Referrals worksheet' and Worksheet 971 'When to refer someone to a psychologist', both from the Toolbox.

The following conditions are required for the construction of a referral system:

- Available professional resources (doctors, psychiatrists, psychologists, social workers);
- A collaboration agreement with the professionals concerned;
- The criteria for referrals defined in line with what is required and what is possible.

**Who should be referred?** Patients presenting severe or chronic problems requiring specific care (therapy, medication, etc.) over the long term.

**Why?** Because counselling proves insufficient.

**To whom?** The first referral will always be to a doctor. In fact, it is important to ensure that the problem does not have a physiological origin. Referral to a psychiatrist is sometimes required in order to ensure treatment by medication. Referral to a national psychologist is indicated when the patient requires psychotherapy over the longer term.

**How?** Referral will be backed by support and follow-up. The fact of being referred to a health professional may be frightening for a patient. The counsellor will therefore take care to explain the reasons, will try to get the patient's agreement and will ensure the handover.

The counsellors must be capable of understanding the criteria for referrals and of asking advice from their supervisor.

An education – awareness programme should be set up for the health professionals we want to work with. This programme will deal with the specific problems related to stress and trauma.

**N.B.:** We only try to detect people with severe problems if we are able to offer them an appropriate service! If there are no mental health resources, or only inadequate ones, we limit ourselves to individual counselling while stressing the community dynamic.
Social activities

Social activities (dances, music, songs, ceremonies and celebrations):

- Reduce stress and lower the risk of conflict. People living under permanent and intense stress become unhappy and aggressive, which encourages the emergence of conflicts;
- Reduce the feeling of isolation and strengthen social links. Survivors living in the same camp or village can still feel alone and isolated;
- Help the beneficiaries to deal with their problems by stimulating them to work together at finding solutions to them.

Even in difficult conditions where there are many reasons for being unhappy, such activities and social displays ought to be encouraged.

Productive and useful activities

Productive and useful activities allow the survivors:

- To improve their living conditions by sharing their needs and their resources;
- To recover the self respect that their role of victim has taken from them. In fact, by giving them back power and control over what happens to them, enabling them to have a useful and recognised role, these activities restore their human dignity;
- To take account of and actively include the 'healthy' members of the beneficiary community.

People with the resources to encourage collective work need to be pinpointed.

Some examples of useful activities:

- Women can participate in the communal preparation of food.
- They can organise workshops for sewing, knitting, etc.
- They can set up a nursery and a support programme for young mothers.
- Teachers can organise activities for children and adolescents.
- Men and women can organise workshops to make toys for the children.
- Men can help to set up tents, and to rehabilitate schools, places of worship and houses.

Cultural and festive activities

All human beings encourage cultural and festive activities, which help to reduce stress naturally and strengthen social links. These cultural rituals should be encouraged because:
They help the survivors to renew the links with their traditions and their basic values.

They install reference points in a world that has been violently disrupted by the traumatic event.

Members of the community (artists, religious actors, community leaders and teachers) should be encouraged to assume responsibility for organising such activities.

Some examples of activities:

- Traditional music and dancing have an important role in many societies. They bring people together and re-dynamize the group by providing a structure in time and space. They offer, within a reassuring framework, a means of expressing feelings that, thanks to its cathartic effect, can smooth tensions.
- In many cultures, stories are handed down from generation to generation thanks to the oral tradition. They are intended for a wide audience and interest adults as much as children.
- In difficult situations, for a majority of human beings throughout the world, religious rites are a great help. Individuals speak of their suffering and concerns and pray for the alleviation of their pain and to keep up their hopes.

Games and sports activities

Games and sports activities are:

- A means of relieving stress and anxiety;
- A means of meeting people and interacting with them;
- Cultural points of reference.

It is important to identify and encourage key people to organise games and sports activities and competitions.

Some examples:

- Football practice and a competition, with the formation of several teams. This event provides an occasion for everybody in the community to participate: the women by preparing food and drink, the children by making flags, etc;
- Traditional sports, which usually require little material;
- Some games (card games, dominos, etc.) are very popular.
Training counsellors

For more detailed information, see Worksheet 701 'Selecting counsellors' and Worksheet 702 'Training counsellors', both from the Toolbox.

It goes without saying that all community members with a profession linked to working with human beings (teacher, medical and para-medical personnel, social workers, activity leaders, etc.) or with experience in helping or supporting people who suffer can be trained as counsellors.

SUMMARY

In the post-emergency phase, the priorities are:
- To supply information about stress;
- To promote stress management through education and the organisation of activities;
- To encourage exchanges between beneficiaries and mutual help for one another;
- To offer psychological support to people presenting psychological problems in the wake of traumatising events;
- To refer people who are experiencing great psychological suffering and require specific care;
- To encourage social activities (activities that are productive and useful, cultural and festive, games and sports);
- To train counsellors.
Chapter 10: Support for children

A return to a daily routine is the first way of responding to the fundamental needs of children. Installing a structured life presupposes that we are working with the parents.

In order to help the children, it is essential to know about their lifestyle. A culture is accompanied by a whole set of beliefs and values on which the community is founded. It also serves as a cradle in which children forge their identity and the community establishes continuity.

The psychological support team will therefore have to inform itself about:

- The way in which the community traditionally looks after its children;
- The rituals and celebrations in their honour;
- The hopes that the community nourishes for their children’s future;
- The different roles that the members of the family take in regard to the children.
- The way the community takes care of the unaccompanied children.

Helping parents

Children’s needs: security, stability, predictability

Surviving children are confronted with separations, loss, uncertainty and stress, not to mention the difficulties inherent to their living conditions (camps, houses in various states of destruction, etc.). For a child, the best way of recovering from a traumatic event is a return to normal daily routine as quickly as possible. We will therefore encourage families to reinstall family habits as soon as they can, thus providing rules, standards, activities, etc. The return to security, that a strong and stable family can offer, enables children to get rid of their impression of the adult world as one of chaos and breakdown.

Separations are often inevitable when there are large-scale population displacements. However, children have emotional needs (particularly for stability and security). These must be satisfied if their development (present and future) is to proceed at a normal pace.

Each child will have to be placed as rapidly as possible in a situation in which the conditions will enable him/her to maintain an affective relationship with an adult from the community. We seek to reunite parents and separated children by making enquiries in tracing centres where both parents and children can come to look for information about each other.
**Support for parents**

For more detailed information, see Worksheet 1001 'Advising parents how to help their children' and Worksheet 1043 'Helping child victims of sexual violence', both from the Toolbox.

Parents experience numerous problems and also suffer from the traumatic events that they have lived through, as well as their consequences. In addition, they see their roles as adults and as parents considerably modified. They are often no longer able to take care of their children as they were accustomed to do and feel powerless to help them. Stress may even lead families to abuse or neglect their children.

A lot of work has been devoted to the clinical effects among the children of people suffering from psycho-traumatism\(^{15}\). Surviving parents, incapable of establishing normal affective relationships, induce affect development deficits in their children, as well as psychological problems, an inhibition of the need to fulfil themselves and behavioural problems. This phenomenon is known as a 'trans-generationally transmitted traumatism' and has very long-term affects across several generations.

The priority and the necessity will thus be to offer support to the parents and to work with them so that they can again become stable and formative educators. As quickly as possible, the children should be put in the charge of their family and community. In fact, survivor populations can themselves help their children if they are given the chance to do so. Helping the whole community to retrieve and/or to maintain its mental health is the best way of supplying psychological support to the children.

The families can be offered advice and there are various ways of doing this: through brochures, during 'talking groups', during mother-child workshops, etc.

The advice given should be adapted according to the culture of the beneficiaries.

---

**Support for depressed mothers**

For more detailed information, see Toolbox Worksheet 1010 'Hints for helping depressed mothers'.

Some mothers are so severely depressed that they are not able to look after their children.

We saw an example of this in Burundi, in the hospital for the war-wounded, where mothers hid their babies within the medical structure and abandoned them. Such serious negligence has led to children dying.

\[\Rightarrow\] It is always preferable not to distance the mother and child far from where they belong.

---

\(^{15}\) Zajde 1993; Barocas, Salomon quoted by Crocq, p.352, 1999
Mother and child must never be separated. Everywhere in the world, parents are concerned for the well-being of their children. If they cease to provide the necessary care, it is because, for one reason or another, they are no longer capable. A mother in difficulty has need of help and not of being discredited or judged.

These mothers need special help from the psychosocial team and/or counsellors and/or members of the community.

**Activities for children**

For more detailed information, see Worksheet 1020 'Workshops for children aged from 0 to 2 years'; Worksheet 1021 'Workshops for children aged from 3 to 6 years'; Worksheet 1022 'Workshops for children aged 6 years and older'; Worksheet 1023 'Hints for leading a children’s group'; Worksheet 1024 'Talking group' for children aged 8 years and older' and Worksheet 1043 'Helping child victims of sexual violence', all from the Toolbox.

The activities selected depend on the age of the children. However, from birth to adolescence, play, recreational and sports activities, education and the expression of the emotional experience are the best ways of allowing children to continue their development.

**Information**

Experiencing war or an earthquake arouses in children, as in adults, a feeling of loss of control and autonomy. In order to give a better impression to children that 'the situation is under control', it is important to explain to them the events they have just lived through, what is happening now and what is likely to happen in the near future. Children, like adults, are more frightened when they do not understand what is happening around them.

Children can understand and accept what is happening to them, if there is sincerity and transparency in the explanations given to them, which should be expressed in simple terms appropriate to their age. We should not under-estimate the capacity of even very young children to absorb factual information.

In a critical situation, adults clearly have a tendency to try to hide the truth from children. They express themselves in a vague manner and keep quiet about some details. Their reasoning is honourable: they want to spare their children. However, the consequences are harmful: instead of feeling confidence, the children are troubled, fearful and lack assurance.

This information could be given by parents, teachers or other resource people who, by their activities, are in contact with the children.
Play

Children have need of games, to play, to be able to laugh and to recover their carefree nature. Play is a way of:

⇒ Relaxing;
⇒ Interacting with others;
⇒ Developing physical, mental, emotional and social skills;
⇒ Learning;
⇒ Expressing experience.

Recreational and sport activities

A traumatic event, by its very intensity, mobilises the whole sensorial system and the other biological mechanisms that ensure survival. The majority of children who have experienced such an event are affected by the sensorial impressions of what they have seen, heard, felt and touched. Consequently, they may have a broken and incoherent image of their body, which is transposed into a lack of psychomotor coordination, a tense bodily stance, etc.

Recovering sense reactions (touching, seeing, smelling, etc.) and rediscovering the pleasure of the body in a reassuring context enables a natural evacuation of the trauma.

Gymnastic exercises, dance and sport (football, races, teams games with balls or scarves) act on the body, the rhythm, space and the feeling of group belonging. They also help to build a realistic image of the body that is associated with enjoyment and interaction with other children.

Education

In order that children continue to develop and acquire new skills, it is essential that they are able to have the normal experiences of a normal life full of opportunities for stimulation and learning. It is therefore important that they receive an education.

Expression

For more detailed information, see Worksheet 1030 'Hints for helping children to express their emotions' and Worksheet 1024 "Talking groups for children aged 8 years and over', both from the Toolbox.

Few children are capable of speaking openly about their problems. We therefore have to give them the opportunity to express their concerns indirectly. This process may make use of
various forms of expression familiar to children: drawing, stories, writing, singing, putting on plays, dancing, poetry, etc.

It is important that the children are able to express what they have lived through. However, it is also essential to avoid adding to their suffering by constantly seeking at any cost to work through their traumatic memories. Children have many emotions to express. The joy of living is one of them and it is in this healthy part that we should go to draw on their resources.

**Identification of children in difficulty**

For more detailed information, see Worksheet 1040 'Hints for identifying children experiencing problems'; Worksheet 1041 'Evaluating the impact of a traumatic event and its consequences for children' and Worksheet 1042 'Follow-up worksheet for child and adolescent victims of sexual violence', all from the Toolbox.

Some children will not be ready to be included in a group intervention setting. This includes:

- Young children who cannot be apart from their mothers because the separation would seriously upset them. These children could be directed towards a mother-child group.
- Children who are so aggressive or so active that they could not usefully participate in group activities. These children may be extremely traumatised, in which case some one-on-one care may prepare them to integrate in a group.
- Children who have been seriously traumatised (especially those who have experienced sexual violence) and thus whose experiences could seem disproportionately greater than those of the other participants.

The main condition for justifying the identification of children in difficulty is the possibility of offering them specific follow-up or referral to a service and to people who could take charge of them and offer effective help.

**SUMMARY**

In order to help the children, we take care to:
- Provide a maximum amount of care for unaccompanied children;
- Reunite children with their families as quickly as possible;
- Support depressed mothers who are unable to look after their children;
- Help parents to help their children;
- Organise recreational activities;
- Encourage schooling activities;
- Organise child day care services so that parents can occupy themselves with the problems involved in returning to a normal life (for example, when the family is living in a partly ruined house).
Chapter 11: Support for adolescents

The most important stage for adolescents is becoming independent, which means progressively separating from their parents. In order to do this, adolescents need models, meaning adults, whose behaviour they are able to imitate so as to gradually take on their own role as adults within their community and society. The situation of adolescent survivors or refugees may be aggravated because in such situations:

- Youngsters are prematurely separated from their families (death, poverty, displacement, etc.);
- The role of young people in the community may have changed, as well as the community itself.
- By force of circumstance, youngsters may take on an adult role prematurely (for example, to become head of the family).

Activities

The main difficulties experienced by adolescents after a traumatic event, due to the upset in their usual activities, are boredom and isolation from their peers. In order to remedy this, we should take care to organise activities with and for adolescents as quickly as possible.

Such activities should be capable of stimulating:

- Self-expression and creativity: dance, music, putting on plays, poetry, writing, creating a newssheet, painting a mural, drawing, etc.;
- Self-knowledge and knowledge of others: group reflection, diaries;
- Vitality and action: team sports, useful and productive activities, apprenticeships;
- Mutual help: helping the most vulnerable, looking after children while their families take care of relocation problems, organising games for the youngest children, contributing to the re-building process (for example, in case of earthquakes);
- Inter-personal exchanges between young people: discussion and meeting groups, mutual aid groups (for example, for adolescents mourning a death(s)) and 'talking groups'. Adolescents usually find it easier to relate to other adolescents than to adults.

Groups of adolescents function well if:

- Those leading them are flexible, can ensure emotional support and organise activities based on the needs and desires of the participants;
- The participants are given a say in the selection and organisation of such activities;
- The objectives are reached through recreational and social activities;
They can find support from some of the adults in the community.

**SUMMARY**

In order to help adolescents, we must organise activities that allow them to:
- Express themselves and enable sharing and exchanging between themselves and with adults;
- Relax and expend physical energy;
- (Re)socialise and make themselves useful to their community.
Chapter 12: Support for the elderly

The elderly may at first be perturbed by the radical upset that the traumatic event inevitably brings to their way of life. Having lost all their usual reference points, they may show significant emotional reactions (confusion, mental disorganisation). Also, more than any other group, they have need of information that will enable them to understand the events that have occurred, as well as those that are expected. Care should also be taken to ensure as normal a life as possible (for example, by avoiding successive relocations) in order to give them back a sense of security and predictability in their environment.

In addition, some of them, because they suffer from handicaps or disabling illnesses should receive specific medical care and sustained practical help (housing, food, administrative requirements, etc.).

We also need to be aware that the elderly are sometimes isolated and have difficulty in moving about. Also, those requiring more aid are often those who have the least access. It is therefore useful to envisage an active outreach approach.

People in good physical health will recover more quickly from a traumatic event if they can practise a useful activity (for example, looking after children).

**SUMMARY**

Remember:
- Use an active outreach approach for reaching the elderly;
- Provide them with information;
- Ensure health care for them;
- Supply practical help;
- Get them involved in useful activities.
Chapter 13: Psychopharmacology

Make psychotherapy the priority: a pharmaco/psychotherapeutic combination will only be envisaged straightaway in severe or disabling cases. Psychotropic medicines help to reduce the intensity of post-traumatic symptoms, especially when specific psychiatric problems are associated with them.

There are two possible options:

- The introduction of an antidepressant from the start:
  - Tricyclical: amitriptyline, used in doses up to 300mg/day, is especially active on the depressive symptoms, anxiety, intrusive thoughts and avoidance symptoms. The secondary effects (dryness of the mouth, constipation, visual focus problems, tachycardia, etc.) often make it uncomfortable for the patient to use, particularly in high doses.
  - SRI (serotonin recapture inhibitors) constitute a more recent class of antidepressants and essentially have the advantage of fewer secondary effects than the tricyclics. Fluoxetine (Prozac®) is the leader here and has recently become available in generic form. Its effectiveness in PTSD has been confirmed on many occasions. As with amitriptyline, it is often necessary to employ higher doses than those used in depression (up to 60mg/day), beginning with lower doses and progressively increasing the dosage.

In both case, it takes six to eight weeks of treatment before concluding whether it is ineffective and changing the molecule. The total recommended course of treatment is from six to twelve months.

Or,

- Treatment of the associated symptom(s):
  - Especially if there are intrusive thoughts, hyper-vigilance or impulsive behaviour, use:
    - Carbamazepine (Tegrétol®): an anti-epileptic medication used in psychiatry as a mood stabiliser;
    - Or valproic acid (Dépakine®): an anti-epileptic medication also used as a mood stabiliser;
    - Or lithium: a medication well known for its mood-stabilising action, but difficult to use because of the secondary effects and the need to check blood levels;
    - Or propanolol (Indéral®): a beta blocker used to reduce the symptoms of adrenergic hyperactivity;
    - Or clonidine (Catapressan®): antihypertensive medication used for having the same properties. Watch out for blood pressure falling among sensitive patients.
If the patient is mainly suffering from anxiety with no marked depression, feeling of intrusion or avoidance, use:

- Alprazolam (Xanax®): the benzodiazepines are effective in combating anxiety, but these medicines have a powerful ability to induce abuse and dependence. They will therefore be used with great prudence and avoided for patients who already have this type of problem. If alprazolam is not available, diazepam (Valium®) is an equally efficient alternative.

If there are mainly depressive symptoms present, but without obvious avoidance tendencies, use:

- Tricyclics (amitriptyline) (see above);
- Or SSRI (see above).

If the main symptoms are psychotic, aggression or agitation, use:

- An anti-psychotic: recently studies have shown that it is sometimes interesting to use small doses of the latest generation of anti-psychotics, risperidone (Risperdal®) and quetiapine (Seroquel®), not only in cases of psychotic symptoms or agitation, but also, in resistant PTSD, but in small doses. The use of the 'old' antipsychotics, although still present in less favourable contexts, such as haloperidol (Haldol®) or chlorpromazine (Largactil®), has not been studied as such, but would certainly be useful in case of agitation or symptoms of delirium or hallucination.

If there are concomitant sleep problems, use:

- Nefazodone (Serzone®) or trazodone (Trazolan®) are antidepressants characterised primarily by their predominant sedative power. They are usually used for this sedative, even hypnogenic effect. Nefazodone is not available in Belgium. Trazodone has recently become available in generic form. These products do not lead to dependence and are therefore an interesting alternative to sleeping pills, especially the benzodiazepines;
- Or cyproheptadine (Périactin®): an antihistamine also characterised by a sedative effect, therefore used to this end, like the previous products. Promethazine (Phenergan®) is available in generic form and has the same properties and uses.
Appendix: Humanitarian personnel

For more detailed information, see Worksheet A 'How to take care of yourself in an aid situation', Worksheet B 'Checklist of ten points for evaluating your state of stress', Worksheet C 'Prevention, preparation and follow-up for humanitarian personnel' and Worksheet D 'List of psychologists', all from the Toolbox.

The humanitarian personnel assigned to mission in countries ravaged by war or natural disaster often experience intense emotions because of the very context of their work (witnessing violence, identification with the victims, etc.). These difficult conditions may trigger off psychological suffering to a greater or lesser extent; this is known as secondary traumatisation or vicarious traumatisation. On the other hand, aid personnel may themselves have been confronted with a dangerous situation (or critical incident) and therefore experience a psycho-traumatism.

The medical coordinators, with responsibility for expatriate health, also have to concern themselves about the mental health of their teams. Not all missions have the advantage of the presence of a mental health professional to help them. The following should enable the medical coordinators to detect people in difficulty in order to offer support.

Difficulties encountered by humanitarian workers and the psychological support team

Professional stress factors

- The time factor

The pressures imposed by this factor are all the greater as the chances of the victims’ survival are closely related to the time elapsing before assistance arrives.

The time factor therefore imposes the following requirements:

- A need to work rapidly and efficiently;
- Little or no preparation time prior to the intervention;
- A feeling of powerlessness in front of the immensity of the needs: a large number of people requiring help and little time to spend on each of them.

- The physical requirements:
  - An ability to withstand working long hours in difficult conditions;
An ability to perform tasks that may be repetitive and nerve-racking.

The emotional requirements

Humanitarian personnel care for victims in a state of stress and are exposed to traumatising stimuli. The traumatising factors are:

- Confrontation with violence in all its forms;
- Situations of insecurity and danger (alarming rumours, the uncontrollable forces of nature, clearing through check-point, mined routes, expulsions from the work place or residence, attacks by combatants or bandits, shelling, direct or indirect intimidation and threats by armed individuals, threat of a coup d’état, etc.);
- The scene of chaos and severely wounded or very mutilated victims, death, sometimes on a large scale;
- Situations involving breast-feeding infants or children;
- Contact with people in distress, suffering from misery, hunger and lack of nourishment, decimated by epidemics;
- The inability of those offering assistance to satisfy the demands of the populations in danger ('the trauma of the powerless witness');
- The feeling of being powerless to offer comfort to the victims for whom one of the main needs is to be listened to and understood;
- The attitude of those surrounding a victim when aid is being given (families experiencing great suffering who ask for a lot of attention);
- Having to announce bad news to the beneficiaries (for example, about deaths);
- Hearing testimony of ill treatment, torture, rape, etc;
- Helpers have to control their own emotions;
- The fact of facing moral and ethical dilemmas (powerless witness before acts that are abuses of human rights);
- Confrontation with an unfamiliar environment, a different culture and language;
- Having no control over many aspects of the situation (when the traumatic event occurs, where, who are present, what skills are needed, etc.);
- Having to take difficult decision while working in a setting ruled by fear, anger, grief, etc;
- Additional stress factors for the psychological support team:
  - Are particularly exposed to the intensity of the emotions present by their relational proximity to the victims;
  - Know nothing about the prior morbidity and psychological antecedents of the victims;
  - Are afraid of being, or feel that they are being, intrusive
The mental requirements

- Necessity of having good judgement, a clear mind and ability to think with precision, to establish priorities and to take decisions in a chaotic situation;
- An ability for multi-tasking is sometimes required, with each task considered a priority.

Harassment and obstacles placed by the authorities or by armed gangs.

To all this must be added:

**Structural factors related to the organisation**

- Adapting to hierarchical superiors (to which may be added difficulties in communicating, accepting their style of team management, etc.);
- Integrating into a team (to which may be added difficulties between colleagues, etc.);
- Learning and accepting work methods and procedures;
- The working conditions;
- The operational responsibilities;
- The sometimes limited resources (in personnel, equipment, funding);
- The discomfort, fatigue, lack of sleep and rest because the demands are so pressing that it is difficult to respect reasonable working hours;
- The lack of acknowledgement of the work accomplished by those in charge of the mission or by headquarters;
- The organisation's requirement for results, results that are sometimes difficulty to quantify;
- The mixed (or even impossible) expectations for objectives are set very or too high (or even unrealistic);
- The expectations of the team in the field may be the opposite of what those at headquarters are expecting;
- The expectations with regard to the psychological support team:
  - the organisation may have large, but ill-defined, expectations as far as the psychological aid team is concerned;
  - the organisation's expectations may be different from those of the victims or those of the psychological support team itself.
Humanitarian personnel are often subject to cumulative stress from successive missions.

**Living conditions**

- Community life (close proximity to one another, confinement, team rules);
- Communal life with colleagues who may be victims of cumulative stress or character problems;
- Housing (precarious conditions, lack of comfort, cold, heat, noise, lack of hygiene possibilities, etc.);
- Food (lack of food, monotony of what is available to eat);
- Lack of leisure possibilities (not available or access forbidden for security reasons);
- Limited ability to move about (insecurity, curfew, etc.).

**Additional complications that may occur**

- Illness (benign and serious);
- Road accidents;
- Domestic accidents;
- Bad news about family members or friends who have remained in the home country;
- Sentimental difficulties.

In a conflict or danger zone, these events, on top of the stress, may trigger off a psychological traumatism.

**Feelings that may intrude on those providing help**

The following factors will have an impact on the feelings and emotions of those providing help:

- Fear and anguish in the face of the danger;
- A feeling of vulnerability in regard to one's own death;
- A feeling of impotence in the face of the immensity of the needs;
- A profound identification with the victims;
- Sadness, sorrow, depression, discouragement;
Bad mood, aggressiveness;
A feeling of guilt about being on the right side of the fence (for example, people working in refugee camps leave at nightfall and go back to their base where they have security and comfort);
Revulsion and anger in the face of injustice (for example; having to accept working for the victims although knowing who is humanly or politically responsible);
A feeling of ineffectiveness or uselessness about one's personal actions compared with finding a just and rapid solution to resolve the situation overall;
An intolerable feeling of indirect complicity when witnessing dreadful facts without being able to denounce them publically, or knowing that the really guilty will remain unpunished (for example: the hijacking of humanitarian aid for political ends, the rape of beneficiaries by those supposed to ensure their security);
Disgust at the manipulation of information or the search for a scoop by some of the media who play on the misery of those concerned;
A feeling of frustration faced with the fact that it is not possible to share the victims' fate right to the end.

Alarm signals among those providing help

Excessive fatigue (physical and mental);
Sleep problems (insomnia and nightmares) and loss of appetite;
A lack of pleasure in working, demotivation;
Non-productive and exhausting hyperactivity, inability to relax, inability to delegate;
Problems with concentration, confusion;
Becoming cynical (tasteless jokes, inappropriate humour, talk that jars on the nerves of others, sexism, racism) or aggressive (which may lead to abusive behaviour), judging others, having a negative or pessimistic attitude;
Intellectualising, rigidity of thought, resistance to change, excessive control;
Logorrhoea (a need to talk unceasingly);
A tendency towards the use of psychoactive substances (alcohol, psychotropic medicines, drugs);
A loss of objectivity with regard to professional achievements;
Failure to be efficient professionally;
Recurring psychosomatic complaints (especially gastro-intestinal problems, headaches, palpitations, vertigo, etc.) or excessive complaints about minor health problems;
Hyper-vigilance (constantly on the alert);
Increase in the emotional demands made on colleagues, family and friends (a need for somebody to listen, to be taken care of, etc.);

Withdrawal (avoiding relationships with family, and/or friends, and/or social, and/or professional), apathy;

Increased mood problems (significant mood swings, increased sensitivity, breaking out in tears, anger, etc.);

Anxiety and unjustified or disproportional fears with regard to the situation (particularly of becoming oneself the victim of the same type of traumatic event as that experienced by the beneficiaries);

A loss of energy so that it becomes impossible to accomplish professional tasks;

Difficulties in surmounting the minor problems of daily life;

Self-destructive behaviour, such as taking unconsidered risks (denial of one's own vulnerability) or having unprotected sex;

The presence of intrusive memories (flashbacks) of a critical incident;

Suicidal ideas.

People suffering great distress often do not recognise their state of physical exhaustion and deny their lack of efficiency. It is therefore generally necessary to take a decision for them and insist that they accept a period of forced rest.
List of the worksheets included in the Toolbox

1. Theoretical questions
- Worksheet 101: The traumatic event of natural disaster
- Worksheet 102: The traumatic event of armed conflict
- Worksheet 103: The female victims of sexual violence
- Worksheet 104: The male victims of sexual violence
- Worksheet 201: States of acute stress
- Worksheet 202: The post-traumatic stress disorder (PTSD)
- Worksheet 203: Mood disorders
- Worksheet 204: Anxiety disorders
- Worksheet 205: Problems linked with substance abuse
- Worksheet 206: Psychotic disorder
- Worksheet 207: Children's reactions to a traumatic event (by age)
- Worksheet 208: Child victims of sexual violence
- Worksheet 209: Stages of grieving
- Worksheet 210: Children's grief
- Worksheet 401: Vulnerable elderly people

2. Strategies
- Worksheet 700: Logical framework
- Worksheet 701: Selecting counsellors
- Worksheet 702: Training counsellors

3. Entering an emergency
   1. INFORMATION
      - Worksheet 801: Some hints for an information centre
      - Worksheet 802: Information in cartoon form: 'What is an earthquake?'
   2. ENSURING A FEELING OF SECURITY
      - Worksheet 810: Immediate psychological support
      - Worksheet 812: Basic attitude of those assisting with saving victims
      - Worksheet 812: How to behave with people in distress
      - Worksheet 814: Active listening
      - Worksheet 815: How to break the news of a death
      - Worksheet 820: Some ideas for the organisation of a camp

3. DATA-GATHERING
- Worksheet 831: General data
- Worksheet 832: How to gather useful data with regard to mental health
- Worksheet 833: Useful data with regard to mental health
Worksheet 834: Rapid assessment of mental health needs of refugees, displaced and other populations affected by conflicts and post-conflict situations
Worksheet 835: Impact of event scale

4. DEBRIEFING
Worksheet 841: The debriefing

4. The post-emergency phase

1. STRESS MANAGEMENT
Worksheet 901: Causes and symptoms of stress. Text to be distributed.
Worksheet 910: Sleeping disorders
Worksheet 920: The hyperventilation syndrome
Worksheet 921: Text for breathing exercises to stop hyperventilation
Worksheet 930: Bodily expressions
Worksheet 931: Physical training

2. TALKING GROUPS
Worksheet 940: 'Talking groups'

3. COUNSELLING
Worksheet 950: The different stages of counselling
Worksheet 951: Patients' files
Worksheet 952: Fortnightly synoptic tables
Worksheet 953: Fortnightly summary sheet
Worksheet 954: Summary sheet (Excel)
Worksheet 955: Home visits
Worksheet 956: Impact scale of the traumatic event
Worksheet 957: Helping the bereaved
Worksheet 958: Helping male victims of sexual violence
Worksheet 959: Helping female victims of sexual violence
Worksheet 960: Follow-up worksheet for female victims of sexual violence

4. REFERRALS
Worksheet 970: Referrals worksheet
Worksheet 971: When to refer someone to a psychologist

5. CHILDREN AND ADOLESCENTS
Worksheet 1001: Advising parents how to help their children
Worksheet 1010: Hints for helping depressed mothers
Worksheet 1020: Workshops for children aged from 0 to 2 years
Worksheet 1021: Workshops for children aged from 3 to 6 years
Worksheet 1022: Workshops for children aged 6 years and older
Worksheet 1023: Hints for leading a children's group
Worksheet 1024: 'Talking group' for children aged 8 years and older
Worksheet 1030: Hints for helping children to express their emotions
Worksheet 1040: Hints for identifying children experiencing problems
Worksheet 1041: Evaluating the impact of a traumatic event and its consequences for children
Worksheet 1042: Follow-up worksheet for child and adolescent victims of sexual violence
Worksheet 1043: Helping child victims of sexual violence

6. THE ELDERLY
Worksheet 1201: Helping the elderly

Appendices
Worksheet A: How to take care of yourself in an aid situation
Worksheet B: Checklist of ten points for evaluating your state of stress
Worksheet C: Prevention, preparation and follow-up for humanitarian personnel
Worksheet D: List of psychologists
Bibliography


Abdallah S., Burnham G., 'Public health guide for emergencies', The Johns Hopkins and Red Cross / Red Crescent. Learn Ware International Corporation, Baltimore, Maryland, USA.


American Red Cross (1999), 'Symposium report: Psychosocial effects of complex emergencies', Washington, D.C.


CICR (2002), 'Les femmes face à la guerre', Division de la doctrine et de la coopération au sein du Mouvement, Genève


Desai N., Gupta D., Joshi P.C., Lal M., Kumar A. (2001), 'Mental health service needs and service delivery models in the disaster (earthquake)-affected population in Gujarat: A pilot phase study', Delhi, Institute of Human Behaviour and Allied Sciences (IHBAS).


FHS (La Haute école pour les réfugiés) (1999), 'Cours psychosociaux à l’attention des familles de réfugiés souffrant de traumatismes' avec le soutien de la Commission Européenne, Copenhague.


OMS (1999), 'Introduction aux techniques de counselling dans la prise en charge des victimes de violence. Module B'.

Régie Régionale de la Santé et des Services sociaux (2003), 'Document de formation sur l'intervention psychosociale auprès des victimes d’agression sexuelle'.

Presoons et al. (2003), 'L’état de stress post-traumatique chez l’adulte', Neurone.


Santé et Bien-être Social Canada (1990), 'Services personnels. Planification psychosociale en cas de sinistres', Ministre des Approvisionnements et Services Canada.


Young B., Ford J., Rusek J., Friedman M., Gudman F. 'Disaster Mental Health Services. A guidebook for clinicians and administrators', Department of Veteran Affairs, The National Centre for Posttraumatic Stress Disorder, California (on-line)