**Mental Health, Psychosocial Assistance, and Cultural Integration in Emergency and Displacement: IOM Perspective**

Displacement due to conflict, war and natural disasters, and more generally living in a conflict, post-conflict, or post-disaster situation generally requires major adaptations, as people need to redefine personal, interpersonal, socioeconomic, cultural, and geographic boundaries. This implies a redefinition of individual, familiar, group, and collective identities, roles and value systems, and may represent an upheaval and a source of stress for the individual, the family and the communities involved. Conflict and war create specific psychosocial vulnerabilities that, if combined with other risk factors, including pre-existing conditions and social and security predicaments of the present, can affect the mental health of the individuals involved.

Providing psychosocial assistance to conflict and disaster affected populations in educational, cultural, religious, and primary health setting reduces vulnerabilities, and prevents their stagnation, which may in turn result in long-term mental problems, and social pathologies.

The same mental health and psychosocial issues affect the population who doesn't flee the displaced, and the returnees. Indeed, the breakdown of the socioeconomic, cultural and anthropological environment caused by armed conflict requires major re-adaptations as it does the necessity to adapt to a new environment in the case of displacement. Returnees are usually equally affected, since the environment changed or deteriorated during the time of displacement, bringing to a breakdown of known structures, and changes took place in the individual psychosocial status of the displaced during the same period.

Finally, populations affected by the conflict or the disaster include individuals with pre-existing psychiatric and psychosocial vulnerabilities, whose effects may be enhanced by the emergency and the displacement, due to presence of stresses, accessibility of adequate services, and different cultural and medical approaches to mental uneasiness between the host and the receiving country.

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**Definitions and scope**

Mental Health is a state of well-being in which an individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2002). The concept of Mental Health is therefore larger than the absence of mental disorders. Moreover, war, endemic conflict, and armed conflicts are not to be considered "normal" stresses of life that is why such situations are labeled as "emergency". Therefore, the temporary inability to cope with such un-normal stresses is not to be associated to mental uneasiness or biomedical malfunctioning.

The term psychosocial pertains to the influence of social factors on an individual's mind and behaviour, and to the interrelation between mind and society (OED, 1997). Psychosocial activities are therefore looking at the interconnectedness of social-collective issues, individual-personal, internalized states, and the cultural and anthropological constructs around this relation, and not merely at the social implications of mental care, or at the psychological implications of social needs and related responses.

Mental health and psychosocial wellbeing, based on the above-mentioned definitions are in fact synonymous. This is also IOM policy. However, in interagency and humanitarian languages psychosocial is usually referred to the continuum of care, as illustrated in the pyramid below, while mental health refers to specialized mental care, such as to the apex of the pyramid.

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**Example of IOM Comprehensive Psychosocial Programming.**

The Belgian Development Cooperation-funded Psychosocial Response in Lebanon.

**Capacity Building:** Executive Professional Master in "Psychosocial Animation in War-Torn Societies".

The Executive Professional Master in "Psychosocial Animation in War-Torn Societies", run in collaboration with UNICEF, the Lebanese MSaA, and the Lebanese University and funded by the Belgian Development Cooperation and UNICEF involved more than 30 international, regional and national professors, experts and practitioners, who work in compliance with IOM MH-PPS approach. They offered to 27 expert students, chosen among psychologists, social workers, artists, medical doctors and educators already involved in assistance on the field, ethics, models and practical tools to work with conflict affected displaced populations. These included on the counseling, community readjustment, conflict resolution and social communication levels, therefore responding in an integrated manner to the various psychosocial necessities of war-torn societies. The Master took place in a residential format over the weekends, in order to involve professionals already providing assistance to the populations and have an immediate secondary effect on the final beneficiaries. The combination of practical-in service training with academic standards and critical review of the work done is internationally considered a best practice.

**Direct Interventions:** Dari: Recreational and Counseling Center for Families

The Dari Center was established in collaboration with the Ministry of Social Affairs, UNICEF, the Municipality of Baalbeck and funded by the Belgian Development Cooperation in its first year. Born as emergency intervention, the Center has expanded its activities into the early recovery and stabilization phases, through a combination of MSaA, Municipality of Baalbeck, local NGOs and Foundation D'Harcourt’s in kind and financial contributions, and the continuous involvement of associations such as APEG (Association pour la Protection des Enfants de la Guerre), Catharsis (Lebanese Association for Drama Therapy) and the Islamic Orphans Association. The Center offering a combination of socializing structured and unstructured activities, and specialized therapeutic services for children, youth, women, elderly and male adults; it provided more than 5,000 individuals affected by the conflict with social, community integration and counseling services, and act as a community center as well as a provider of non stigmatizing mental health services. A mobile Unit attached to the Center extends services and training to schools and vulnerable neighborhoods in the region (ONGOING).

**Preparedness:** Psychosocial Expert Teams

Based on the practices elaborated during the Master program, and on the expertise and network built, IOM together with the Ministry of Social affairs, in collaboration with the Ministry of Health and the Ministry of Education, and funded by the Italian Cooperation has established 6 Psychosocial Resources Centers in Lebanese Regions, attached to the Social Development Centers. The Resilience Centers (called Expert Teams) led by 6 IOM Masters graduates, are tasked with devising a national and regional psychosocial emergency preparedness plans. The experts have mapped the existing mental health and psychosocial services in the respective region, whose complete list and description is now available on the web at. Moreover they have designed and devised trainings in psychosocial response to emergencies, psychosocial response tools and methods, coordination and the IASC guidelines for more than 2000 professionals from the above mentioned services as well as officials from the MSaA, MoE, MoH. The work will result in the creation of plans of action. In case a new emergency will occur in each region a coordination plan will be in place, officials from all sectors, who received harmonized trainings should be able to make it operational, and professionals from different services, mapped and trained, could be activated for referral (ONGOING).

**Example of Sectoral Mental Health and Psychosocial Capacity Building, Belgian Ministry of Health Funded Mental Health Capacity Building Program in Congo (Goma and the Kivus).**

This small scale program aims at responding at the capacity needs of the MoH-Mental Health sector in Goma and Kivus to respond to the challenges arising from the emergency displacement in the region. After a rapid assessment was conducted, a training plan was devised as well as a 5 –day induction session on psychosocial issues in displacement, and community-based response tools, based on IOM models of work, for community leaders, primary health care staff, and mental health care staff of the MoH. Three one-week trainings have been additionally conducted for primary Health and secondary Mental Health staff in psychological first aid, trauma informed care, discrimination between pre-existing pathologies and normal psychological consequences of displacement, and counseling methods. Specialized trainings for secondary mental health care staff will follow in a second phase of the program.

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Psychosocial Approach-Psychosocial programming

A psychosocial response to emergencies encompasses the psychological, social, and cultural anthropological dimensions in an integrated manner. This could take the form of psychosocial programs, which respond to all three aspects in an integrated fashion, or of a psychosocial approach to different humanitarian programs. The latter consists in the consideration of the interconnectedness of the three realms in humanitarian action, including health, food and non-food items, shelter, water, and sanitation.

Psychosocial programming is most used by IOM in emergencies and forced displacement, since in those situations it is impossible to separate the individual and the collective dimension of the experiences, and the social, emotional, and anthropological impact of certain occurrences, by instance when someone is homeless and the head of the household in the displacement.

Psychosocial approach to different humanitarian programs can be illustrated by the following examples. A psychosocial approach to food distribution is one that considers the psychological consequences of certain modalities of distribution, and the anthropological impact of distribution on the family structure and the role of the household in patriarchal societies, reducing to the minimum the possible negative psychological and anthropological side-effects in the adapted modality. A psychosocial approach to mental health is instead one that considers the social normalization of the affected individuals, the cultural relevance of certain illnesses, and the protection of the emotional well-being of the affected individual throughout the healing process.

Psychosocial Challenges in Emergency Displacement

Usually displacement, especially the forced one, is accompanied by stresses that challenge mental health and psychosocial wellbeing, including: economic constraints, security issues, breakdown of primary social, economic and symbolic structures, devaluation or modification of social roles, persecution and discrimination, loss of family and loved ones, unstable and psychosocial life conditions, difficult access to services, losing social and cultural competence, experience of violence, threats, mistreatment, and personal violations.

The combination of these factors bring to feeling of grief, loss, guilt towards the people who did not flee or other members of the family, a sense of inferiority compared to the resident population, isolation, withdrawal, restlessness, psychosomatic symptoms, fears, sadness, anger, anxiety, insecurity-instability, depression and detachment.

These feelings are in most of the cases NORMAL REACTIONS to the situations, but need to be responded to in a multidisciplinary fashion, in order to avoid long-term pathological stagnation and the building up of unhealthy societies.

Mental Health Challenges in Emergency Displacement

A war-torn society includes individuals with pre-existing psychiatric and psychological vulnerabilities, whose relevance may be augmented by the conditions and reasons for fleeing. Caring for these individuals is usually made more difficult by language barriers, inaccessibility of mental health services, anthropological differences in the way the vulnerability is perceived and treated in the host and in the receiving country, and the sudden loss of family and community support systems, and remedies.

In relation to post traumatic experiences, it would be wrong to assume that all possibly traumatizing events bring to psychological trauma, because different people respond differently to events. International literature shows that even in war situations, the rates of psychological trauma rendering people unfunctional are on average of 10% to 15%. Psychological trauma rendering people unable to function is epiphenomenal, and incidence of post traumatic symptoms may vary dramatically with the normalization of the security and socio-economic situation.

Without including in the existing debate on the appropriateness of the medical construction of PTSD (Post Traumatic Stress Disorder), IOM favors a non individual-pathology approach to assessment and response, and strongly discourages the conduction of PTSD assessments in the first three months after the occurrences and in all those situations, where the probability of the present may bias the assessments results, and normal reactions to ongoing occurrences may be misdiagnosed as symptoms of persisting reactions to traumatizing occurrences of the past.

An effective and ethical humanitarian programs. The last consists in the consideration of the interconnectedness of the three realms in each humanitarian action, including health, food and non-food items, shelter, water, and sanitation.

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IOM’s Central Unit for Mental Health, Psychosocial Responses, and Cultural/Medical Integration provides its expertise in the fields of psychosocial well being, mental health, community-based responses, creative and arts-based intervention, and cultural integration. IOM has been active in psychosocial support in emergencies since 1998, developing intervention, trainings and researches in Albania, Colombia, Georgia, Iraq, Kenya, Kosovo, Jordan, Lebanon, Liberia, Macedonia, Myanmar, Palestine, Serbia, Syria, and Sri Lanka. Along with the more established psychosocial tools, the IOM also uses other instruments and languages, including social theatre, community animation, creative arts, oral history, systemic and narrative counseling, trans-cultural approaches, and small-scale conflict management. The methodology adopted is active and participatory, adapting to different cultural contexts of life and belonging of migrants, war displaced populations and returnees. In this perspective the general objective of IOM psychosocial interventions is to:

1. De-pathologizes migrants, displaced and war affected populations
2. Strengthen their internal and communal resources, in order to confront their complex experience
3. De-stigmatize emotional occurrences related to migration and war and
4. Avoid use fabricated culturally inappropriate tools, through the active participation of national and local experts, and beneficiaries in designing the intervention.
5. Strengthen the capacity of national and local actors
6. Create international networks of excellence to promote a quality and critical standard of interventions also in emergency situations
7. Activities have included capacity building for professionals, Governments, Agencies, IOM Departments through:
   a. Assessments, analysis, researches: including the Assessment on Psychosocial Needs of Iraqis in Jordan and Lebanon, with Libyan returnees after the 2006 wars, with Iraqi IDPs after the 2006 operations, with Kenyan IDPs following the 2006 post-electoral violence, with children former combatants in Liberia, with Serbian minorities in Kosovo.
   c. Interagency coordination, through the active participation to the Inter Agency Standing Committee Reference Group on Mental Health and Psychosocial Response in Emergency Settings, and the efforts in mainstreaming the relevant Interagency Standing Committee Guidelines, IOM has led the Inter Agency Mental Health and Psychosocial Working Group in Kenya and Myanmar, and is leading the mainstreaming of the Guidelines in the Camp Management and Camp Coordination Cluster.
   d. Support to Governments in the development of policy papers, guidelines, national strategies, including the “Psychosocial Policy Paper” of the Lebanese Ministry of Health and Psychosocial National Response Strategy” of the Kenyan Ministries of Health and Special Programs, the authorship of the IOM-UNICEF

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<td>1. Medicizes communities and individuals, who are just having normal reactions to abnormal situations</td>
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<td>2. Use culturally inappropriate investigation and early diagnostic tools</td>
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<td>3. Have non professionally equipped staff to perform diagnostic assessment and or early counseling</td>
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<td>4. Initiate psychosocial processes which lack of sustainability</td>
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<td>5. Perform inappropriate explorations of the stressful experience, this may harm the person</td>
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<td>6. Indulge in awareness raising, when a referral system is lacking</td>
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<td>7. Go against traditional and faith oriented coping mechanisms, that are valid responses on the short-term</td>
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<td>8. Provide widespread and short-term trauma counseling</td>
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<td>9. Focus the programming on a single diagnosis (e.g. PTSD) and support instead a programming considering the wider range of urgent pre-existing neuro-psychic needs</td>
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<td>10. Fragment the assistance provided between categories (women, children), and address instead the family as a whole</td>
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<td>11. Disregard the needs of male adults and elderly</td>
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<td>12. Address the needs of adults only through their families (parents), even though the parents responsibilities and the concern for the children play a big role in the psychosocial wellness of parents, they may have other individual psychosocial needs</td>
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<td>13. Always use the Do Not Harm rule.</td>
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ICM Expertise

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JORDAN: Paintings on the Wall is an interactive performance for the integration of Jordanian and Iraqi youth in schools in Jordan