Chapter

# Innovative Family Therapy for Households in Global Complex Humanitarian Crises

*Oluwatoyin Olatundun Ilesanmi, Faith Ibitoyosi Ilesanmi and Raouf Hajji*

## Abstract

The relief societies are diverse and consist of humanitarian organizations and humanitarian NGOs. They provide emergency aid interventions to victims of armed conflicts, protracted wars, famines, and natural disasters across the globe. The relief societies have witnessed multiple arrays of complex humanitarian catastrophes affecting families in varying degrees in a global dimension and impact. These societies have been providing lifesaving assistance and protection for victims of war, orphans, and vulnerable groups. They have been reducing the impact of humanitarian crises on families and communities, providing aid for recovery and improving preparedness for future emergencies for moral, altruistic, and emotional reasons. Crisis-impacted families may be located far from the fragile locale or in the eye of the storm. Their losses may be psychosocial, economic, or psychological distress or mental health issues. At the onset of the Russian–Ukrainian War, families across the global community are already counting their losses. These call for novel therapeutic interventions among clinicians and counseling psychotherapists. This chapter, therefore, highlights existing strategies for innovative therapeutic measures for families affected by complex humanitarian emergencies.

**Keywords:** effects, innovative family-focused therapies, households, vulnerable persons, complex humanitarian emergencies

## 1. Introduction

The humanitarian community is diverse with multiple arrays of complex emergencies (war, natural disasters, famine, armed conflict, food insecurity, climate change, both natural and industrial disasters, and disease outbreaks) with varying severity and impacts on families across the globe [1]. The global community has witnessed waves of violent and protracted complex humanitarian crises in Burkina Faso, Myanmar, Yemen, Venezuela, Ethiopia, Afghanistan, the Democratic Republic of Congo, Nigeria, Iraq, South Sudan, Syria, Somalia, and Ukraine.

Humanitarian catastrophes (conflicts and calamities) pose serious threats to individual families' survival and adaptation [2]. They engender widespread human

suffering and destructive events that require a wide range of emergency relief resources and timely intervention.

Although the humanitarian catastrophe-impacted families may be located far from the fragile locale or in the eye of the storm, they may suffer the loss of loved ones, displacement, loss of income, food scarcity, inflation, and the rising cost of living. Accompanying disasters and humanitarian crises are widespread human distress amidst high levels of immediate chaos and delays in the restoration of formal health and social services in the locale of impact [2].

The intensity of the impact of disasters and humanitarian crises such as war, mass conflict, or overwhelming natural disasters on families and households depends on the type, suddenness, and scale of the catastrophe and the socio-cultural and historical context of the domain of occurrence [3]. The over two decades of conflict and political instability and the nascent complex humanitarian crises (Ebola, cholera, COVID-19, and the 2021 volcanic eruption) have worsened the health systems, resulted in high levels of acute food insecurity, and increased the number of internally displaced people (5 million) in the Democratic Republic of Congo (DRC) [2].

In terms of displacement, the UNHCR reported that more than 89.3 million people were classified as forcibly displaced due to conflict, war, violence, persecution, human rights abuses, or events seriously disturbing public order as at the end of 2021 [4, 5]. Part of these displaced persons are 21.3 million refugees under UNHCR's mandate, 5.8 million Palestine refugees under UNRWA's mandate, 53.2 million internally displaced people, 4.6 million asylum seekers, and 4.4 million Venezuelans displaced abroad [5]. The Russian invasion of Ukraine has pushed the figure of forcibly displaced persons to over 100 million [5, 6]. Afghanistan appears to have the largest displaced population globally due to its decades of violent conflict and natural disasters [7].

Families exposed to prolonged and violent conflicts and the Covid-19 pandemic, including displacements, famine, and other forms of humanitarian crises in fragile nations such as Afghanistan, Ethiopia, Myanmar, the central Sahel (Burkina Faso, Mali, and the Niger), Cabo Delgado Province in Mozambique, South Sudan, Sudan, the Bolivarian Republic of Venezuela, and Yemen, suffer losses and severe violations of human dignities, such as torture and sexual violence. The losses usually include psychosocial, economic, or psychological distress (such as anger, depression, grief, etc.) or mental health issues (such as depression, anxiety, post-traumatic stress disorder, psychosis, etc.) [8].

Since the onset of the Russian–Ukrainian War, for instance, families across the global community (Asia, Africa, and global North and South) are already counting their losses [9]. The humanitarian crisis has devastated many families and rendered many stateless and homeless [10]. A lot of the crisis-affected families are currently living under extreme fear and tension; have limited resources to fulfill their needs; live in tents; have limited food, water, and clothing; and face many difficulties and unexpected hardships including cultural and language barrier problems. The refugees' children and international students caught in the war are finding it very hard to continue their education. A lot of such students have had to return to their home country without a clear definitive idea of what the future holds for them [9, 10]. Besides, such families are also experiencing financial difficulties, discrimination, and psychological problems [11, 12].

Among the vulnerable are young couples, children, nursing mothers, and surrogate mothers for international parents, among others. These could be classified as emergency-affected families, veteran families, traumatized and emotionally disturbed families, traumatized couples, suburban couples, single families, non-domiciled/homeless families, aged families, and vulnerable children and orphans.

The impact of complex humanitarian crises on such families is worsened by the emergence of mass destitution, homelessness, statelessness, and mass deportation to their country of origin [13]. This means that they have no home, lack a fixed abode or address, and do not belong to any state. No state considers them as their nationals [14, 15]. These often culminate in an emotional state of feeling lost and deprived of human relationships and increased anxiety [16].

The key psychosocial domains of individual families that are threatened by disasters and humanitarian crises include security and safety; interpersonal bonds and networks (the family, kinship groups, community, and society); identities and roles (parent, worker, student, citizen, social leader, etc.); justice and protection from abuse; and institutions of existential meaning and coherence (traditions, religion, spiritual practices, and political and social participation) [17]. These have great implications on the individual and collective family mental health and well-being.

Article 1 of the United Nations Convention on Status of Refugees stipulated that 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion', refugees are outside the country of their nationality and are unable to or, owing to such fear, are unwilling to avail themselves of the protection of their host country.

Despite this, there are various universally agreed-upon conventions, declarations, protocols, agreements, laws, and statutes safeguarding and protecting the rights of persons caught in complex humanitarian emergencies including refugees. Examples include the UN Convention Relating to the Status of Refugees, 1951, and Protocol, 1949; Protocol Relating to the Status of Refugees, 1967; the New York Declaration for Refugees and Migrants, 2016; UN Declaration on Territorial Asylum, 1948; Universal Declaration of Human Rights, 1948; Convention Relating to the Status of Stateless Persons, 1954; International Convention on Civil and Political Rights; Convention on the Reduction of Statelessness, 1961; Convention on the Elimination of Discrimination against Women, 1979; and the Guiding Principles on Internal Displacement, 1998. Some of the regional refugee laws are the Cartagena Declaration (1984) and the Asian African Legal Consultative Committee Principles (1996).

The demands of some of these international documents are the need for innovative psychological care of individuals and families vulnerable to disasters and complex humanitarian emergencies. Consequently, the psychological and existential conditions of contemporary persons and families in complex humanitarian emergencies rest principally on Maslow's pyramid of needs—physiological, safety, love, esteem, and self-actualization [18]. Thus, there is an urgent need for novel therapeutic interventions and counseling, especially innovations in family therapy among clinicians and counseling psychotherapists without borders. This chapter, therefore, suggests strategies for innovative therapeutic measures for families affected by complex humanitarian emergencies.

## 2. Rationale

Sociologically, the family is a major component of society [19]. Healthy families sustain and improve the sociocultural, socioeconomic, and emotional life of healthy societies. In psychological parlance, families are the bedrock and systems of interpersonal interactions for the protection of individual members from societal manipulative influences of society. A family provides individual members with adaptation skills and strategies for proper and effective functioning in life. More so, Vygotsky opines that the family is the most important element of the social situation of an individual's

development [20]. However, Shapiro [19] asserts that both the personal and the social are present in disaster-prone and complex humanitarian emergency-ridden terrains.

The impact of complex humanitarian emergencies on families' social situations encompasses a wide range of acute and chronic psychological issues in different settings. It also involves mass displacement of people, homelessness, heightened poverty, and psychosocial problems such as abuse and neglect. These negative effects of disasters and complex humanitarian emergencies on families' social situations sometimes aggravate the different aspects of an individual's existence within the family/household, thereby resulting in the formation of complex personality disorders [21]. Such complexes, psychological problems, crises, and conflicts sometimes require the efforts of family therapy specialists to remedy them [20].

Acknowledging earlier works by the mental health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG) [1] on brief versions of structured psychological interventions for people experiencing symptoms of common mental disorders (CMDs), therefore, triggered the need for this paper, which highlights the effects of complex humanitarian crises on families' social situations and the exiting innovative family-focused therapies for households affected by complex humanitarian emergencies in the global community.

## 3. Research questions

a. What are the varied forms of complex humanitarian emergencies?

b. What are the psychological effects of complex humanitarian crises on families' social situations?

c. What are the exciting innovative family-focused therapies for households affected by complex humanitarian emergencies in the global community?

## 4. Forms of complex humanitarian emergencies

Complex humanitarian catastrophes (CHC) could be acute crises, cyclical disasters, or man-made complex humanitarian emergencies [22, 23]. Natural disasters such as hurricanes (typhoons), tsunamis, wildfires, tornados, earthquakes, floods, volcanic eruptions, landslides/avalanches, heat waves, and blizzards are examples of acute humanitarian catastrophes [24]. These have been categorized as geophysical disasters such as earthquakes, tsunamis, and volcanic eruptions; hydrological disasters such as floods and avalanches; climatological disasters like droughts; meteorological disasters like storms and cyclones; and biological disasters such as plagues and epidemics.

Examples of cyclical disasters are water insecurity, food insecurity, debilitating/life-threatening endemic diseases, refugee crisis, and internally displaced persons [22]. Man-made complex humanitarian emergencies are forms of disasters triggered by either civil wars or international wars or ethnic cleansing or genocide and resulting in large-scale population displacement with accompanying deterioration of living conditions (such as food, potable water, shelter, and sanitation) and an increase in mortality over a limited period. Examples include the Holocaust in Europe in the 1930s and 1940s, the Bengal Famine of 1943, the murder or expulsion of the Chinese from Indonesia in the 1960s, as well as the more recent wars, ethnic cleansing, forced

migration, and genocide occurring in places such as Somalia, Bosnia, Rwanda, Kosovo, Sierra Leone, and East Timor [25].

## 5. Psychological effects of CHC and Vignettes of innovative therapies

Disasters and humanitarian emergencies are extremely distressing and traumatic events that threaten safety and security, interpersonal bonds, systems of justice, roles and identities, and institutions that promote meaning and coherence [8]. These often take a great toll on people's physical, mental, and psychological well-being, triggering a wide range of emotional, cognitive, behavioral, and somatic reactions among survivors. Some of these wide-ranging effects include:

a. **Fear response:** This is a psychological response (avoidance and arousal responses) to threats of natural or man-made disasters and humanitarian crises. It mobilizes physiological and behavioral reactions that protect individuals from death or injury in the face of violent clashes, wars, genocides, war crimes, etc. As depicted in the vignette below, the intensity of an individual's avoidance and arousal responses to disasters and humanitarian crises could be dynamic, persistent, chronic, and potentially disabling depending on the nature of the crisis [26].

b. **Post-traumatic stress disorders (PTSD)**: These consist of psychological issues (re-experiencing, avoidance, and a heightened sense of current threat) resulting from exposure to any form of natural or complex humanitarian crisis.

**Vignette of constant fear of insecurity and fear of the worst in the voice of a young mother, who suddenly became the head of her home in Southern Kaduna, Nigeria**

Hadiza, a petty trader and young mother of four (one girl and three boys), widowed when armed bandits raided Hayin Kanwa village, Yakawada ward in Giwa Local Government Area of Kaduna State, Nigeria, sat amidst the children on a badly tattered mat in the cool of the day sharing a meal of "tuwo" in front of their small mud brick home, made up of two rooms. While the children devoured the meal prepared by their mother, suddenly, Hadiza lost in thoughts and with a sobered burdened face, filled with worries, gazed into the distance, and pondering how she will sustain her four children: 8, 6, 4, and 2 years of age.

When asked, "why are you not eating with the children?" She responded, "I am in deep pain." Hadiza sobbed and then stated further, "The children and I survived unknown gunmen attacks by mere luck." Her husband was killed for delaying opening the door of their home to the bandits when they attacked the community. "I feel helpless, without my husband I do not know how I will cope; paying for food every day, paying school fees and buying medicines when the children fall sick, it is a big responsibility that troubles me. Besides, I do not know how I can protect my sons from being kidnapped by the bandits and my daughter from being raped if the bandits attacked again."

The loss of Hadiza's husband to bandits' attacks deepened her poverty status and plunged her into sadness, sorrow, and persistent grief. The children, who are oblivious to the depth of their mother's pain, are likely to experience further traumatic encounters with the unknown bandits, who have persistently been shooting people and burning houses including religious buildings in rural communities across the state.

Psychologists attending to young poor widows like Hadiza, who can be diagnosed with manifesting co-occurring post-traumatic depression and anxiety, need to deploy

hands-on skills for resilience and hope-building. Although Nigerian psychologists are not trained as humanitarian actors, to fit into this mode, there is the need for them to acquire psychotherapeutic and counseling skills necessary for trauma counseling in highly volatile and disaster crisis-prone settings like Northern Nigeria. Such skill sets will include resilience building (the ability to rebound, bounce back, and overcome), assessment skills necessary for uncovering and disrupting negative automatic thoughts, and listening skills.

a. **Acute traumatic stress disorders**: Acute traumatic stress disorder may be a normative response to disasters and humanitarian crises. It often tends to subside once conditions of safety are established. Symptoms include a wide range of non-specific psychological and medically unexplained physical complaints.

b. **Insomnia and other sleep problems:** Insomnia with considerable difficulty in daily functioning is one of the problems commonly experienced by individuals after experiencing extreme stress due to exposure to any form of natural or complex humanitarian crisis. Psychologically oriented interventions (e.g., relaxation techniques) may be considered for any family experiencing insomnia.

**Vignette of Transient mental trauma and sleep disturbances experienced by a father and two sons in East Nusa Tenggara islands in 2021**

John, a father of two, who lost his wife to the deadly Indonesian cyclone Seroja in the East Nusa Tenggara islands, reported that his children experienced temporary mental trauma and sleep disturbances, which is manifested by crying when a sudden change in the weather occurs. The cyclone brought strong winds and heavy rains that triggered flash floods and landslides. "I cry every time the wind becomes stronger. (I cry) because I recall (the event)." I do not want the typhoon to recur in their place. I do not want my children and me to be killed. The cyclone resulted in a complicated tragedy and sadness. I cannot sleep for a day."

Sleep disturbances are often referred to as a hallmark and core symptom of PTSD. The literature affirms that untreated sleep disturbances can worsen the exacerbation of PTSD symptoms, which may have negative effects on a patient's treatment response and constitute a risk factor for poor treatment outcomes. The mental health treatment as usual (TAU) for PTSD comprises 10 sessions with a medical doctor (pharmacological treatment and psychoeducation) and 16–20 sessions with a psychologist (manual-based cognitive behavioral therapy) for a period of 8 to 12 months.

Bruhn, Laugesen, Kromann-Larsen, Trevino, Eplov, Hjorthøj, and Carlsson's [27] utilization of add-on (integrated care) intervention to TAU strengthened the coordination between mental health treatment and employment interventions with three cross-sectoral collaborative meetings during the mental health treatment. It drew attention to the bidirectional impact of mental health problems and post-migration stressors and focused on cross-sectoral shared plans.

The primary outcome is functioning, measured by WHODAS 2.0, the interviewer-administered 12-item version, with secondary outcomes measuring the quality of life, mental health symptoms, and post-migration stressors.

In another study, Sandahl and Jennum [28] utilized add-on treatment with mianserin and/or Imagery Rehearsal Therapy (IRT) in addition to TAU as a sleep-

enhancing treatment in refugees (18 years or older) with PTSD at a Danish outpatient clinic. The refugees were from Afghanistan, Ex-Yugoslavia, Iraq, Iran, Lebanon, and Syria. The TAU was an interdisciplinary treatment approach covering a period of 6–8 months with pharmacological treatment, physiotherapy, psychoeducation, and manual-based cognitive behavioral therapy within a framework of weekly sessions with a physician, physiotherapist, or psychologist.

a. **Somatoform disorders**: These are psychological thoughts, feelings, and behaviors such as constant worry and fear about potential illness or signs of severe physical illness even when there is no evidence as a result of exposure to natural disasters such as chemical weapons and other forms of complex humanitarian crises.

b. **Complicated/prolonged grief disorder**: Grief is the emotional suffering people feel after a loss of homes and livelihoods or bereavement due to any form of natural or complex humanitarian crisis. This emotional reaction may be self-limiting without becoming a mental disorder or may prolong over an extended period. Prolonged grief disorder involves a severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months (and for a period that is much longer than what is expected in the person's culture). Symptoms of prolonged grief disorder include moderate–severe depressive disorder (DEP), psychosis (PSY), harmful use of alcohol and drugs (SUB), self-harm/suicide (SUI), and other significant mental health complaints (OTH).

c. **Depression/helplessness**: This may range from moderate to severe depressive disorder (DEP) for individuals or among family members who have been exposed to any form of natural or complex humanitarian crisis.

**Vignette of Catastrophizing/Reminiscence, Selflessness, Bonding, and Rebuilding Lives**

The overall intensity and catastrophe of 2013 super typhoon Haiyan (locally known as Yolanda), which hit the town of Visayas, the northern part of Cebu, Philippines on November 8, 2013, left families and all its victims (children to the older population) living with a deep sense of helplessness, intense fear, confusing, and sometimes frightening emotional toll [29]

The devastation impaired the sensory awareness and physical mobility of many. It also worsened their health conditions and weakened their social and economic capabilities. The survivors experienced fear, difficulty, loss, helplessness before and during the typhoon, and sadness by the loss of the properties they had invested in for many years due to the calamity. The typhoon-induced aggravated fear including fear of personal safety, security of loved ones, the absence of mature family members who can help protect them in the family, and fear of death at the height of the catastrophe.

In Visayas, the less affected young and older adults looked out for their neighbors, supported distressed families, mobilized resources, and cared for orphans and vulnerable children (OVC) and other dependents during the traumatic event. After the crisis, they were able to reminisce about their experience and rebuild their lives and community.

The survivors in the Visayas compensated for their feelings of intense fear, loss, and helplessness, with a sense of selflessness, strengthening social bonds, rebuilding their lives, and reminiscence. Through reminiscence, they tried reliving memories and compared them with their current experiences. Sharing memories helps older adults

to relive and explore their thoughts and feelings about their unique traumatic experience of the typhoon. They were also able to put their past experiences in perspective with what is happening to them in the present or what is expected to happen in the future. Thus, reminiscence, social bonding, and rebuilding became the mechanism for coping with changes in their life situation or circumstances. Sales and Pinazo-Hernandis [30] opine that reminiscence therapy (consisting of 10 sessions lasting 60 min each) is a psychological intervention that can be used to assist an individual to remember and interpret life events, feelings, and thoughts that define and give meaning to him/her. Reminiscence of earlier emergency experiences, coping strategies, traditional skills, and local environmental knowledge can result in positive mental health for survivors of catastrophic emergencies.

a. **Psychosis (PSY)**: The symptoms include abnormal behavior (e.g., strange appearance, self-neglect, incoherent speech, wandering, mumbling, or laughing to self), strange beliefs, hearing voices or seeing things that are not there, extreme suspicion, lack of desire to be with or talk with others, and lack of motivation to do daily chores and work.

**Vignette for refugees with a high burden of unaddressed grief, loss, trauma, and depression**

Assefa, a refugee who fled from the conflict in Tigray to Gedaref, a state in eastern Sudan with his family, recounted how his family had struggled to support his daughter, who was experiencing a mental health condition: "Almaz is my daughter. The situation in Tigray affected her mental health and she started behaving violently and erratically. We did not know how to manage things, so we used to tie her up. I tied her up in our car on our way here, tied her up in the tent we were given, and later at our house. There was no health facility available at the time, nor any medication for her treatment."

Besides Assefa's case, Pieter Ventevogel, a senior mental health and psychosocial support officer with UNHCR, reported the high burden of unaddressed grief, loss, trauma, and depression among refugees, who fled from Tigray, Ethiopia, to eastern Sudan in 2022. He also reported cases of unaddressed gender-based violence among female refugees and saw children depicting violence and dead bodies in their drawings.

a. **Survivors of sexual and gender-based violence (S/GBV)**: Incidences of sexual and gender-based violence in conflict settings are risk factors for mental health and psychosocial well-being. The World Report on Violence and Health posits that these are any form of sexual act, attempted sexual act, unwanted sexual comments or advances, acts of human trafficking, or otherwise directed against any person's sexuality through coercive means regardless of their relationship in any setting [31]. All women, girls, boys, men, and unaccompanied minors, who have been vulnerable to such violent abuses in conflict-affected settings and during forced displacement, should be offered trauma-focused cognitive processing family therapy [32].

b. **Social avoidance/social withdrawal**: Any survivor of a complex humanitarian crisis exhibiting social avoidance also needs family therapies.

c. **Irritability and aggressive behavior**: Teenagers who have been exposed to or witnessed complex humanitarian crises tend to act irritably and repeat abusive

behaviors—fight, engage in risky sexual activities, or dabble in drugs and alcohol.

d. **Harmful use of alcohol and drugs (SUB)**: Humanitarian crisis can worsen the harmful use of alcohol, narcotic drug use, and air pollution. The SDG Target 3.5 on mental health aims at strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Consequently, family psychotherapists need to be able to manage harmful use of alcohol and drugs as well as life-threatening withdrawal among anyone affected by a humanitarian crisis.

e. **Suicide (SUI) and suicidal risks**: Suicidal behavior (suicide attempt, suicide, and suicidal ideation) can be triggered by traumatic experiences of hazardous journeys, the loss of resources and belongings, death of loved ones, separation from family members, harsh circumstances in refugee camps, and direct exposure to armed conflict and violence, war, and torture [33].

## 6. The psychological needs of families affected by humanitarian crises

Exposure to disasters and complex humanitarian crises such as genocide,
Based on Abraham Maslow's [34] hierarchy of needs, the following are the basic needs of family members and whole families caught up with and directly impacted by humanitarian crises:

1. **Physiological Needs:** Physiological needs are the basic needs and requirements for the body to survive—water, clean air (oxygen), food, and sleep. These are the basic needs of anyone caught up in a humanitarian crisis.

2. **Security Needs**: Security needs include the need for a safe family environment, steady employment, a safe neighborhood, and a stable financial situation.

3. **Social Needs:** Social needs include the need for belonging, love, intimacy, and affection. Relationships with friends, romantic partners, and families fulfill this need, as does involvement in communities and social or religious groups.

4. **Esteem Needs**: Esteem needs include the need for validation from others (status, respect, recognition, and reputation) and positive self-evaluation (competence, confidence in ability, accomplishment, and skills mastery).

5. **Self-Actualization Needs**: This category includes the need to maximize one's potential or the need for personal growth, creativity, morality, and meaning making.

## 7. Innovative psychosocial support and family-focused therapies for groups and households affected by complex humanitarian emergencies

The following are the psychosocial support and family-focused therapies that should be deployed for treating psychological distress and strengthening the mental

health and well-being of adolescents, families, kinship groups, orphans and vulnerable groups, unaccompanied children, and communities in humanitarian settings:

a. **Psychosocial Supports**: Psychosocial support programs address the emotional, social, mental, and spiritual needs of persons and families in crisis. They help in building resilience in children and families. They essentially focus on people's experiences of humanitarian crises within broader social dimensions to facilitate individual and community resilience strategies to mitigate that impact. They can be provided at the individual, family, and community levels by promoting and providing everyday activities such as schooling, activating social networks, as well as developing and building on existing coping mechanisms to manage the impact of humanitarian crises.

   For unaccompanied children, orphans, and vulnerable children in humanitarian settings, the main goal of psychosocial support programs is to ensure that they are properly placed in stable and supportive family environments. They also focus on how family members respond to the harsh realities of humanitarian catastrophes based on their age, gender, and circumstances.

   The following are some of the basic psychosocial support programs recommended for individuals or families experiencing serious psychosocial and emotional distress due to their exposure to complex humanitarian emergencies:

   i. **Psychological first aid (PFA)**: PFA is needed immediately after the occurrence of an extremely stressful event. It begins with the identification of the current psychosocial stressors experienced by and the basic needs of all or any members of the family through stress management techniques such as listening to their unpressurized communication and probing for their psychosocial needs and concerns. PFA strategies for addressing their current psychosocial stressors entail the reactivation and strengthening of their family social support networks by providing direct or indirect psychosocial support through socialization processes such as family gatherings, visit to neighbors, and participation in community activities. They also entail the provision of access to services and protection from further harm. The greatest need of families affected by disasters and humanitarian emergencies is to be heard or listened to.

   ii. **Psychoeducation programs**: This entails training on stress management and normal reactions to grief and acute stress. These programs solely provide education on the impact of exposure to humanitarian crises and seek to empower people by promoting awareness and managing the impact of that exposure via educational materials and tools.

   iii. **Health-related interventions**: During humanitarian crises, psychosocial support activities can be integrated into existing community and health systems and can foster support groups for parents, families, community caregivers, and youth (peers).

b. **Family-focused therapies:** Family-focused counseling and psychotherapies are the mainstays of intervention treatment for mental disorders [35]. Highlighted

below are some of the effective family therapies that could be used for households affected by complex humanitarian emergencies:

i. **Problem-solving psychotherapy:** This is a cognitive–behavioral intervention geared toward improving an individual's ability to cope with stressful life experiences. It can be utilized with vulnerable groups and families during humanitarian emergencies based on the assumption that symptoms of psychopathology may be a negative consequence of maladaptive adjustment and coping to the crisis events. Examples of these modes of intervention include psychoeducation, interactive problem-solving exercises, and motivational homework assignments [36].

ii. **Interpersonal therapy (IPT):** This is a benchmark therapy for depression and other mental health conditions that are elevated in humanitarian settings. Administering interpersonal therapy (IPT) as a family-focused therapy should be the first-line treatment for pregnant and breastfeeding women, survivors of gender-based violence, and families mourning the loss of their loved ones in humanitarian settings.

iii. **Behavioral activation therapy:** This action-oriented approach is a structured treatment suited for use among individuals with co-occurring depression and substance use disorders (SUDs). It reduces the symptoms of depression and substance dependence through the activation of increasing rewarding experiences in their lives. Scheduling of the behavioral activation activities and other techniques to be completed outside the brief manualized therapy sessions should be done collaboratively by the therapists and individual vulnerable groups/families exposed to humanitarian crises.

iv. **Relaxation techniques:** Autogenic training, deep breathing, progressive muscle relaxation, massage, tai chi, yoga, biofeedback, music and art therapy, aromatherapy, meditation, and guided imagery can be used to move distressed people in humanitarian settings into a deep state of relaxation [37].

v. **Gestalt family therapy**: This provides face-to-face talk or body psychotherapy and addresses the intrapsychic and interpersonal impact of humanitarian crises to support improved overall psychological functioning and coping skills.

vi. **Cognitive behavioral therapy (CBT)**: CBT provides face-to-face, individual, or group-talking therapy (i.e., not online or via media or other materials) as well as a digital or Internet-delivered mode of intervention. It is useful in exploring and making explicit links between specific thoughts, emotions, somatic and non-somatic feelings, and behaviors of families within and outside the terrains of complex humanitarian crises. It is effective in positively changing a person's thinking ('cognitive') to elicit change in what they do (behavioral) [38]. Digital or Internet-delivered cognitive behavioral therapy (iCBT)

is a short-term therapist-assisted Internet-delivered therapeutic intervention for improving the well-being and overall mental health of families in complex humanitarian emergencies. The treatment program components consist of eight text-based modules, where each module is expected to be completed within 1 week.

vii. **Narrative exposure therapy (NET)**: This exposure-based, psychodynamic, narrative, and supportive counseling therapy is useful for the reduction of PTSD, depression, stress, and anxiety symptoms as well as improvement of functioning among individuals and families affected by humanitarian crises [39]. It was effectively used for the psychosocial management of refugees in Uganda [40], the survivors of the 2008 Sichuan earthquake in China [41], Mozambican civil war survivors [42], and widowed and orphaned survivors of the Rwandan genocide [43]. NET can be used to facilitate exposure to specific or non-specific reminders, cues, or memories related to exposure to a traumatic event [38]. It can be used to help persons or families affected by complex humanitarian emergencies to reconstruct a consistent and/or coherent narrative about their traumatic experience either verbally or through writing to aid symptom reduction [38]. Examples of NET include:

   - **Brief testimony psychotherapy**: This short-term therapy is useful for the psychosocial treatment of traumatized victims of war or other organized violence. The therapy consists of 12 sessions that enable patients to narrate their life stories, including traumatic experiences [44]. This brief therapy consists of six sessions, of approximately 90 minutes, weekly or biweekly [39].

## 8. Conclusion

Mitigating emergencies is necessary to overcome the overwhelming burden of losses faced by communities in distress. This paper looked into the psychological effects of complex humanitarian crises on families, the psychological needs of families affected by humanitarian crises, and therapies for groups and households affected by complex humanitarian emergencies. Therefore, this chapter emphasizes the need for innovative psychosocial support and family-focused therapies in the management of complex humanitarian crises.

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## Author details

Oluwatoyin Olatundun Ilesanmi[1*], Faith Ibitoyosi Ilesanmi[2] and Raouf Hajji[3]

1 Centre for Gender and Humanitarian and Development Studies, Redeemer's University, Ede, Nigeria

2 Centre for Gender, Health and Social Rehabilitation, Ile-Ife, Nigeria

3 Internal Medicine Department, Sidi Bouzid Hospital, Medicine Faculty of Sousse, University of Sousse, Tunisia

*Address all correspondence to: ilesanmit@run.edu.ng

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