Chapter 38

BEHAVIORAL HEALTH ISSUES IN HUMANITARIAN AND MILITARY RELIEF OPERATIONS: THE SPECIAL PROBLEM OF COMPLEX EMERGENCIES

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INTRODUCTION

The provision of timely, effective, and culturally competent disaster behavioral health services is critical in all phases of a disaster response. Historically, disaster management and humanitarian assistance planners have divided events into three general categories: (1) natural, (2) technological, (3) and complex. Natural disasters include common geological and meteorological events such as floods, cyclonic storms, earthquakes, volcanic eruptions, and tsunamis. For those directly affected, these events can be catastrophic, but they do not constitute meaningful political threats for the public at large. The same may be said for most technological emergencies, such as the Bhopal, India, chemical accident of 1984, or for catastrophic infrastructure failure, such as the Chernobyl nuclear reactor meltdown in the Soviet Union in 1986. These disasters are often the result of human error, but they do not generally represent acts of political intention or willful malice. Local teams of trained personnel typically provide the response to these events, with regional or national assets deployed as required. However, in very large or regional natural disasters, such as the December 26, 2004, Indian Ocean tsunami, or in complex emergencies involving politically mediated security and logistical problems, such as the conflicts in Somalia or the former Yugoslavia, the operating environment may require an integrated multinational civil-military response.[1]

A number of recent events have provided opportunities to examine the capacities and limitations of civil-military collaboration in disaster response in general,[2] and in the provision of behavioral health support in particular.[3] Because of the organizational and logistical burden of large-scale and complex emergencies, civilian and military behavioral health providers must have a sound working knowledge of the shared operating space and the players who help shape the context of services. This chapter will consider (*a*) the humanitarian space and its players, (*b*) benefits and challenges to effective civil-military collaboration, (*c*) special behavioral health considerations in complex environments, and (*d*) principles with demonstrated utility in helping affected populations return to predisaster functioning.

OPERATIONAL BEHAVIORAL HEALTH IN CONTEXT: THE HUMANITARIAN SPACE AND ITS PLAYERS

Knowledge of the organizational and logistical aspects of integrated disaster response is critical to the efficacy of behavioral health services. The working environment is often referred to as the "humanitarian space"; it has been described in functional terms as an environment with the independence, flexibility, and freedom of action necessary to gain access and provide assistance to beneficiaries in a humanitarian emergency. For many civilian operators, including international and nongovernment organizations (NGOs), humanitarian space is achieved through acceptance of and adherence to the humanitarian principles of impartiality, neutrality, and independence as modeled by the International Committee of the Red Cross (ICRC).[4] Specifically, this means that aid is given regardless of race, creed, or nationality; aid is not used to further a particular political or religious position; and humanitarian and relief agencies do not act as tools of a state or policy.

Because military organizations responding to disasters are by definition not impartial, neutral, or independent, concern has arisen over the use of the term "humanitarian" in reference to military support in some contexts. The United Nations (UN) Inter-Agency Standing Committee provides useful guidance on this issue in a reference paper, *Civil-Military Relationship in Complex Emergencies*.[5] In part, the committee recommends that military efforts should be termed "relief" instead of "humanitarian." The difference in terminology is not just academic: the security and logistical support provided by the military can be critical to the success of the overall humanitarian effort; however, civilian humanitarians express concern that the perception of their affiliation with the military could negatively affect their security and ability to access vulnerable groups.

Well-orchestrated civil-military responses can offer great benefits, but such efforts take careful planning, a clear understanding of roles of civilian and military personnel, and effective communication between the two groups. This coordination is especially important in behavioral health services because of the profound effect of sociocultural issues in the acceptability of care. A central theme of disaster behavioral healthcare is the need for cultural competence in the delivery of services. Especially in large-scale disasters, it is critical for providers to know the context of services: what other agencies and activities are involved, how the range of services is coordinated, and what personnel and programs are available.

The first task for military personnel is to understand the types of organizations and personnel who share the environment—the "players." Personnel arriving on site should expect to find the humanitarian operating space shared by a range of "actors" (the acceptable generic reference in much of the literature in applied social and behavior science in political environments, such as terrorism, area studies, and complex disas-

ters, especially when the mix includes a broad range of groups—in this case, active belligerents, military personnel, civilian agencies, and international organizations) presenting highly diverse organizational cultures and roles, as well as the affected population. In addition to various host nation assets, the key actors in a large-scale humanitarian response frequently include donor governments and agencies, UN operational agencies, NGOs, the International Red Cross and Red Crescent Movement, other international and regional organizations, and the media. Some of these organizations may provide acute behavioral health services, but the goal of many is the development of long-term, self-sustaining programs as an integrated part of capacity building and development. Successful behavioral health service is directly related to the physical, social, psychological, and spiritual support provided by these programs.

The International Community

Major donors in the international community include the European Community Humanitarian Office, Japanese International Cooperation Agency, Australian Council for International Aid, United Kingdom Department for International Development, US Agency for International Development, and Canadian International Development Agency. UN agencies, funds, and programs are also much in evidence. Although no agency has a primary behavioral health mandate, many UN activities make meaningful contributions to behavioral healthcare through pursuit of physical security, stability, sanitation, shelter, child development programs, and other essential support. Among these, the UN Development Program works in poverty reduction, development goals, democratic governance, crisis prevention, information and communication technology, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) response, and landmine action in 166 countries. The UN High Commissioner for Refugees (UNHCR) has a mandate under international law to protect and assist refugees as specified in the 1951 Refugee Convention.[6] Focused on provision of food, shelter, and other basic necessities, this support is especially important in environments where the affected groups may include refugees, internally displaced persons, or migrants, a situation that can bring additional distress even in stable environments. UNHCR has approximately 5,000 staff in 120 countries with a current caseload of over 20 million people worldwide.

The World Food Program, the largest provider of food aid in the UN system, responds to both emergency needs and long-term economic and social development goals. In 2004, the program fed 113 million people in 80 countries. Operating in over 140 countries, the UN Children's Fund prioritizes girls' education, early childhood development, immunization, protection from violence and exploitation, HIV/AIDS services, health and nutrition programs for children and pregnant women, and children's rights. In recent years the program has also worked for the demobilization and reintegration of former child combatants through community-based efforts.[7]

The UN established the World Health Organization (WHO) in 1948; its constitutional objective is "the attainment by all peoples of the highest possible level of health." In disasters, WHO provides medical assessments and supplies and trains healthcare workers as part of building capacity. WHO is staffed by some 3,500 health experts, other experts, and support staff on fixed-term appointments, working at the Geneva, Switzerland, headquarters; in six regional offices; and in countries around the world. WHO actively pursues relations with NGOs to promote its policies, strategies, and activities.

A common feature of complex humanitarian emergencies (CHEs) is psychic trauma caused by the failure to maintain basic human rights. UNHCR, the secretariat for all UN human rights bodies, ensures that human rights are "mainstreamed" into all other UN activities. In addition to national capacity building, UNHCR maintains a field presence of human rights monitors and observers.

International organizations established by treaties also work closely with the UN and other actors. The International Organization for Migration, established in 1951 to assist with the movement of displaced persons in Europe, is the leading intergovernmental organization in the field of migration and now operates worldwide with 120 member states and offices in over 100 countries. This organization works closely with governmental, intergovernmental, and nongovernmental partners in managing the movement of migrants, resettling refugees to third countries or returning them to places of origin, and countering trafficking of people. The International Red Cross and Red Crescent Movement is the world's largest humanitarian network, with a presence and activities in almost every country. The Movement has three distinct entities: (1) the Geneva-based ICRC directs and coordinates international relief efforts in situations of conflict and promotes and strengthens humanitarian law (Geneva Conventions) and universal humanitarian principles; (2) the International Federation of Red Cross and Red Crescent Societies acts as the official representative of the member national societies and directs and coordinates the international assistance efforts of the individual member societies; and (3) the individual

National Red Cross and Red Crescent Societies provide a range of auxiliary disaster, development, and capacity-building services to the national authorities in their own countries. Although not officially a part of the UN, the Movement has observer status at UN headquarters in New York City.

Nongovernmental Organizations

The term "NGO" defines a very diverse group with respect to size, style of management, and type of operations. The World Bank defines NGOs as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development."[8] Tens of thousands of NGOs exist; many consult to governments and the UN, and some have a meaningful influence in world affairs. According to Hall-Jones,[9] the NGO sector now represents the eighth largest economy in the world. NGOs are generally funded by grants or private donations, although some receive large donations from governments. The groups may be national (indigenous) or international and are typically staffed by skilled professionals such as physicians, nurses, logisticians, engineers, and lawyers. NGOs are sometimes classified by their orientation (religious or secular); mission types (operational or advocacy); specific interests (medical care, child protection, food distribution); or operating area (community based, national, or international). Their size varies from small community-based groups to very large international organizations with equally large budgets.

Many NGOs have been working in particular locations for many years and have vast knowledge of the areas and access to the local population. InterAction is the largest alliance of US-based international development and humanitarian NGOs, with more than 160 member organizations.[10] The largest of these, in terms of financial assets, is currently the Bill and Melinda Gates Foundation, with an endowment of $28.8 billion.[9]

Military Support to Other Players

In recent years the military forces of many nations have deployed in response to humanitarian crises. These missions involve various forms of logistical and security support to protect civilian aid workers and ensure that relief reaches the populations in need. Types of military support can be conceptualized as belonging to five general service clusters, all of which have security as a central theme[11]:

1. Direct assistance: the face-to-face distribution of goods and services (these services often embrace a meaningful security component).
2. Indirect assistance: activities such as transporting relief goods or relief personnel (at least one step removed from the population).
3. Infrastructure support: general services such as road repair, airspace management, or power generation that facilitate relief but are not necessarily visible to or solely for the benefit of the affected population.
4. Peacetime missions: responses to large-scale natural disasters (eg, the Indian Ocean tsunami).
5. Training and exercises conducted in a region with no hostile intent.

The UN's *Guidelines on the Use of Military and Civil Defence Assets in Disaster Relief*,[1] originally released in 1994 and revised in December 2005, is the principal document specifying the obligations and limits of military support in humanitarian relief. Because the original document was developed at an international conference in Oslo, Norway, it is generally referred to as the "Oslo Guidelines." Under these guidelines, UN military and civil defense assets in humanitarian space are under UN control.

Other peace operations or support missions include a range of tasks undertaken by military forces that may not be under UN command, including peacekeeping, peace enforcement, peace building, and other operations with forces deployed under parameters that dictate a minimum necessary use of force. In some circumstances, the humanitarian mission may exist alongside traditional combat missions, including behavioral health services for detainees, as in Iraq and Afghanistan.

PRINCIPLES AND PRACTICE OF CIVIL-MILITARY COLLABORATION IN BEHAVIORAL HEALTH

The practice of civilian aid workers sharing the humanitarian space with the military is not new. Much of the recent interest in civil-military collaboration, however, may be traced to the success of Operation Provide Comfort in 1991, when NGOs and the military, working toward a common goal, achieved unprecedented success in providing humanitarian relief for the Kurds of northern Iraq.[12] Since that time, many senior military training institutions have developed curricula dedicated to civil-military issues. Civilian and military

organizations differ greatly in their respective cultures, but each group possesses knowledge, skills, and assets that in collaboration create a synergy neither can achieve independently.

The coordination of these skills and assets, however, can be a critical challenge. Bessler and Seki[13] have provided a useful overview of common problems in the development of civil-military collaboration in the humanitarian space They point out, for example, that civilian humanitarians may express concern over the militarization of aid, especially in the area of military civil affairs projects designed to "win the hearts and minds" of the populace. These efforts are often a key part of the reconstruction process and have great pragmatic value; however, they can also create the perception that humanitarians might be used as de facto force multipliers or field operators of the local government. Humanitarians note that the perception of a military affiliation may compromise their principles of impartiality and neutrality, with a negative effect on the security of their staff or their ability to access affected populations. Given such problems, military and civilian workers must have a clear understanding of each other's needs to create a pragmatic and principled response.

Security Needs and Information Sharing

McHale[11] offers useful general guidance on security and informational requirements of civilian and military actors in the humanitarian space. Although specific needs of humanitarian actors vary widely, civilian humanitarians commonly seek military support for the following:

- security in the area to allow humanitarians to conduct operations, although usually not to the extent of one-on-one protection of their staff;
- reaction forces to assist personnel in danger, possibly requiring one-on-one security and evacuation of humanitarian staff;
- access to airfields, ports, and facilities if these are not readily open for humanitarian use;
- communication technology;
- logistical transport of materials and possibly personnel;
- emergency medical support and possible medical evacuation of personnel; and
- emergency infrastructure repairs.

McHale advises military operators in the humanitarian space to avoid classifying information unless necessary for security of operations or personnel. The military can often share with NGOs the following information:

- details on the security situation to inform humanitarian risk assessment, including areas of ongoing military action, banditry, or general instability;
- status of air and sea points of debarkation and lines of communication;
- checkpoint locations and pass-through procedures, which greatly reduces the chances of accidental injuries to humanitarian staff;
- location of unexploded ordnance, mines, and mine action activities;
- information on population movements, conditions, and activities;
- types of humanitarian (relief or support) projects planned by military; and
- poststrike information, including location of persons in need and unexploded ordnance.

Civilian humanitarian organizations are often hesitant to share information with the military, concerned over the perception of alignment with military intelligence. However, military personnel have suggested that security and efficacy is improved for both partners when NGOs offer the following information:

- location of humanitarian staff and operations, which lessens the chance of accidentally targeting areas with ongoing humanitarian operations or humanitarian staff;
- locations for possible evacuation of humanitarian staff if necessary; and
- a complete list of humanitarian projects, to avoid competition and duplication.

Practical Considerations

Because effective behavioral health services are an integral part of the overall disaster response, providers must be familiar with the coordination mechanisms and position themselves to be an ongoing and integrated part of the response. The most common administrative mechanism for coordination is the civil-military operations center (CMOC). The US Department of Defense defines a CMOC as

> an ad hoc organization, normally established by the geographic combatant commander or subordinate joint force commander, to assist in the coordination of activities of engaged military forces, and other United States Government agencies, nongovernmental organizations, private voluntary organizations, and regional and international organizations.

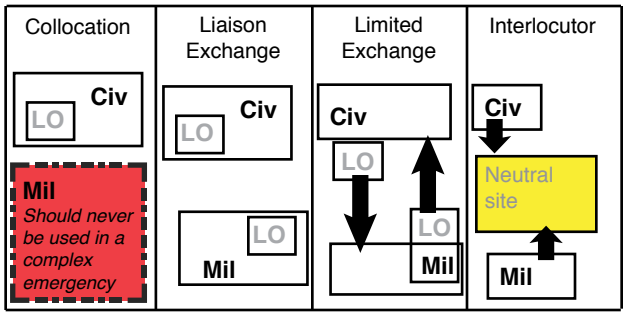

Figure 38-1. Civil-military coordination: four approaches to liaison arrangements. **Collocation:** humanitarian agencies and military units operate from within the same compound. The perception that civilian actors may be affiliated with the military can have negative security implications for the civilian humanitarian agency staff. For this reason, collocation is rarely used and should never be used in a complex emergency. **Liaison exchange:** liaison officers are assigned to and work in the offices of the other unit or agency. **Limited exchange:** liaison officers maintain an office in their own unit or agency but travel to the other actor's office to conduct business. **Interlocutor:** liaison officers maintain an office in their own unit or agency and travel to a neutral site to conduct business, such as a United Nations or local governmental office. This is often the most secure option for civilian humanitarian agency staff operating in an insecure environment.
Civ: civilian LO: liaison office Mil: military

There is no established structure, and its size and composition are situation dependent.[14]

The Center for Excellence in Disaster Management and Humanitarian Assistance agrees that the physical structure of the CMOC and the liaison arrangement best suited for the mission are determined on a case-by-case basis, outlining four principal approaches to liaison placement (Figure 38-1).[11] Civil and military leaders benefit from a careful consideration of perceptions, accountability, the need for transparency, and how these issues may affect the security of civilian humanitarian staff and beneficiaries. The center also offers a number of operating principles obtained from successful CMOC endeavors (Exhibit 38-1).[11]

EXHIBIT 38-1

OPERATING PRINCIPLES LEARNED FROM SUCCESSFUL CIVIL-MILITARY OPERATIONS CENTERS

- Remember that coordination is personality and perception driven.
- Have respect for other actors and their operations; your personality and how you are perceived will dramatically affect whether coordination occurs.
- Have meetings chaired or co-chaired by civilian actors.
- Understand the roles, responsibilities, and constraints of the other humanitarian actors.
- Understand that nongovernmental organizations (NGOs) vary in their degree of comfort in working with the military; some NGOs will never be comfortable working with the military.
- When possible, work to establish areas of common responsibility.
- Establish open communications and sharing of information.
- Avoid classifying information unless necessary.
- Respond in a timely manner to requests for information or assistance.
- Understand that civilian actors may be hesitant to share information with you, especially in an open forum.
- Ensure that communications equipment (radio, mobile phones, e-mail) is compatible.
- Offer assistance when possible; understand that offers may be rejected.
- Know the market prices for local goods and services.
- Do not drive up prices by overbidding.
- Work with civilian actors to build consensus in operations.
- The collaborative process may benefit from a third party (eg, the US Office for the Coordination of Humanitarian Affairs) through which to share information.

Adapted from: McHale S. The International humanitarian community: overview and issues in civil-military coordination. Paper presented at: Combined Humanitarian Assistance Response Training; June 29, 2006; Marine Corps Bases Japan.

SPECIAL BEHAVIORAL HEALTH CONSIDERATIONS IN COMPLEX HUMANITARIAN ENVIRONMENTS

Equipped with an understanding of the players and a strategy for coordinating services, behavioral health providers can next consider important contextual issues that affect service delivery. Among the more important of these issues is how the psychic environment of CHEs differs from that of natural or technological emergencies. Although a CHE has several definitions, the UN Inter-Agency Standing Committee characterizes such a

situation as

> a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program.[15]

Many recent CHEs originated in the 1940s and 1950s, when the historical colonial powers began divesting themselves of overseas outposts. This trend accelerated at end of the Cold War, as the world experienced a dramatic rise in struggles for autonomy among newly liberated groups. These struggles often emerged along ethnic or religious lines, accompanied by a volatile mix of social, political, economic, and cultural variables that fueled internal conflicts. Humanitarian disasters that have emerged from these conflicts approximate civil wars and are labeled CHEs. CHEs are typically characterized by politically mediated excess mortality and morbidity; loss of civil police and judicial processes; massive displacement of people within the country (internally displaced persons) or across borders (refugees); destruction of critical infrastructure; and widespread damage to civil society and economies. The UN Office for Coordination of Humanitarian Affairs adds that

> [r]esponders typically face the need for a large-scale, multi-faceted humanitarian response in which delivery of assistance is hindered or prevented by political/military constraints, including significant security risks for humanitarian aid workers.[16]

Frequently, CHEs emerge from a weak or failed political infrastructure confronted by catastrophic economic distress or a natural disaster. The disaggregation of the former Yugoslavia and the Rwandan genocide of 1994 are illustrative of CHEs at the state level. The specific targeting of civilians to terrorize, displace, and create psychological distress is often a military goal. Garfield and Neugut note that World War I produced civilian casualty rates of approximately 14%; in World War II the rate had risen to 67%. By the 1990s the rate of casualties among noncombatants reached 90%.[17]

Factors Influencing Survivor Psychic Distress

Behavioral health providers should understand the ways in which the anarchic aspects of CHEs create psychic environments that differ greatly from those typically associated with natural or technological disasters. Any individual's subjective experience of psychic distress is a product of the complex interactions between the personal characteristics of the survivor and characteristics of the traumatizing event. Survivor characteristics may include a history of previous trauma, personality organization, physical health, availability of psychosocial support, and material resources.

The two principal characteristics of the traumatizing event itself are the gradient of exposure and the magnitude of personal loss and impact. The gradient of exposure defines how much trauma survivors were exposed to: how "close" it was and how many times they were exposed. The magnitude of personal loss and impact concerns the comprehensiveness of the event: Did the survivor hear about it, read about it, see it on electronic media, or witness it personally? Did it happen to someone they know? A loved one? Did they experience it personally? How many times? In general, the more directly and persistently an individual is affected, the higher the risk of meaningful behavioral health problems. In complex emergencies where losses result from intentional, human-mediated violence, the emotional proximity, comprehensiveness, and persistence of the trauma can be devastating to survivors and their greater communities.

Psychic Ground Effects

Measured by the gradient of effect and magnitude of personal loss, CHEs expose survivors to physical, emotional, and environmental sources of psychic trauma that are persistent and highly interrelated. Specific sources of distress may include persecution, oppression, marginalization, detention, incarceration, torture, witnessing atrocities, and separation from loved ones. In natural or technological disasters, emergency relief personnel and assets are limited largely by logistical constraints. In addition, the immediate cause of the threat is usually time-limited (eg, cyclonic storm, earthquake), so survivors can begin the response and recovery process in a fairly short time. CHEs, however, often involve an ongoing threat of armed aggression, including hostile resistance to both military humanitarian support and civilian aid workers.

Even following the official cessation of hostilities, threats in a CHE may extend into the "postconflict" environment for both survivors and responders. In the aftermath of a complex emergency, survivors may know not only victims, but also perpetrators. After the Rwandan genocide of 1994, aid workers frequently encountered Tutsi survivors who returned to their home areas only to encounter the very people who had killed members of their families.[18] Retributive

violence can also persist long after the official "peace" has been declared.

In addition to ongoing physical and psychic threats to their safety and autonomy, survivors in CHEs often experience meaningful material deprivation, including loss of home, personal possessions, important records, economic and material resources, employment, social position, or authority. These problems are exacerbated by the loss of customary social, psychological, spiritual, and cultural institutions that could otherwise provide support.

Among the most distressing of behavioral health issues in CHEs is gender-based violence. Especially in CHEs involving ethnic conflict, sexual violence against women and girls is often a planned and systematic military weapon designed to humiliate, induce terror, and destabilize communities. Although reliable statistics are difficult to obtain, a large body of information obtained from NGO and international organization investigations documents the problem. Concerning the protracted conflict in Sudan, for example, the Watchlist Project notes that gender-related violence

> connected to conflict, including sexual slavery of women and children, rape by military forces, forced prostitution and forced marriage, is known to be a widespread problem in Sudan. No statistics are available. Children, especially girls from these areas, are victims of sexual exploitation, sexual slavery, forced marriage, rape and other forms of violence after abduction by . . . militias and opposition groups.[19]

Similarly, Roque reported,

> In Bosnia, for example, public rape of women and girls preceded the flight or expulsion of entire Muslim populations from their villages, and strategies of ethnic cleansing included forced impregnation In Rwanda, Hutu extremists encouraged mass rape and sexual mutilation of Tutsi women as an expression of contempt, which sometimes included intentional HIV transmission.[20]

In addition to the trauma of the violence itself, survivors of gender-based violence may also experience social rejection from their own group. In many traditional collectivist societies, family, tribe, or other group affiliation largely determines the sense of self and social role. Forcing women to bear the children of their enemies disrupts the social fabric of community organization. Gourevitch has described a Tutsi woman who had survived the Hutu massacre in Rwanda commenting on her relationship with the restored government:

> And they would say, "If they killed everyone and you survived, maybe you collaborated." To a woman who was raped 20 times a day, day after day, and now has a baby from that, they would say this.[18]

This circumstance might be thought of as an interethnic, multigenerational psychic insult A successful clinical response to such a problem would require an exceptionally well-resourced, culturally embedded, long-term commitment. UN-sponsored programs for the reintegration of former child combatants may provide a heuristic model for program development.

Environmental Threats

Environmental threats, both direct and indirect, negatively affect survivors' subjective sense of safety and security and are a major source of psychic distress. In addition to active armed conflict, direct threats may be represented by the loss of secure shelter or the presence of landmines and unexploded ordnance. Indirect threats often involve destroyed or degraded infrastructure, including utility and public health assets associated with transportation, power generation, water, sanitation, and basic health services. For many, living circumstances are austere and overcrowded. These problems often have the effect of forcing traumatized people to live in close proximity to others who are equally distressed, and with whom they may have to compete for scarce resources. The effects of this situation are especially deleterious for the most vulnerable people. Groups at high risk include children (especially unaccompanied minors), pregnant and lactating women, the elderly and infirm, the chronically and persistently mentally ill, displaced persons, and refugees.

During complex emergencies, the definition of "high-risk group" may evolve through the life span of the emergency. In general, anyone who is physically or psychologically vulnerable may be thought of as a high-risk individual, but because of the political nature of CHEs, high-risk groups may be determined by social, religious, educational, or political affiliation. For example, during many long-term CHEs such as the civil war in Mozambique (1975–1994), male adolescents became vulnerable to kidnapping and induction into irregular militias or paramilitary groups because of the depletion of older male soldiers lost in the fighting. Social and medical risks are often reflected in a high incidence of drug and alcohol abuse, domestic violence, and related pathology. These aspects of the psychic environment of CHEs have meaningful implications for behavioral health providers attending to the

needs of both civilian survivors and military personnel operating in theater. Little doubt exists that the severity and persistence of human-mediated trauma in complex emergencies carries a much higher risk of long-term psychic distress than the trauma of natural or technological disasters.[21]

The most common behavioral health diagnoses among survivors of CHEs include anxiety disorders, especially acute or posttraumatic stress disorder, and mood disorders, especially depression. These conditions are often accompanied by a range of somatic complaints including body pains, sleep disturbances, and restlessness. Neglect of one's own health is common, as are substance use disorders. Apart from diagnosable disorders, however, the single greatest source of psychic distress is typically the problem of loss and grief. Loss and grief are axiomatic to human experience, but in CHEs the sheer magnitude of loss coupled with the absence of usual support structures can present a special clinical challenge for practitioners. The successful resolution of grief is an essential part of the recovery process; unresolved grief can be a rate-limiting factor in the successful return to predisaster functioning for both individuals and communities at large.

Although the response to acute grief is unique to each person, a number of descriptive models of bereavement and mourning have been advanced to describe common themes.[22–26] For a vast majority of survivors, the early grieving process includes preoccupation with persons or things lost and feelings of profound sadness, loneliness, fear, powerlessness, anger, anxiety, and despair. A central component of grief is the need to engage the mourning process to achieve appropriate levels of relief, resolution, reintegration, and return to functioning. In mourning, the reality of the pain is consciously identified and openly expressed with some degree of support seeking, psychological unburdening, and reestablishment of equilibrium. In unmourned loss, however, the reality of the pain is denied or suppressed, and the pain tends to remain fresh. The bereaved have a critical need for timely support to properly mourn their losses. Not grief itself, but grief that is unmourned, is associated with the development of more serious psychological problems; these may include pathological grief responses, depression, and posttraumatic stress disorder. These serious psychological problems are especially significant in complex emergencies, where the scale of destruction and social disorder creates cumulative risks at the same time that it precludes the ability of survivors to engage the normal mourning process in a timely way.

Despite the intensity of their experiences, some of the bereaved may initially fail to seek help because they are overwhelmed or immobilized by the shock and magnitude of their losses. Other survivors may actually decline help in an effort to preserve their sense of autonomy, competence, or dignity. Because social customs, religious practices, and traditional rituals exert great influence on the mourning process, behavioral health support should be integrated into other support and recovery activities provided by local providers and organizations. If possible, service providers should seek collaborative relationships with local traditional healers.

PRINCIPLES OF BEHAVIORAL HEALTHCARE IN HUMANITARIAN ENVIRONMENTS

Because of cultural and logistical problems, many traditional Western behavioral health interventions may be of limited use in disasters requiring a multinational response, especially complex emergencies. The most effective behavioral healthcare strategies pursue integration of sociocultural, medical, and psychological assets, ideally involving collaboration among relevant organizations. Practitioners are often less invested in direct clinical care for individuals and small groups and more focused on supportive and facilitative activities.

The WHO Department of Mental Health and Substance Dependence offers some general behavioral health service principles that have demonstrated utility across a range of disasters and cultures.[27] If circumstances permit, predisaster preparation should include a plan that identifies specific tasks, responsible personnel, and detailed communication and coordination strategies for key actors and agencies. If the key actors include international organizations, the leadership should be reminded that, to the degree possible, staff (including managers) should be hired from the local community. This practice increases the cultural competence of care and sets the stage for the development of long-term, self-sustaining programs.

Acute Phase

In the acute phase of a complex emergency, the crude mortality rate generally rises after loss of basic needs, including security, food, water and sanitation, and access to primary and public health services. Disaster behavioral health workers note that the reestablishment of these basic services is also essential in helping survivors recapture a sense of autonomy and efficacy in their environment. The process is enhanced by dissemination of information about relief efforts, including location of aid organizations and, when

possible, information concerning the location of relatives. For survivors with behavioral disorders, whether disaster-induced or not, basic behavioral healthcare is best provided through general health services or through community-based primary healthcare resources within the health sector. In addition, providers should ensure the availability of essential medications for persons with acute psychiatric emergencies.

During complex emergencies, when the acute phase may be protracted, many survivors respond well to the principles of "psychological first aid."[28] Credentialed providers can also use psychological first aid materials to provide on-the-job training and supervision in core psychological care skills for existing healthcare providers, social service workers, and community leaders. This training expands the cadre of service providers available to the community while facilitating the integration of behavioral health into primary healthcare for the longer term. Also useful is the creation of community-based support and self-help groups to provide emotional support and enhance coping strategies, especially in grief management. Other helpful efforts, when possible, include encouraging the reestablishment of normal religious and cultural activities, specifically including orphans, those who have lost partners, and those without families.

One of the most practical behavioral health priorities is reopening schools. Schools normalize life for children and provide opportunities for them to interact with others in a familiar environment. Children in school are also much less likely to become involved in criminal or other high-risk behavior, and less likely to become victims of child exploitation, a tragically common occurrence following large-scale disasters. With children in a secure environment, other family members are freed to attend to pressing needs. Schools are also an accessible, low-visibility platform for disseminating behavioral health and social services information in an environment that is culturally confluent and preserves self-esteem. Uncomplicated, empathic information should focus on normal reactions, give practical advice, and provide specific information about availability and location of behavioral health and social service resources. These self-empowerment techniques provide immediate practical relief as they establish templates for self-sustaining, locally managed programs that can eventually serve the medium- and long-term needs of the community.

Reconsolidation Phase

In the reconsolidation phase, survivors often face a lengthy period of adjustment to the losses created by the disaster. Especially in response to very large-scale events, the enormity of the losses often predicts a rise in the most serious behavioral health problems, including posttraumatic stress disorder, depression, and suicidal thoughts. To meet the long-term needs of survivors, behavioral health services must be organized, sustained, and integrated into the local community.

The US Department of Veterans Affairs National Center for Posttraumatic Stress Disorder[29] recommends that following disasters, long-term tasks for behavioral health providers should include public education, screening, and where indicated, referral and treatment. Educational activities include programs on enhancing self-care and coping techniques, and providing information about social, financial, legal, and medical services. These activities help survivors normalize their reactions to trauma and develop healthy forms of coping. Screening seeks to identify those at increased risk for negative psychological outcomes. Survivors with a prior history of psychiatric illness, psychological trauma, or substance use disorders are particularly vulnerable, as are members of historically marginalized or disenfranchised groups. Survivors typically have a brief interview with a behavioral health provider and complete a risk-assessment questionnaire. Where appropriate, the screening process may rely on informal sources, including aid workers, friends, or family members. Based on screening assessments, survivors can be referred to counseling for specific problems, such as alcohol abuse or complicated bereavement, or to more medically or psychiatrically based interventions.

A principal behavioral health challenge of the reconsolidation phase is the establishment or reinvigoration of sustainable economic support programs to respond to the long-term consequences of the disaster's impact. Especially for survivors whose predisaster livelihoods depended on subsistence work, the ability to generate income is a critical link to emotional recovery. In disasters involving a multinational response, the success of these programs requires a high degree of collaboration among public and private programs from both the host nation and donor countries. Because of the sensitivities that invariably accompany humanitarian aid, the host government must be able to exercise maximum administrative influence over the community's return to predisaster functioning. Andrew Natsios, former director of the US Agency for International Development, describes the concepts of local ownership, capacity building, and sustainability as the "iron triad" of all successful reconstruction and development projects, an observation that generalizes well to behavioral healthcare.[30]

SUMMARY

Established principles and evolving research in the reconstruction and development fields inform the civilian and military humanitarian response communities, including behavioral health providers. In the humanitarian space, it is critical for behavioral health providers to know the key players, their respective roles, typical tasks, and relationships to each other. In part, this knowledge requires an understanding of the host culture, the challenges and opportunities of civil-military collaboration, and the best mechanisms to share resources and expertise among contributing groups. These knowledge sets permit practitioners to function as behavioral health force multipliers through their identification and support of community-based psychosocial and educational programs, the development of information networks, and collaboration with traditional healers and other local assets. The most effective practitioners also understand how the psychological ground effects in complex emergencies differ from those in natural and technological disasters, and how those differences affect the potential for psychological trauma and disability, especially in response to grief.

The greatest impetus and funding for behavioral health services typically occurs during the emergency phase of the response. However, evidence shows that the need for behavioral health services actually goes up over time, so that the most pressing needs often surface after the assets available in the acute period have diminished. The best strategy for responding to this problem is to ensure that local planners and other leadership are aware of the circumstance and that providers invest maximum effort in the establishment of culturally competent, indigenously managed programs. Behavioral health providers should initiate training and supervision of local personnel early in the response to ensure long-term behavioral health support.

Successful behavioral health service in the humanitarian space demands a high level of clinical expertise in an environment fraught with meaningful challenges. To meet these challenges, providers must develop skills in fields ranging from cultural anthropology to diplomacy, logistics, economics, and organizational behavior. The successful integration of these skills is rewarded with the development of timely, efficacious, and self-sustaining behavioral health services to help those in need.

REFERENCES

1. United Nations Office for the Coordination of Humanitarian Affairs. *Guidelines on Military and Civil Defence Assets in Disaster Relief—"Oslo Guidelines."* Rev 1. Geneva, Switzerland: UN; 2006.

2. March A. The Australian government's response to the Indian Ocean Tsunami. *Liaison*. 2006;3:50–54.

3. Perez JT, Coady J, De Jesus EL, McGuinness KM, Bondan S. Operation Unified Assistance: population-based programs of the US Public Health Service and international team. *Mil Med.* 2006;171:53–58.

4. International Committee of the Red Cross. *Proclamation of the Fundamental Principles of the Red Cross and Red Crescent*. ICRC Web site. Available at: http://www.icrc.org/web/eng/siteeng0.nsf/html/p0513. Accessed December 15, 2009.

5. United Nations Inter-Agency Standing Committee Working Group. *Civil-Military Relationship in Complex Emergencies*. Geneva, Switzerland: UN; 2004. Available at: http://ochaonline.un.org/mcdu/guidelines. Accessed December 15, 2009.

6. United Nations. Convention relating to the Status of Refugees; July 28, 1951. UN Office of the High Commissioner for Human Rights Web site. Available at: http://www2.ohchr.org/english/law/refugees.htm. December 15, 2009.

7. Ditzler T, Hubner M, Batzer W. Caring for former child combatants: evidence-based practices for reintegration. *Aust J Hum Security*. 2005;1:15–12

8. The World Bank. *Involving NGOs in Bank-Supported Activities*. Washington, DC: World Bank, USA; 1989. Operational Directive 14.70.

9. Hall-Jones P. The rise and rise of NGOs. Global Policy Forum Web site. May 2006. Available at: http://www.globalpolicy.org/component/content/article/176-general/31937.html. Accessed December 15, 2009.

10. InterAction: American Council on Voluntary International Action Web site. Available at: http://us.oneworld.net/member/interaction-american-council-voluntary-international-action. December 15, 2009.

11. McHale S. The International humanitarian community: overview and issues in civil-military coordination. Paper presented at: Combined Humanitarian Assistance Response Training; June 29, 2006. Marine Corps Bases Japan.

12. Successful aspects of the NGO-military interface. In: Davidson L, Daly-Hayes M, Landon J. *Humanitarian and Peace Operations: NGOs and the Military in the Interagency Process*. Washington, DC: National Defense University; 1996. Chapter 3. Available at: http://www.dodccrp.org/files/Davidson_Humanitarian.pdf. Accessed December 15, 2009.

13. Bessler M, Seki K. Civil-military relations in armed conflicts: a humanitarian perspective. *Liaison*. 2006;3:4–10.

14. US military glossary. About.com: US military Web site. Available at: http://usmilitary.about.com/od/theorderlyroom/l/blglossasry.htm. Accessed December 15, 2009.

15. United Nations Inter-Agency Standing Committee Web site. Available at: http://www.humanitarianinfo.org/iasc/content/default.asp. Accessed December 15, 2009.

16. US Office for the Coordination of Humanitarian Affairs. *OCHA Orientation Handbook of Complex Emergencies*. New York, NY: UN; 1999. Available at: http://www.reliefweb.int/library/documents/ocha__orientation__handbook_on__.htm. Accessed December 15, 2009.

17. Garfield RM, Neugut AI. The human consequences of war. In: Levy BS, Sidel VW. *War and Public Health*. New York, NY: Oxford University Press; 2000: 27–38.

18. Gourevitch P. *We Wish to Inform You That Tomorrow We Will Be Killed With Our Families*. New York, NY: Picador USA; 1998: 304–308.

19. Watchlist Project. *Watch List on Children and Armed Conflict*. New York, NY: Women's Commission for Refugee Women and Children; 2003. Available at: http://www.womenscommission.org/pdf/wl_sd.pdf. Accessed December 15, 2009.

20. Roque H. Addressing gender-based violence: if not now, when? *The United Nations Chronicle* [serial online]. 2002;39(3). Available at: http://www.un.org/Pubs/chronicle/2002/issue3/0302p77_gender_based_violence.html. Accessed December 15, 2009.

21. Ditzler TF. *Psychic Trauma in Complex Emergencies: Sources and Interventions. Health Emergencies in Large Populations 2005: A Training Course for the Management of Health Intervention in Armed Conflict* [CD-ROM]. Honolulu, Hawaii: DoD Center for Excellence in Disaster Management and Humanitarian Assistance and International Committee of the Red Cross; 2005.

22. Lindemann E. Symptomatology and management of acute grief. *Am J Psychiatry*. 1994;151(6 suppl):155–160.

23. Engel GL. Grief and grieving. *Am J Nurs*. 1964;64:93–98.

24. Kübler-Ross E. *On Death and Dying*. New York, NY: Macmillan; 1969.

25. Bowlby J. *Attachment and Loss*. Vols 1–3. New York, NY: Basic Books; 1979.

26. Westphal R. Dynamic grief model. Paper presented at: Shea-Arentzen Nursing Symposium; "Navigating New Frontiers of Nursing Practice: The Challenges of Health Care Reform," La Jolla, Calif. March 20–24, 1995; La Jolla, Calif.

27. World Health Organization, Department of Behavioral Health and Substance Dependence. *Behavioral Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*. Geneva, Switzerland: WHO; 2003. Available at: www.who.int/whr/en. Accessed December 15,2009.

28. National Child Traumatic Stress Network, Department of Veterans Affairs National Center for Posttraumatic Stress Disorder. *Psychological First Aid: Field Operations Guide*. 2nd ed. Washington, DC: DVA; 2006. Available at: http://www.ncptsd.va.gov/. Accessed December 15, 2009.

29. Department of Veterans Affairs National Center for Posttraumatic Stress Disorder. Secondary behavioral health treatment following disasters. National Center for PTSD fact sheet. Available at: http://www.ncptsd.va.gov/. Accessed December 15, 2009.

30. Natsios AS. The nine principles of reconstruction and development. *Parameters*. 2005;Autumn:4–20.