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Psychological Work in Humanitarian Emergencies in Haiti and Democratic Republic of Congo: some considerations based on two work experiences¹

Intervenção Psicológica em Emergências Humanitárias no Haiti e na República Democrática do Congo: considerações baseadas em duas experiências de trabalho

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Abstract

Through the description of two examples of psychological interventions in humanitarian emergencies, this article aims to problematize the work of the psychologist in those situations. The concepts of “humanitarianism” and “emergency” are discussed based on two interventions made in Haiti and in the Democratic Republic of Congo. In both countries the mental health interventions happened inside a humanitarian organization and the objective of those interventions was to offer psychosocial support to the population of concern through a national mental health team. Cultural specificities, as well as theoretical and methodological challenges to the work of the psychologist in those situations are presented, especially those related to moral issues, to gender-based conflicts and to the insertion of the psychological work in a context where there is very little institutional support. Considerations related to theories and techniques of the area are presented, emphasizing the importance of interpreting the contents of the discourses taking into account the culture from where each person comes.

Keywords: Emergency Relief; Psychology; Psychological Aspects; Democratic Republic of Congo; Haiti.

Resumo

Por meio da descrição de dois exemplos de intervenções de saúde mental em emergências humanitárias, esta reflexão visa problematizar o trabalho do psicólogo nestas situações. Os conceitos de “humanitário” e de “emergência” são discutidos à luz dos trabalhos realizados na República Democrática do Congo e no Haiti. Em ambos os países, as intervenções de saúde mental se deram por meio de uma organização humanitária internacional e nos dois casos, o objetivo era oferecer apoio psicológico à população em conjunto com uma equipe nacional formada por profissionais de diferentes áreas. Em ambos os casos, as especificidades culturais, assim como os desafios teóricos e metodológicos da ação do psicólogo são apresentados, notadamente as questões morais, de gênero e de inscrição do trabalho psicológico em contextos de grande carência de redes e de seguridade social. Por fim, são apresentadas considerações a respeito de algumas teorias e técnicas já descritas para este tipo de atuação psicológica, enfatizando-se a importância da escuta e da ressignificação dentro do contexto cultural de cada sujeito.

Palavras-chave: Socorro de urgência; Psicologia; Aspectos psicológicos; República Democrática do Congo; Haiti.

Introduction

Psychological work in humanitarian emergencies is becoming more frequent in Brazil and in other countries. In Brazil, it is possible to take the 1st. *Seminário Nacional da Psicologia das Emergências e dos Desastres* (First National Seminar on the Psychology of Emergencies and Disasters), which was held in 2006, or the different workshops organized by the Regional and National Psychology Councils in 2010 and 2011, as examples of the growing interest in the theme. It is also possible to check the increasing number of psychological groups (volunteers, universities, NGOs and others) that are offering themselves (for free or through payment) to work in catastrophe situations, such as the mudslides in the mountains of Rio de Janeiro in January 2011.

To Fassin and Rechtman (2009), ‘trauma’ (directly related to war and catastrophes, making it be strongly linked to humanitarian interventions) has become a major signifier of contemporary times. It is connected, according to the authors, with the current compassion and humanitarian reasoning and moral, creating new politics of reparation, testimony and proof. It is possible to see, in the history of trauma, as the authors propose, a shift from what was, at the times of the First World War, a matter of doubt and discredit to those suffering trauma, to a current context where trauma is “[...] *an experience that excites sympathy and merits compensation*” (Fassin and Rechtman, 2009, p. 5).

Nevertheless, it is difficult to specify when the concept of “humanitarianism” was born. It is possible to describe the rise and the consequent development of the so-called humanitarian organizations. The Swiss Henri Dunant, after the Napoleon wars and the famous battle of Solferino, is accounted one of the most important actors in this story with his efforts around the creation of the International Committee of the Red Cross - ICRC (Forsythe, 2005; Fassin and Rechtman, 2009). It is since the end of the 19th century that the very idea of something being considered “humanitarian” in spite of other interventions starts to be discussed by different authors, in the sense that any intervention is human if it is made by humans; therefore, why have some acquired this definition - “humanitarian” -, but not

others? (Benevides and Passos, 2005) To what extent this concept can be used is a matter of great debate and disagreement, and also of great importance in the current Social Sciences, as stated by Fassin (2010) in his book about the rise of humanitarian reasoning: it is important to understand how this new language is imposed nowadays and how it seems to be better instrumented to produce political results; in addition, in what ways it is preferred to speak about humanitarian actions in order to legitimize international actions, such as 'preventive wars' and switches in political power.

Another point added in this history of humanitarian interventions by Fassin and Rechtman (2009) is what the authors call a "second era of humanitarianism" (p. 192), which consists in a shift from the strategies of negotiation, protection and attempts to have access to victims, as humanitarianism was in the beginning. In this second era of humanitarianism, the major international NGOs are also obliged by themselves to bear witness to what is happening to the people they are trying to take care of, moving ahead of the criticism the ICRC, for example, has received due to its silence during the II World War and the Nazi concentration camps.

The times of Henri Dunant are apparently long gone. The humanitarian interventions, whether the name is appropriate or not, are becoming more and more common in catastrophes, conflicts and lack of access situations, and have been used for different objectives during the last years (Harrell-Bond, 2002; Fassin and Rechtman, 2009).

In spite of that growth and the important questioning of the uses of the term "humanitarian" and even of the concept of "trauma" to validate what can be seen as political (or biopolitical, as Fassin and Rechtman would call) intentions, some characteristics can still define what is being considered as "humanitarian work" by international organizations: volunteerism (meaning: a strong willingness to help), contexts where there is lack of access to health care (due to shortage of staff and/or of infrastructure), the possibility of intervening in those situations (Bouchet-Saulnier, 2000), the independence of political and financial powers, and the possibility to bear witness to probable disrespects of human rights (Ferreira, 2004; Fassin and Rechtman, 2009).

On the other hand, "emergency" is understood here as an unplanned, sudden event, that results in important consequences to those that suffered this event (IASC, 2010). An HIV/AIDS project is described here as an "emergency", together with a post-earthquake intervention: in some contexts, untreated, badly financed, chronic diseases are emergencies, since those persons are in terrible need of the delivery of quality health care. The division between "emergency" and "urgency", even if is important for the health sciences, will not be discussed here, and the two terms will be used as synonyms.

In this context, this article aims to problematize the work of the psychologist in emergency situations through the description of examples of this work, taking into account this broader context of debate and growth of "humanitarian" interventions and the associated growth in interest in "emergency" relief.

The argumentation is based on two work experiences through an international non-governmental organization in the years of 2009 and 2010: an HIV-Aids program in the Democratic Republic of Congo and the post-earthquake emergency response in Haiti. The type of intervention that is mentioned in this article is a psychological work in humanitarian situations, as defined above, that has been gaining more and more space in the last decades (Baubet et al., 2003; Fassin and Rechtman, 2009) as an indispensable part of the broader health interventions made by international organizations. The challenges that it brings to the science of psychology and to the very concept of what it is to do a humanitarian work are still to be discussed. Another important point in the debate is the very idea of a psychological intervention, considering the growth and the processes that are related to humanitarian interventions, as stated above.

The above-mentioned organization focuses on health and emergencies, either natural or man-made catastrophes and situations where there is an important lack of health care. The psychological interventions happen inside broader health care projects, be it hospitals, mobile clinics, outpatient structures or vaccination campaigns, and are always in line with the main objectives of the project. One intervention may have a health component as

well as sanitation and logistical ones, such as the building of new health structures, or the building of latrines, or distribution of non-food items, as well as delivery of medical consultations, surgery and rehabilitation. The projects have a pre-defined period of time. They are evaluated every year, and their objectives reviewed if that is the case. The organization is present for a certain period of time and aims to, whenever possible, build local partnerships in order to assure a continuation of the health care delivered.

This leads to the fact that, in this organization, the main psychological interventions currently consist of training and supervision of local psychological teams, in order to strengthen the scope of action within local communities (due to language and cultural aspects) and to increase the possibility of continuation of a project after the organization leaves the country. As a foreigner or expatriate psychologist, the work will happen with a national team and the contact with patients and beneficiaries will be through their accounts, except when there is a situation that the team cannot handle or in which the team asks for help. The organization of their work, their logic of intervention and the discussion of cases are the most important aspects of the two experiences that will be presented here.

In order to debate those psychological interventions in the Democratic Republic of Congo and in Haiti, different references are used. Nevertheless, the debates are based on an effort to interchange the clinical psychological work with the cultural aspects of the persons who have received care.

In both contexts, the interventions were carried out inside broader health care projects, as explained above, in what can be called a “humanitarian” and an “emergency” context: the descriptions are about individual or familiar therapeutic projects, from which derive the methodological proposals and reflections. In both cases, the psychological interventions had two main objectives: to reinforce the national teams’ capacity to deal with the emotional suffering demands of the patients (or staff) and to increase the projects’ capacity to deal with psychological demands of patients and staff. Therefore, one of the important points of the analysis will derive from the following question: what is the cultural bias

and the cultural codes that are playing a role in this intervention set-up?

The non-governmental organization through which this work was carried out has its own way of collecting data from patients and consultations. This method consists in an Excel database where the mental health team should encode information related to the consultations made, a report (weekly or monthly) that should be written by the team on the main outcomes and other important registers of activities, such as trainings and supervisions, discussion of specific cases and reorganization of the mental health service. Therefore, the results and specific cases presented here in this article were collected on site by the author, through the method used by the NGO and through the author’s own notes.

DR Congo: humanitarian psychological work in the country where the king has never been

DR Congo was colonized by Belgium during the 19th century in one of the most violent and destructive processes of Africa (Hochschild, 1999). Despite the importance of the colony, the king who started it, Leopold II, never visited the reason of so much of his richness.

In this 70-million-people country, with 1.2 to 1.5% of HIV prevalence (PNMLS, 2008), and a strong feminization and ruralization of the epidemic, the needs are as enormous and diverse as its land.

Working with people living with HIV/Aids in DRC as a psychologist has brought a very interesting experience concerning how to deal with prejudice and the need of counseling and testing as many people as possible. Here it is important to reinforce that, in this situation, the work of the foreign psychologist was mainly with the national teams, and not directly with the patients. This has several reasons: language and communication difficulties, cultural comprehension difficulties and interest in training and improving the skills of the national team, which will stay in the country and can reproduce their work in other sites if possible.

This intervention was based on the counseling

perspective. The strategy of “counseling” is a very common one when dealing with chronic diseases such as HIV/Aids and tuberculosis, and has its base on three pillars: emotional support, educational support and information sharing (WHO, 2003; Souza et al., 2008). This means that the HIV counseling has a non-coherent approach in some way: it gives rules of behavior (how to take the medication, how to have sexual relationships, how to become pregnant, etc.) but it proposes to hear the person in a non-judgmental way (Souza et al., 2008).

In this project in Kinshasa, the capital of DR Congo, the psychological national team consisted of seven nurses trained in counseling skills and one patient that had been hired as a “peer counselor”, who was also trained in counseling skills and had the same tasks as the others. Their activity was inscribed in the daily path of the patients in the health structure and could also be activated on demand, that is, if either the nurses or the patient himself felt it would be good to talk to a counselor, they could also ask for them.

In a 20-bed hospital and a cohort of about 2300 patients, the main work of the seven counselors was to deal with the different steps of the treatment of patients. One of the most challenging situations was when a woman living with the virus would get pregnant and her husband, who was not aware of her serological status, would normally need to be informed that something was going on since she would have to follow special care during her pregnancy, the birth and the feeding of the baby in the first 6 months.

The counseling staff, worried that this husband would leave his wife after finding out she had the virus, managed to invite the husband and the wife at the same time to do the test; so, the woman would take it for the second time, pretending it was the first. The idea behind it was that, if he found out at the same time as her that she was HIV positive, he would be less likely to be upset since the counselor would be there and would help to explain to him what that meant.

Although the team agreed that this strategy was very strange, it was the only one they could think about to avoid the common “divorces of the HIV” that they had experienced. By discussing that strategy

in more detail, one other important element came to light: it was one of the counselors, who was HIV positive herself, who had pushed months before for that strategy, since she herself had been thrown on the street when her husband’s family found out she had the virus. It was only after five or six years living on the streets of Kinshasa that she found treatment for her and, little by little, started to work as a volunteer until she got the job as a counselor and “peer support” staff.

This situation expressed a confrontation between a certain kind of “truth” - since the team was lying to those women’s husbands in order to avoid worse consequences - and a cultural solution to a cultural problem. It also brings an important challenge to a foreigner psychologist, who may look at it and directly label that strategy as a “lie”, not considering the cultural context in which it was created. Nevertheless, since the team was also not comfortable with that solution, it was decided to adapt it to two other proposals: an intervention in the community to explain to men the importance of the HIV/Aids testing and the consequences of discovering yourself with Aids, and the proposal that all women coming to be tested could come again with their husbands if they wanted to.

In one of his works, Nathan (1988) describes a similar situation with Maghrebien couples that looked for artificial insemination in France: a practice condemned by culture, which also condemned not having children. But why, and how, would those people look for medical help? To him, medicine was considered by those persons as a mixture of fear and respect, just like the domain of the sacred things, and that permitted its inscription in their way of dealing with the fertility problem. The works of Nathan are considered by some, including Fassin and Rechtman (2009), as another form of colonialism, since they try to explain all the differences of foreigners (be them immigrants, as in this study of 1988, or locals from developing countries) as being related to culture, probably excluding or justifying some intolerable inequalities as being a cultural aspect. Although this criticism is pertinent to a large part of what is called ‘ethnopsychiatry’ (a psychiatric field developed strongly by Georges Devereux, Tobie Nathan and successors), it is important to notice

that research using that perspective also brought to psychology and psychiatry a contrast with anthropology and sociology.

For this group of Congolese participating in the project, having and raising children seemed to be an identity for women. HIV/Aids, in this sense, brought a very strong difficulty in the fulfillment of this task, since women would then need to take special (meaning: non-expected, abnormal) care of themselves, their sexual intercourse and their babies if they wanted to become pregnant. Not understanding the strong relation that exists between expressing to their husbands their HIV status and the cultural place of women in that society would render impossible the task of helping them to continue living.

Port-au-Prince: post-emergency relief in the country where night starts after mid-day

Are catastrophes natural? Or made by God? Or just a matter of chance? The most recognizable mark of a catastrophe can be defined as its incertitude and unexpectedness.

In a post-earthquake context, those questions arise all the time from visitors to citizens, from children to adults, patients to health staff. On the 12th of January 2010 a strong earthquake hit Haiti, the poorest country in America, and left about 230 thousand people killed and more than one million unsheltered.

As the psychological intervention carried out by the same specific international humanitarian organization focused on the staff and the patients who were hospitalized during the days that followed the event, the amount of people that referred that God was the only helper they had was enormous. Some Haitians mentioned that God caused the earthquake to kill persons who had sinned; for others, it was after the survival that God appeared to be important.

In this case, the national team had to be hired in a hurry: this hospital became a project for the international organization just two days after the earthquake, and had only one Haitian psychiatrist to work with the demands of patients, that increased exponentially in the days following the event. For

this reason, a new team was hired and consisted of two Haitian psychologists and two Haitian social workers, who were first divided by wards (there were two wards, a maternity and a traumatology one) and then by group of interest: staff or patients. First, the focus was on the staff and the most urgent patients and families, and after a few weeks it was possible to follow up all patients that were hospitalized when the work with the staff had diminished. The objectives of the mental health intervention were to increase the project's capacity to deal with the emotional suffering of patients and staff, related or not to the earthquake, and to organize the psychological service in the logic of the hospital's health treatment.

From all the life stories that it was possible to get in contact with, the one of Florence (names were changed), 13 years old, was one of the deepest. Fourteen members of her family were killed on 12th of January 2010, and only she and her father survived. She had an injury on her right leg, due to the fall of her house over her, and on her left hand. Together with her, other teenagers were also hospitalized in this 100-bed hospital that became a traumatology center after the event and that worked with its full capacity during the following month.

The strategy decided by the team of two Haitian psychologists and two Haitian social workers was to discuss with her father how the bad news of the death of her family members would be given to her and, at the same time, to try to establish some channels of communication between her and the other teenagers of the hospital since her injuries required a long and hard hospitalization.

Together with this first situation of mourning, the father had to deal with another unexpected event, as well as the team: Florence had to amputate one finger from her injured hand due to an infection a few weeks after the quake, and this was only decided when she was already unconscious for the cleaning of her wounds in the surgical room. He was called by the doctors to give his agreement and, when she woke up from surgery, he asked the mental health team if he could tell her that the finger would grow up again, since he was very uncomfortable with the role of bearing this other bad news.

With that situation, it was possible to discuss

with him the importance he would give to telling the truth, as difficult as it might be, and with as much care as it was possible. Again, the importance of telling the truth had to be seen in his culture. Even if this intervention, like in DR Congo, was made by the national, Haitian, team, it was an occidental version of truth that was being discussed: a child must not be lied to, no matter the situation. This father was worried of all the other “truths” he had not told his daughter, such as the number of members of their family that had died, the real feelings he had for her mother, who had abandoned them, the fear he had himself of starting their lives again, and the fear that she would be criticized by others due to her handicap. By discussing these concepts of truth and lies, the national team managed to help him think about the reasons and consequences of his decision, and help him to decide where he wanted to put more effort on.

For the father, the balance between the fear of her being rejected by their community due to a handicap had to be balanced with the fear of losing the love of the only family member he had left, if she discovered the news by herself or someone else other than him.

This girl had also started to contact other teenagers, through a group of teenagers one of the social workers developed at the back of the hospital, out under the sun. He managed to teach them how to use the wheelchairs and crutches, and invited them every day at the same time to come and play, talk, sing, and, through this, talk about difficult subjects, such as amputation, loss of family members, tiredness of hospitalization, fear of the surgical ward. The group quickly started to meet even in extra hours, when the teenagers managed to find one another and enough wheelchairs to move around the hospital.

As for the religious explanations that had been found for what the country and themselves were going through, the group strategy and the willingness to play and talk about teenager interests were also other forms of elaborating and dealing with the suffering in this micro-sphere of the hospital that was found in this situation. Curiously enough, the screams of pain were mainly religious, especially from women: “Jesus” was the most common one.

In Haiti, night does not seem to frighten those few patients: even if Haitian politeness says that one should greet “good evening” after mid-day, even with the sun as high as possible and the light very strong, for those Haitians the strength of life and the capacity to deal with the unexpected and the horror seem to be beyond limits for the vast majorities of those that were met – what would be the other choice? To consider this population as ‘traumatized’, as sick of ‘post-traumatic stress’, as ‘in need’ of a strong psychic treatment, taking away their history of survival (even if, it is easy to see, there were not so many choices), may mean removing an important part of their identity and resources. There definitely lies the challenge to the psychologist: to what extent should social problems be “analyzed” as personal problems and how far shall we go in this discussion if the easiest and quickest thing to do may be giving psychological treatment?

A Few Methodological Questions for Psychological Intervention in Emergencies

There are innumerable questions that arise from any intervention, and it is not different when this action takes place in a very complex and needy context and also abroad, out of the psychologist’s own language and culture. One could argue that the very existence of an intervention can be questioned, since it risks replacing a (non) existing responsibility of the authorities to take care of the citizens. The challenges that the psychological work faces are, above all, based on its own need: how can support be given to someone that has lost everything and has many difficulties in finding social support? How can “support” be defined? Is it medication, religion, therapy, money, political change, or all these? Or none?

Many possibilities of answer have been discussed for this problem in the history of psychology and humanitarianism. They are presented below in three summarized groups: focus on treatment of diseases, focus on social and anthropological aspects, and focus on the clinical and psychological aspects of the person or small group of persons. Despite this division, that is only didactic, it is fundamental

to highlight that the psychologist can work, and does work, with any of those three approaches in a humanitarian intervention. What is normally seen is a combination of the three, with more emphasis on one or the other.

The focus on the treatment of diseases has a good example in the creation of the concept of Post Traumatic Stress Disorder (Young, 1997) by American psychiatrists after the Vietnam War. With that approach, the mental health team will look for signs and symptoms of this pathology in the patients, and treat the few ones that can be put in that category (Cloitre, 2009). The risk that this approach brings (Pedersen, 2007) is mainly the possibility of “pathologizing” a normal and expected reaction to a loss, grief, mourning or to a collective despair situation (Di Loreto, 1997). The value, though, is that the very few ones that really have a dysfunctional and non-elaborative reaction can be supported (Hustache, 2009).

The social and anthropological focus is very well described in the concept of “social suffering” as found in the work of Veena Das (2007) and Arthur Kleinman (1997). Suffering comes from a congregation of elements, such as health, society, justice, well-being and politics, which are materialized in the bodies and languages of the subjects. Therefore, an intervention is made in that congregation of factors, and has a special focus on the political and social aspects that are related to the very cause of the suffering. The risk of this approach, in humanitarian interventions, is the magnitude of each element: there are lacks and problems in so many aspects that the broader focus it brings may get lost. The added value, if compared to the medical approach, is clearly the addition of other elements of analysis and comprehension of the problem: instead of dealing with consequences, there is the possibility of working on the agents of this nameless suffering.

The focus on the clinical and psychological aspects of the person or small group of persons has many different expressions, depending on how much it is linked with a medical comprehension or with a social/ anthropological comprehension of human suffering. It can be purely a psychotherapy proposal, such as individual support sessions, group sessions,

relaxation sessions, or a social-psychological proposal, such as therapy combined with interventions in the environment, in the logic of the health care service, or in the community. The psychological approach, in a humanitarian intervention, is no different from an intervention in a crisis or trauma situation in more stable contexts (a context where there are health and social institutions functioning, and where people have a minimum of quality of life and dignity) - it does have a much larger scale but should be based on the same reflections about elaboration and cultural adaptation (Knobloch, 1998a, 1998b).

That means: the psychologist can also be the one to ensure that the basic needs are being provided, such as shelter, food, information on the situation, some “normalization” of life, in order to promote possibilities of dealing with the suffering.

If human beings are built in relationship, with reciprocity, the rupture that trauma brings to life has to be restored by relationship. The importance of bringing back, by talking, the heritage, the story, the culture of the persons, is paramount for a successful intervention.

The added value of this approach is the possibility of giving special attention to how each person lives and experiences the situation, and developing an adapted intervention project to each one. The challenges it brings are many: for example, choosing a focus, be it a person, a group of persons or a situation when the entire support network is affected, destroyed or is non-existing.

The two interventions presented above are based on individual or small group support strategies. They are also clearly identified with a health perspective, rather than a disease treatment focus. This means that there was an attempt to find the main strengths and possibilities of persons, in their culture, in their support strategies and with the impact of the “global” culture - how they could deal with the social problems they had. The focus was not placed on the roots of those problems - why do houses fall more in Haiti than in Chile? Why is HIV/Aids infection affecting more and more poor and rural-based women all over the world? -, even if it is mandatory that, for any likely intervention, it is necessary to

comprehend and try to understand the stories of collective suffering and inequalities that are behind the individuals, as well as to be attentive to acute cases that can arise.

Final Comments

The role of the psychologist in humanitarian emergencies is strongly evident. In spite of that, the methodology of work, and the theory behind it, are in constant challenge due to the complexity of the context and the size of the task.

The two short experiences presented in this article are examples of concrete cases that can be faced in those interventions, and are not to be taken as a guide to action.

Brazil, nowadays, wants to develop its expertise in this matter of psychosocial interventions in crises and disasters and has actually already started to do it. If that will be an opportunity to debate methodologies and the production of them in society, or another misuse of a concept - as was said before, are humanitarian emergencies, for the psychologist and for human suffering, that different from other forms of suffering? It is still to be seen.

References

BAUBET, T. et al. *Soigner malgré tout: trauma, cultures et soins*. Grenoble: La Pensée Sauvage, 2003. v. 1.

BENEVIDES, R.; PASSOS, E. Humanização na saúde: um novo modismo? *Interface*, Niterói, v. 19, n. 17, p. 389 - 394, mar.-ago. 2005.

BOUCHET-SAULNIER, F. *Dictionnaire pratique du droit humanitaire*. Paris: La Découverte, 2000.

CLOITRE M. Effective psychotherapies for posttraumatic stress disorder: a review and critique. *CNS Spectrums*, New York, v. 14, n. 1, p. 32-43, jan. 2009. Suplemento 1.

DI LORETO, O. D. M. Em defesa do meu direito de ser triste. *Psicologia em estudo*, São Paulo, v. 2, n. 3, p. 1-52, 1997.

DAS, V. *Life and Words: violence and the descent into the ordinary*. London: University of California Press, 2007.

FASSIN, D.; RECHTMAN, R. *The empire of trauma: an inquiry in the condition of victimhood*. Princeton: Princeton University Press, 2009.

FASSIN, D. *La raison humanitaire: une histoire morale du temps présent*. Paris: Seuil, Gallimard, 2010.

FORSYTHE, D. P. *The humanitarians: The International Committee of the Red Cross*. New York: Cambridge University Press, 2005.

FERREIRA, J. *Soigner les mal-soignés: ethnologie d'un centre de soins gratuits de Médecins du Monde*. Paris: L'Hartmann, 2004.

HARREL-BOND, B. Can humanitarian work with refugees be human? *Human Rights Quarterly*, Baltimore, v. 24, p. 51-85, feb. 2002.

HOCHSCHILD, A. *O fantasma do rei Leopoldo: uma história de cobiça, terror e heroísmo na África colonial*. São Paulo: Companhia das Letras, 1999.

HUSTACHE, S. et al. Evaluation of psychological support for victims of sexual violence in a conflict setting: results from Brazzaville, Congo. *International Journal of Mental Health Systems*, Londres, v. 3, n. 7, 2009.

IASC. Reference Group for Mental Health and Psychosocial Support in Emergency Settings. *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* Geneva: IASC, 2010.

KLEINMAN, A. *Writing at the margin: discourse between anthropology and medicine*. London: University of California Press, 1997.

KNOBLOCH, F. Reflexões sobre o tempo do traumático. In: KNOBLOCH, F. *O tempo do traumático*. São Paulo: Educ, Fapesp, 1998a. p. 115-149.

KNOBLOCH, F. Le travail du trauma. *Les lettres de la Société de Psychoanalyse Française*, Paris, v. 2, n. 4, p. 121-131, 1998b.

NATHAN, T. *Psychoanalyse païenne: essais ethnopsychanalytiques*. Paris: Dunod, 1988.

PEDERSEN D. Reformulando a violência política e efeitos na saúde mental: esboçando uma agenda de pesquisa e ação para a América Latina e região do Caribe. *Ciência e Saúde Coletiva*, Rio de Janeiro, v. 11, p. 1189-1198, 2007.

PNMLS. Programme National Multisectoriel de Lutte contre le Sida. *Rapport national du suivi de la mise en oeuvre de la déclaration d'engagement des chefs d'état et de gouvernement sur le VIH/Sida (GNNAS)*. Kinshasa: PNMLS, 2008.

SOUZA, V.; CZERESNIA, D.; NATIVIDADE, C. Aconselhamento na prevenção do HIV: olhar dos usuários de um centro de testagem. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 24, n. 7, p. 1536-1544, 2008.

WORLD HEALTH ORGANIZATION (WHO). *Adherence to long term therapies: evidences for action*. Genebra: WHO, 2003.

YOUNG, A. *The harmony of illusions: inventing post traumatic stress disorders*. London: Princeton, 1997.

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