*ABC of conflict and disaster***Psychological aspects of providing medical humanitarian aid**

Ian Palmer

All those involved in catastrophes will be changed by the experience. Such change, however small, is irreversible but generally positive. Only a minority of survivors or aid workers will develop a mental disorder such as post-traumatic stress disorder. Humanitarian deployments may be isolating, rife with personal threat (from climate, endemic diseases, violence), and expose individuals to human misery, as well as human resourcefulness in the face of tragedy.

You should deploy only if you are in good physical and mental health. Accept that everyone in your family will be changed by your deployment and that any problems you leave behind will be there on your return: sort them out before you go. Discuss potential outcomes with your family (such as death or being taken hostage) and make a will.

Proper planning and preparation prevent poor performance. Preparation requires information: get as much as you can. The best sources are people who have been to the disaster area before. Beware of media selectivity and bias, and protect family and friends from this after deployment through regular communication.

Expatriate work stressors

Remember you are a “guest” in the country and are there to help local people to help themselves, not to create dependency. Treat all with dignity, especially the dead, who may have died without it. Aim to foster cooperation and the restoration of motivation, self belief, and self sufficiency.

Humanitarian disasters are confusing, and teamwork is vital; leadership means leading by example, and praise and interest are key. Protocols, if understood and followed, are useful, but flexibility is crucial. Some colleagues may have personalities that make them difficult to get on with, or they may develop frank mental illness or drink or drug related problems.

Be aware of what internal pressures you create and can alter and accept those external pressures that you cannot change. Beware of malicious gossip; it is endemic in expatriate communities and corrosive to group functioning. The temptation to relieve stress through alcohol, drugs, and sex should be tempered with knowledge of their potential pitfalls.

It is natural to feel homesick and “down” at times, and support may be drawn from religious faith, belief in mission, communications with family and friends, home comforts, and letters and parcels.

Community responses to disaster

Immediate—Initially survivors are devastated and emotionally labile. Panic is uncommon unless escape is felt to be impossible, and then it is contagious. External help is required to clean up and rebuild. Somatic symptoms are common.

Short to medium term—Excessive dependency is common in the first 48 hours, after which there is a period of searching for meaning in what has happened. This may be followed by hostility: aid workers may become a focus of resentment, on whom feelings of frustration, betrayal, and anger can be projected. Group loyalties or contradictory roles can greatly affect individual and group behaviours. Survivors of massive

Children left homeless and traumatised by the 2004 tsunami, Nagapattinam, Tamil Nadu, India. Misery and grief are inevitable consequences of catastrophes, and no one who encounters them will remain unchanged

Vital pre-deployment questions for humanitarian workers:

- Why am I going?**
- Who am I going with?**
- Are my expectations realistic?**

Risk factors associated with popular ways to relieve stress**Alcohol**

- Aggression
- Risk taking
- Drunk driving (you, colleagues, and local drivers)
- Sexual (mis)adventures, with the attendant risks of venereal diseases
- If alcohol is used to deal with stress, insomnia will in time only confound the original problem

Drugs

- Effects may be unpredictable
- May precipitate acute psychotic mental illness
- Risk of HIV infection with injected drugs

Sexual liaisons

- Take contraceptives with you—and use them (that's the hard part)

Psychological reactions to disaster or catastrophe

- About 25% of people remain effective, with emotional continence and appropriate behaviours
- Some 50-75% are “normal” but bewildered, “numb,” withdrawn, and anxious
- About 15% are ineffective from the outset, with inappropriate “contagious” behaviours

disaster may develop a “concentration camp mentality,” in which they become selfish, compassionless, and focused on personal survival.

Long term—Normality returns gradually with reconstruction and rebuilding through acknowledgement, acceptance, and accommodation to change.

Psychological effects of conflict and disaster

Do not impose your own beliefs on others or try to understand how local populations view loss and illness. Distress and change are the inevitable results of exposure to unpleasant events; mental disorder is not.

Exposure to extreme stress does not seem to increase the incidence of psychoses, and even neurotic mental disorders are uncommon. Post-traumatic mental disorders include depression, anxiety, post-traumatic stress disorder, phobias, medically unexplained symptoms, substance misuse, and personality change.

Any psychological reaction or disorder is multifactorial in genesis and depends on a unique interaction between the individual, the event, the psychosocial environment, and the culture from which the individual comes and to which he or she returns.

Prevention and management

As prevention is better than cure, most early interventions should be social in nature—freedom from threat of death, and access to shelter, clean water, food, and sanitation.

Efforts should be directed at reuniting families and societies and returning them to normality—for example, schooling for children and the dignity of work for adults. Every effort should be made to address culturally relevant interventions, rituals, and spiritual needs. It may, for example, be of more psychological benefit to survivors of war crimes to see their tormentors brought to justice than to be offered psychological debriefing. Although specific psychiatric interventions have a role, care must be taken to avoid their misplaced use (“cultural imperialism”).

Without exposure to traumatic events, post-traumatic stress disorder cannot occur; it is therefore important to avoid potential hazards such as sites of atrocities. Protect the security and safety of those with whom you work by sticking to prescribed routes and ensuring you know, and make known, where you and others are going and when you are returning.

Time and social integrity are important in any healing process. Never start things that cannot be finished, especially in the area of psychosocial responses to catastrophe and disaster.

Specific psychiatric situations

Treating mental illness is seldom a priority in countries ravaged by disaster or war. There is no evidence that the incidence of psychotic illness increases after such events; indeed, mental illness may diminish during community upheaval, as people “come together” to help each other. That there is a psychological cost cannot be doubted, but it may be a Western conceit to medicalise such misery and distress.

Efforts can be made to restore mental hospitals, communities, or institutions, but they will rarely be seen as a priority. Psychotic patients have the same basic needs as everyone else—safety and shelter, clean water, and food. Drugs will be needed, and agencies such as *Pharmaciens Sans Frontières* can help.

Azeri adolescent's painting of an injured child

Former Bosnian Serb internal affairs minister and national police chief Mico Stanisic facing charges of crimes against humanity. Seeing the perpetrators brought to justice may be of more psychological benefit to survivors of war crimes than being offered counselling

The psychological cost of conflict and disaster is obvious, but it may be a Western conceit to medicalise such distress

Specific psychosocial issues

Interpersonal violence—Justice is a potent psychological intervention. As a humanitarian worker, you can help by collecting any evidence you can of acts against human rights, particularly rape and torture. In such cases certain psychological interventions may be useful but must be handled in a culturally sensitive way to avoid further “injury.” Never medicalise people; treat them with respect as survivors. Do not expect them to trust you, and never persuade them to tell you their story unless it (and you) are part of a therapeutic programme. Humanitarian workers may be taken hostage and abused; ensure that your aid agency tells you what support you may receive if this happens.

Disabled people—People disabled by catastrophe or war are in special need extending over the long term. Great effort, sensitivity, and tact are required to restore shattered bodies to the dignity of economic independence.

Soldiers—Both child soldiers and demobilised soldiers have specific needs that are best addressed socially, but the groups reintroducing them into peaceful life and work may need to provide psychological advice to help with rehabilitation.

Repatriation

Repatriation is about readjusting to your previous life and to the changes that have occurred in yourself and in your family. In general, the more problematic the deployment the more problematic the readjustment. Your expectations of reunion will not be met if they are unrealistic or if you have not prepared yourself realistically.

Problems on return?

Generally, traumatic events will upset you when you think about them or images intrude on your thoughts. This may lead to avoidance, which is potentially damaging. You may also become irritable and irascible, which will create interpersonal difficulties. It is important to find someone (safe for you) who can listen to you; in this way most problems resolve with the passage of time.

You should, however, seek further help if you feel that you want help, if someone you respect or care about suggests that you have “changed,” or if you have symptoms of a stress related problem that are severe or are not settling after 6–12 weeks and are interfering with your life. Suitable sources of help are:

- Those who shared the experience
- Family and friends
- Through your aid agency, which should have access to or be able to direct you to psychological support
- Through your family doctor
- Psychiatric and psychological professionals
- A traumatic stress service such as that run by University College Hospital, London, and Maudsley Hospital, London
- If you have been tortured, the Medical Council for the Victims of Torture.

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The ABC of conflict and disaster is edited by Anthony D Redmond, emeritus professor of emergency medicine, Keele University, North Staffordshire; Peter F Mahoney, honorary senior lecturer, Academic Department of Military Emergency Medicine, Royal Centre for Defence Medicine, Birmingham; James M Ryan, Leonard Cheshire professor, University College London, London, and international professor of surgery, Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD USA; and Cara Macnab, research fellow, Leonard Cheshire Centre of Conflict Recovery, University College London, London. The series will be published as a book in the autumn.

The photograph of Indian children left homeless by the 2004 tsunami was supplied by Chris Stowers/Panos Pictures. The photograph of Mico Stanisic was supplied by AP Photo/Fred Ernst.

Rwandan children's drawings of the impact of war on their family and of witnessed events

Preparation for repatriation

Review

- Review the deployment as a group
- How has the experience changed you?
- How will the experience benefit you?
- What you would do differently next time?
- What would you tell other people going to the same area? Write a report and keep a copy

Evaluate expectations

- Yours, your family's, and friends'
- What to do if you feel no one understands
- How will you deal with routine work?

Managing questions

- Routinely:
 - What will you say when people ask about your experiences?
 - What will you do when they stop asking?
 - What questions will you ask?
- After gruesome experiences:
 - What will you tell people without distressing them?

Symptoms of a stress related problem

- Intrusive thoughts, images, or smells triggered by people, places, media reports, etc
- Avoiding such “triggers”
- Avoiding friends and social situations—becoming socially withdrawn
- Relationship problems, especially if related to irritability and anger
- Disturbed sleep, poor concentration
- Becoming overanxious, depressed, or miserable
- Drinking too much, misusing drugs
- Acting “out of character” and impulsively

Further reading

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