DISPLACED CHILDREN AND ORPHANS FUND
PSYCHOSOCIAL PROGRAMMING – GUIDING PRINCIPLES[1]

Natural disasters and complex emergencies can have a variety of psychosocial[2] and mental health consequences for survivors. Children in the midst or aftermath of such events are living in environments that may be characterized by displacement, massive destruction and threat to life; prolonged social and financial disruption and resource loss; separation from families or caregivers; and exploitation and abuse by others. These experiences may increase the vulnerability of children to negative outcomes. Consequently the coping resources of individuals, families and communities may be taxed and require formal interventions to mitigate the negative consequences.

Guiding Principles

The following principles will guide DCOF decisions about psychosocial programming for children, their families and communities.

- Expect normal recovery. Distress, grief, physical and emotional arousal, and physical ailments are examples of common reactions to traumatic events and critical incidents. These are appropriate reactions to extreme events and dissipate over time in most people whose survival is assured and there are opportunities to rebuild the social and economic dimensions of the lives.
- Meet basic needs. Psychosocial well-being and the mitigation of distress is dependent on some degree of fulfillment of biological and material needs, such as food, water, shelter, and safety.
- Restore and foster functioning. The overarching goal of interventions should be to foster and/or restore the functioning of children so that they reach appropriate growth and developmental milestones and resume their roles within the family and community.

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[1] These Guiding Principles are informed by the World Health Organization "Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors" (WHO/MSD/MER/03.01) found at: http://w3.whosea.org/LinkFiles/List_of_Guidelines_for_Health_Emergency_Mental_Emergencies.pdf and the Interagency Working Group "Psychosocial Care and Protection of Tsunami Affected Children: Guiding Principles." The IWG is composed of the International Rescue Committee (IRC), Save the Children UK (SCUK), the United Nations Children's Fund (UNICEF) and the United Nations High Commissioner for Refugees (UNHCR).

[2] The term "psychosocial" reflects an understanding that people have psychological and social responses to events. It acknowledges that the environmental, familial, community and cultural context are necessary to understand the consequences of events and interventions that may be useful. The term psychosocial is commonly used in disaster mental health because it addresses active determinant health factors such as agency, ability and self-determination and not merely the absence of disease and infirmity.

- Honor the culture. Many dimensions of psychosocial well-being are informed by culture and most communities have existing ways to deal with loss, promote solidarity, create purpose and meaning out of events, and promote healing. Our programs should be culturally grounded.
- Focus on wellness, local capacities, strengths, and resilience. Support to children after disasters or in the midst of conflict cannot be adequately conceptualized through an emphasis on trauma or mental illness, which are considered extreme forms of impairment. Effective psychosocial assistance often occurs not through the provision of clinical therapy by outsiders but via support from others in the community. We should identify how the capacity of communities and social networks can provide psychosocial support. In particular, we should analyze how families, peers, traditional helpers, schools, and other community mechanisms can be supported to enhance coping and recovery.
- Promote community solidarity and efficacy. Connection with others and a belief in the ability and power of a community to effect change are important to psychosocial recovery after traumatic events.
- Sequence interventions. Psychosocial and public mental health interventions should be matched to the stages of emergency relief and rehabilitation. For example, the major psychosocial goals in the immediate aftermath of an incident include survival and establishing communication and connection with family/significant others. In the short-term response phase, the focus is on resuming daily activities performed before the event and reducing fears, extreme worries, paralyzing shock and denial. Interventions should be designed and selected to attain those differing objectives.

There is a lack of evidence about which psychosocial interventions are the most effective for children affected by disasters or armed conflict. The following recommendations are based on experience, consensus among practitioners, and the principle of "do no harm." As the evidence based expands, these recommendations may be revised.

Recommended Psychosocial Activities in the Acute Phase of a Disaster or Complex Emergency

- Integrate psychosocial approaches into the delivery of mainstream humanitarian assistance (e.g., shelter, food, wat/san) in ways that foster recovery and well-being.
- Emergency tracing and reunification of separated children and youth; prevention of future family separation. Family connection, protection and support meet crucial developmental and psychosocial needs of survivors.
- Structured activities for children and youth that foster normalcy and stability. Examples of these activities are:
  - emergency education since education-related activities play an important role in helping children resume a routine;
  - social activities offer the opportunity to establish connection with others;
  - creative expressive activities like art, theater and music can provide an outlet to make meaning of distressing or traumatic events;
  - recreational activities like sports may provided needed physical activity, reduce stress and the opportunity to increase confidence and self-efficacy.
- Psychological first aid activities (e.g., crisis intervention, peer support, emotional and practical support for the bereaved;) can protect survivors from further harm, reduce

physiological and emotional arousal and mobilize support for those who are most distressed. ***Such activities should be socially and culturally grounded***, may include traditional helpers and spiritual/religious practices, and be designed to reach large numbers of affected people, including vulnerable or "invisible" populations (e.g., children of marginalized ethnic/religious groups or lower castes, children with physical and mental disabilities).
- Activities that provide opportunities to foster solidarity, re-build social/community connections and networks, and cultivate survivor-to-survivor support are often most effective.
- Stress management and psychosocial support for emergency responders and humanitarian aid workers. Natural disasters and complex emergencies can place humanitarian aid workers and emergency responders at particular risk for negative psychosocial consequences. They are survivors in their own right and inattention to the accumulated stress of aid workers and responders jeopardizes both the well-being of individuals and the strength of USAID-funded programs as stress can compromise the judgment and productivity of implementers. Attention must be paid to both national and international staff.

Recommended Psychosocial Activities in the Post-Acute Phase
- Continue the relevant interventions begun in the acute phase
- Organize outreach and education for community members on availability or choices of psychosocial support and/or mental health care. The public should be educated on the difference between mental illness/psychological disorder and normal psychological distress after an event of this nature. This should be done in a way to avoid suggestions of wide-scale presence of psychopathology and avoiding jargon that carry stigma.
- Train and supervise community health workers, teachers, and others with frequent contact with many members of the community in basic/para-professional psychosocial knowledge and skills.
- In the initial emergency response, we do not currently have good tools that can distinguish between psychosocial needs that can be immediately addressed and persisting problems that may require additional support or resources. Therefore, assessments that determine prevalence rates and more formal mental health interventions should be delayed until this phase.

Activities to Be Avoided
- The establishment of centers or institutions for separated/unaccompanied children and youth. Instead, emergency tracing and reunification should be the first line of defense with community-based solutions developed for those that cannot be traced..
- It is inappropriate to assume that separated children and youth are orphans or that confirmed orphans are without family care. Extended family members are the first line of child-care support, and adoption is a last resort, save institutionalization.
- Wholesale importation of Western therapeutic models or mental health professionals may not be culturally appropriate and is not a sustainable response to improving the psychosocial well-being of children affected by disasters or armed conflict.
- Programs that do not properly train or supervise their service providers. Those working with more distressed populations or delivering more complicated interventions require greater degrees of training and supervision. But all providers should be given appropriate levels of preparation and oversight.