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The International Operational Response to The Psychological Wounds of War: *Understanding and Improving Psycho-social Interventions*

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Introduction

The character of intra- and inter-state conflict has changed dramatically in recent decades. Prior to the Second World War, conflict victims were predominantly found between "established fighting units such as government military troops and armed opposition groups."[1] Today, however, conflicts inflict their greatest harm on civilian populations, 80% of whom are women and children. In the 1990s alone, civilian populations endured nearly 90% of the casualties resulting from war representing a sharp increase from approximately 5% in the 1930s only 60 years prior.[2] The practice of civilian targeting has resulted in mass population movements, or forcible displacement, on a scale previously unknown. In 1999, an estimated 7 million people were driven from their homes by war, civil insurgency or political repression, which "increased the world's uprooted population to 35 million, 14 million of which were refugees."[3] This has taken a huge physical and psychological toll on war-affected individuals and their societies.

The psychological injury incurred by millions as a result of conflict and displacement was, until recently, "invisible" or of secondary concern to international organizations (IO). However, since the 1980s, IOs have taken steps to address them, further facilitating the healing process through "psycho-social" interventions. IOs defend their programs on the basis of widely upheld notions that if massive trauma is left untreated the individual, community and society will suffer the devastating backlash for generations. True rehabilitation and sustainable peace are unattainable objectives if the healing process is not brought to fruition. Operationally speaking, this has led IOs to expand their programming base. While meeting basic needs (food, water and shelter) remains central to relief efforts, alone, however, it is considered insufficient. Most IOs would agree with Kimberly Maynard's view that, "conventional international relief such as food, health care, and shelter does not directly address these less tangible war wounds."[4]

IOs have asserted their commitment to support programs that aim to facilitate

[1] Maynard, K.
[2] Final Report, The Carnegie Commission on Preventing Deadly Conflict
[3] Newmyer, J.
[4] Maynard, K.

healing of "invisible" wounds.[5] Their commitment has been made clear through verbal promises, funding allocations and projects implemented in the field. While their commitment to overarching objectives is solid – their strategy in achieving these objectives is less clear. The lack of agreement and cohesion is clear within and among IOs in a thorough study of the field. First, the field as a whole suffers from the lack of a shared understanding of terms and a shared view on what precisely constitutes a psychosocial intervention. Second, debate and disagreement (sometime contentious) exists among actors (e.g. relief workers, organizations, mental health professionals and academics) and within organizations as to the most appropriate approach to interventions and providing assistance. Third, the field lacks a number of elements and components critical to any assistance programs (evaluation indicators, etc.) leaving any discussion of programs based more on anecdotal evidence than hard data.

This paper has for its objective to add clarity to the discussion surrounding psycho-social work and interventions. In order to accomplish this objective, the paper will first discuss terms and set out the parameters in which psycho-social interventions are currently defined. Second, it will touch on issues central to the debate and disagreement surrounding psycho-social interventions highlighting in particular the dominant paradigms for intervention. Third, this paper will propose a meeting place for actors and dissenters in light of existing debate. Finally, this paper will highlight areas that warrant further investigation and investment and will also put forth recommendations to IOs for action.

The "Trauma of War": The psychological impact of war

Mental health professionals are often found pointing to the likely implications that psychological trauma resulting from war will have on an individual and his or her community and society. This argument is made pointing to both the day-to-day functioning and the long-term well-being of an individual and the society. Although some individuals may escape death, as their societies are ripped apart by conflict, as survivors

[5] In 1987, the IFRCRCS asserted that the "psychological problems are by far the most important health concern of refugees and asylum seekers and stated that the "new feature (of its programming) is the psychological support for victims."[5] WHO also maintains that the psychosocial rehabilitation of forcibly displaced populations is a "main field of activity" among its operations.[5] UNHCR's commitment to alleviating psychological distress among forcibly displaced populations is revealed in its support of both continued research and the development of psycho-social interventions to assist displaced populations.

they are forced to continue their lives, burdened by heavy losses (friends and family members, livelihood, familiarity and identity are among the most commonly experienced). This experience of *massive trauma* (trauma suffered on a wide-scale), takes a toll on many levels, "intimate exposure to brutality and subsequent displacement and civil disorder leave individuals psychologically scarred and the intricate network of social interaction deeply torn."[6]

This does not mean that every individual will suffer from serious mental illness requiring acute psychiatric care, but the vast majority will "experience low-grade but long-lasting mental health problems."[7] At the same time, while the extent and type of suffering experienced endured by individuals varies, it is clear that no one living within a society engaged in war escapes unscathed.[8] The experience of trauma does not end, or "disappear with the ceasefire"[9] or displacement, and life in a refugee camp or transitory settlement, can constitute a "secondary wound".[10]

In many transit settlements, in the period following displacement, the threat of violence is high, children and adolescents are frequently forcibly recruited for military service, and the rates of morbidity and mortality are high, due to overcrowding, poor sanitation and disease. These characteristics coupled with the constraints and boredom of living in a camp usually contribute to the development of a prevailing sense of hopelessness and despair.[11] This, too, constitutes a traumatic experience.[12] Terr maintains that there are two forms of trauma, which she refers to as Type I and Type II. The former referring to single-event based trauma and the latter referring to on-going, or continual trauma.[13] Life in a refugee camp constitutes Type II trauma. A review of Terr's work highlights that the "psychological response to a single event results in PTSD and Type II leads to coping mechanisms (e.g. massive denial, numbing) which develop into characterological and mental health problems."[14]

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[6] Maynard, K.
[7] Mollica
[8] Mollica, R, (2)
[9] De Jong, K.
[10] Mollica, R. and R. Jalbert
[11] Jamal,A.
[12] Crisp, J.
[13] Terr, L.
[14] McCloskey, L., p.2. McCloskey adds that "there has been little empirical support offered for the distinction between single- and multiple-event trauma."

The psychological domain has clear physical implications, as research shows that "trauma can damage all organ systems, causing serious physical and psychological disability." Clinical conditions such as depression and schizophrenia are linked to premature death in refugee populations. WHO maintains that, "long term adverse effects on mental health should be expected in victims of serious violence, particularly when this involved a serious threat of death."[15] The experience and impact has a ripple effect spanning into other spheres of life. Studies have shown that wide-scale trauma can have a deleterious effect on economic well-being measured in diminished productivity (a direct result of health decline). According to Dr. Richard F. Mollica, Director of the Harvard Program for Refugee Trauma, "epidemiological surveys show that this emotional distress is risking lives and affecting economic performance."[16] A number of models explain the significant linkages between psychological and physical impact of trauma (see Models of Trauma and Disability[17] and Baker's Biopsychosocial Model [18]). The importance of acknowledging these links is discussed further in the paper.

The effects of trauma can span years and even generations. Longitudinal studies of holocaust survivors and survivors of the terrors inflicted by the Cambodian Pol Pot Regime and their offspring (and their offspring, or second generation), reveal the intergenerational transmission of trauma.[19] It is now a widely held view that "the effects of massive trauma, tragically…do not end with the deaths of the survivors and may continue as 'unfinished business' into the lives of their children."[20] Studies have shown that both "parental suffering and parental crimes affect children."

The impact is multi-dimensional. For example, studies have found that, "children of seriously depressed mothers are less likely than other children to develop secure attachments in the first year of life (Osofsky, 1995). Neglect is common, leading to the prospect of inhibited brain development."[21] In conflicts where children are often forced to perpetrate crimes, there is also considerable danger posed to future

[15] WHO meeting convened in The Hague (1981) from Psychosocial Problems of Refugees, page 17.
[16] Mollica, R. (1)
[17] Ibid.
[18] The Psychosocial Problems of Refugees.
[19] For further information on the inter-generational, or "transgenerational" transmission of trauma, see Lumsden, Malvern, "Breaking the Cycle of Violence."
[20] The Psychosocial Problems of Refugees
[21] Apfel, R. and Simon, B. (eds.), p. 36.

generations.[22] A number of articles have focused on the impact that psychological trauma, feelings of hopelessness and despair, among displaced populations, can have on children, leaving them more vulnerable to the incitement of violence.[23]

When these findings are applied to modern-day conflicts, the resulting prognosis is grim. One worker from Doctors without Borders (*Medicins sans Frontiers, MSF*) in Sierra Leone asserted that the severe "psychosocial problems...may ultimately threaten the prospects for long-term stability in society." While an Interagency Appeal for the CIS region claims that psychological trauma is "deep" and will "probably lead to irreversible psychological consequences."[24]

Studies have found that there is a strong linkage between psychological trauma and poorer nutrition. An article entitled "Mental Health Needed for Caring Capacity"[25] by Saskia Van der Kam draws a "direct link between the mental state of emergency affected populations and care provision at household and community level." The author argues that, "nutritional status is often influenced by the mental health of emergency-affected populations." Meaning, in part that, the "mental health of individuals can affect their ability to provide care for dependents" which would implicitly have "repercussions for the physical and nutritional state" of their family members. The author highlights the importance of mental health in the ability of a society to undertake reconstruction and reparation after the conflict is over. She asserts that "a society needs to be mentally healthy to make optimal use of the 'rehabilitation' resources made available by agencies in the wake of an emergency in order to improve nutritional and food security, e.g. agricultural programmes, nutritional education."

The Response of the International Community

The psychological wounds resulting from the "trauma of war" have caught the donors' attention – and their funding – in the last two decades, particularly in the last ten years. Some argue that the visible surge in "psycho-social" programming was a reflection of a virtual "'take-off' in concern over psychosocial impacts of trauma" that

[22] Bar-On, Dan in Apfel, R. and Simon, B. (eds.), pp. 165-166. It is important to note here that there is "less information on the effects of the holocaust on descendants of Nazi perpetrators." (page 166).
[23] See Report on Burundi and violence in Camps. Also see Lumsden, Malvern, "Breaking the Cycle of Violence".
[24] Agencies submitting appeal: WHO, UNFPA and UNICEF
[25] Van der Kam, S.

occurred in the 1990s as a result of the conflict and brutality that led to the disintegration of Yugoslavia. [26] The tendency for organizations to discount the psychological impact of conflict and displacement – as a separate realm, diminished as the interplay between the psychological and social dimensions of suffering became more clear. Psycho-social interventions are founded on the premise that there is a formidable interplay in the psychological and social dimensions of suffering, and therefore, recovery as well.

Kimberly Maynard in *Rebuilding Community* examines the relationship of these dimensions:

> "The psychological and social damages of war are inexorably intertwined. Poor individual psychological health erodes community stability through the exhibition of paranoia and blatant mistrust, irrational behavior, and the need for constant care. At the same time, ruined social institutions and inter-group relations further the impression of chaos, exacerbating mental vulnerability. As a result, internal warfare can have extreme deleterious effects on the psychosocial health of communities subjected to violence."[27]

Although there is significant speculation as to the reasons for the growing interest and concern in the psychological implications of suffering and need, it is likely the result of *factor convergence*. As an individual's suffering has psychological and social components, it follows that interventions to treat their suffering would be most effective were they to promote healing and reparation in both areas as well. This determination is, however, beyond the scope of this paper.

The most critical issue with the regards to this shift in thinking is its result: the arrival of hundreds of IOs and NGOs who devoted extensive resources to healing through "psycho-social" interventions.[28] The sheer number of projects and publications, financial and human resource investments related to psycho-social interventions reveals their newfound popularity among donors, IOs and NGOs. As is so often the case with funding cycles for relief and development assistance – as funding trickled in – a practice was borne. Psycho-social interventions and activities have since become an integral part of programs popular among donors and IOs.

Existing Confusion

Despite the growing consensus that the issues and field warrant further attention and resource investment, confusion persists as to what precisely constitutes a psycho-

[26] Sinclair, M.
[27] Maynard, K., p. 208

social intervention. The field remains plagued by questions and ambiguities. Among some of the questions most commonly asked – and warrant considerable attention – are: How can "psycho-social" interventions be distinguished from any relief intervention that leads to greater psycho-social well being – such as Income Generating Activities (IGA)? One can hardly argue that interventions such as this, which promote and result in economic gain, financial independence and are likely to restore to some degree an individual's sense of dignity, do not play a role in restoring and improving a war-torn society's psycho-social well-being.

There is also significant confusion as to whether or not psycho-social interventions are different from mental health ones? And if so – how? And who, internally and externally, both inside and among organizations, is responsible for ensuring that assistance is effective and appropriate? And in light of these ambiguities, what qualifications are – or more importantly – *should* be considered as criteria for those designing programs and providing assistance?[29]

Evidence of this confusion within organizations – and the lack of clarity that surrounds the psycho-social field – is pervasive. One example is found in UNICEF's annual financial statements for *Assistance Programs in Central America* (1999)[30]. The statement for Honduras places "psychological support for children, teachers and communities" in the *Education* sector, whereas "psychosocial support for women and children"[31] is found under *Shelter* expenses. In the case of Nicaragua, however, "therapeutic play activities for 300 children leading to detection of cases needing psychological intervention; and related training of teachers, community leaders, parents, and volunteers" is considered as part of the *Special Protection Measures*. And in the

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[28] Sinclair, M.

[29] Sought qualifications vary among organizations. For example, The Center for Victims of Torture (CVT) announced that it was looking for "mental health professional/trainers" to work in refugee or IDP camps in Guinea and Sierra Leone whose responsibilities included: providing psychosocial mental health interventions for refugee children and adults (including individual counseling, group therapy and community training; conduct needs assessments); designing and implementing a training program for refugee community counselors, coordinating with other assistance organizations in the area and program evaluation. CVT requires a "Masters Degree or PhD in Psychology or Clinical Social Work, Experience implementing culturally appropriate mental health interventions in Africa; experience providing individual, group and community mental health interventions for children and adults traumatized by torture and/or war and fluency in English (and, preferably, French). The Center also requires experience in supervision, training, needs assessment, and program evaluation. (Relief web).

[30] www.unicef.org for further information

budget for El Salvador, "provid(ing) psychological and emotional support services for people in the affected areas, particularly children and women" is included under *Health*.

While it is beyond the objective of this paper to argue where precisely such interventions *should* fit in, it is important to understand why further clarity in this regard is critical in the effectiveness of psycho-social interventions. Unclear and undefined parameters leave wide-open the possibility for project duplication, while limiting information-sharing procedures and capacity-building among and within organizations ultimately leaving the development of a "lessons learned" out of reach. Moreover, it limits accountability, and leaves donors and organizations confused as to which programs are most needed. Furthermore, the current structure limits the capacity and celerity by which information can be gleaned from previous interventions.

The psycho-social field: A wide-spectrum of interventions

The very definition of psychosocial elucidates the complexity of making a precise determination as to what precisely constitutes a psycho-social intervention. According to the *Penguin Dictionary*, the term *psychosocial* is "generally, a grab-bag term used freely to cover any situation where both psychological and social factors are assumed to play a role."[32] Adding to the complexity of the field is the prolific and inconsistent use of the term to describe different aspects of an individual's condition, entitlements and needs. Literature discusses the psycho-social characteristics of an issue or condition, insofar as it relates to an individual's well-being, health, stress, treatment, problems, vulnerability, rehabilitation and competence.

To further complicate our understanding, the literature is replete with hybrid descriptor words, which share only the "psycho" prefix but could also be considered psycho-social interventions. One example of this is *psycho-educational* interventions. The resulting confusion, paradoxically clear to anyone undertaking research or developing interventions, is not, therefore, surprising.

A salient characteristic of the field is multi-sectoral involvement, including the interest and contribution of organizations whose mandates include primarily activities in sectors such as education, development, peace-building and conflict resolution (to name a

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[32] The Penguin Dictionary of Psychology.

few). Actors from these domains (and others) aim to play a catalytic role in the healing process. The following excerpt encapsulates the above assertions:

> "The increased international interest in psychosocial issues has led in several related directions. From one perspective, relief and development specialists are reviewing options for mitigating tensions indirectly through community-based reconstruction projects. From another perspective, conflict resolution professionals -- mediators, academics, NGOs and private associations -- are beginning to look at the potential for "field diplomacy". In contrast to the more conventional direct methods of settling disputes involving high-level leaders in short-term cease-fire negotiations, field diplomacy features conflict managers engaging community members over root causes, for an extended period of time. And from yet another direction, psychologists are ascertaining the applicability of PTSD therapy in the Western context to civilians in Third World civil wars."[33]

Operationally speaking, psycho-social interventions are those programs that address the psychological and social needs of individuals and, often, targeted groups. A comprehensive explanation of psycho-social insofar as it relates to IO and NGO interventions was put forth during a conference on "Psychosocial Care and Protection: Children in Armed Conflict" which took place in Nairobi, Kenya in 1997:[34]

> "The word "psychosocial" simply underlines the dynamic relationship between psychological and social effects, each continually influencing each other. "Psychological effects" are those, which affect emotions, behavior, thoughts, memory, learning ability, perceptions and understanding. "Social effects" refer to altered relationships due to death, separation, estrangement and other losses, family and community breakdown, damage to social values and customary practices and the destruction of social facilities and services. "Social effects" also extend to the economic dimension as many individuals and families become destitute through the material and economic devastation thus losing their social status and place in their familiar social network."

It is in the context of psychological and social needs that interventions are based. Psychological needs relate to: 1) emotions; 2) learning capacity; and 3) cognitive development. Social needs relate to: 1) interaction with family and community; and 2) participation in the social environment.[35] A significant part of psycho-social theory is grounded on paradigms that focus on "stressors," risk and protective factors. These variables have been called the "push and pull concepts, the former being the negative influences (or the stressors) and the latter implying the protective factors."[36] It is the individual's coping resources that mitigate their response. An individual's needs in

[33] Maynard, p. 209
[34] "Psychosocial Care and Protection: Children in Armed Conflict," Conference Report.
[35] Ibid.
[36] Reaching Children, p. 119

combination with his/her specific traumatic experience influence the outcome, or reaction, they have as a result of their experience.

Among the protective factors highlighted within psychological and psycho-social literature are: 1) individual coping abilities; 2) family strength and unity; 3) social network; and 4) ideological, political, and/or religious consciousness. Some stressors highlighted in psycho-social literature are: 1) economic hardship; 2) social disruption (separation from family, disappearance of family members, downward change in social role); 3) physical/psychological violence; 4) ethnic persecution; 5) loss of home, country, family, friends; 6) danger/abuse during flight; 7) reception at arrival after flight; 8) settlement in collective centers or private accommodation; and 9) uncertainty about the future. Taken together, some of the post-traumatic risk variables put forth by WHO are:

1. Pre-trauma personal and socio-cultural factors (age, sex, personality type, personal and family history, social setting and organization, political involvement/maturity, cultural interpretation of events, etc.);
2. Nature of the trauma (some may be more deeply felt than others and have more long-lasting effects);
3. Length of exposure to the trauma;
4. Cumulative number of trauma events suffered; and
5. Immediacy and effectiveness of helping interventions.

The objective of a psycho-social intervention, most simply put, is to "enhance the existing psycho-social protective factors and (to) decrease the psycho-social stressor factors at different levels of intervention."[37] It is interesting to note that *the term describing the intervention indicates the overarching objective of the intervention itself*: *to address the individual's psychological and social needs*.

On the ground, psycho-social interventions most often target individuals who are at increased risk of experiencing psychological distress, or developing pathology, who have implicitly heightened vulnerability or those who have "special needs", according to UNHCR. A well-designed program takes into account the aforementioned factors or characteristics of individuals or groups. A thorough and accurate assessment of these variables is critical in an organization's capacity to: 1) identify those in need; 2) determine precisely what they need (that can be provided or more easily obtained with the assistance of the organization); and 3) design a program to meet their needs

[37] The Psycho-Social Projects Under War Conditions

effectively. A number of paradigms employed by IOs are pulled from psychological and developmental theory (e.g. Maslow's Hierarchy of Needs). And organizations, in addition, have also developed their own models for intervention, matching level and type of need with specific provider and/or program (e.g. ICRC Psychosocial Pyramid).

Limited financial and human resources that characterize relief and assistance in a complex humanitarian emergency (CHE), often require the provider, or intervenor, to adopt a system of *triage*.[38] For psycho-social programming this translates into the development of programs to address the needs of groups that can be identified on the basis of specific characteristics or specificity of needs (e.g. unaccompanied minors, former ex-combatants, survivors of sexual and gender-based violence). Although such programs seem to have resulted in positive psycho-social outcomes, this is inherently a sub-optimal approach. While similarities may exist among individuals in their specific traumatic experience or in their reaction, each individual has a unique reaction to trauma.

An individual's reaction is determined by a unique combination of internal and external factors: "psychological stress (as well as positive experiences) resides neither in the situation nor in the person, though it depends on both. It arises from the adaptational relationship as it is appraised by the person."[39] It is for this reason that clinical assistance is frequently provided on an individual basis. However, as this is not viable on such a wide-range scale – other alternatives must be considered.

Groups most frequently targeted for psycho-social assistance are those who are considered to have "special needs". According to UNHCR, these groups include but are not limited to women, children, elderly and disabled. There are also characteristics within members of the group that indicate specific needs and a heightened vulnerability requiring specific types of assistance. For example, among children those who are *unaccompanied* or who were child soldiers will benefit most from assistance tailored to their precise needs. Although these guidelines are not followed in each psycho-social intervention that defines itself as such, the majorities do, indeed, adhere to these criteria.

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[38] According to Webster's Third New International Dictionary, triage is defined as, "the sorting and allocation of treatment to patients and especially battle and disaster victims according to a system of priorities designed to maximize the number of survivors."

[39] Lazarus, Richard S., "The Stress and Coping Paradigm", in Models for Clinical Psychopathology, (Eds. Eisdorfer et al.), SP Medical and Scientific Books, 1981, Spectrum Publications, University of Washington, Seattle.

The most salient characteristic of the psycho-social field is the diverse spectrum that characterizes it. The Center for Crisis Psychology (CCP) in coordination with UNICEF put forth the following Continuum for Psycho-social Interventions, developed in the context of interventions in the Former Yugoslavia. The spectrum includes the five following levels and types of intervention:

1) Unstructured Social and Play Activities;
2) Organized Social/Play or Group Activities;
3) Psychosocial Education and Guided Psychosocial Activities;
4) Counseling: Individual, Group or General Debriefing, Psychological support to traumatized or bereaved[40]; and
5) Specialized Mental Health Services[41] [42]

The last two types of interventions listed within this spectrum are interventions designed to meet individuals who have experienced an acute crisis and have directly suffered from violence.

Additional measures increasingly considered to fit within the Spectrum

The above spectrum illustrates the diversity of interventions in this field. However, there are arguably several interventions that although they might not be defined first and foremost as psycho-social interventions, per se, they have a strong psycho-social component and can and often do result in positive psycho-social outcomes. Among those most often mentioned in the literature and recently the focus of attention among IOs, INGOs and NGOs are *Emergency Education*[43] and Peace Education. A report by Margaret Sinclair, written for UNHCR, addresses the value of education-based interventions in refugee camp settings. It underscores the critical role that education programs can play in refugee camp settings in meeting many of the psychological and social, or psycho-social, needs of children and adults.

A focus of increased investment by UNHCR, peace education is also worth considering in the context of the psycho-social field. Originally piloted in refugee camps in Kenya (Dadaab and Kakuma), the "Education for Life Skills, Peace and Conflict

[40] Delivery of specialized psychological services to individuals or groups who have been affected by a crisis. Services may be delivered by trained paraprofessionals under the supervision of a mental health expert

[41] Psychological or psychiatric services delivered by mental health specialists, and addressing traditional issues of psychopathology. Services only delivered by authorized mental health experts

[42] For further examples of psycho-social interventions consult McDonald, Laura, "Psycho-social Interventions: A Review of the Field and Debate Surrounding It", 2002.

Resolution Programme", has resulted in positive outcomes among children and adult participants and has been lauded by refugee communities as a valuable program.[44] Embracing a participatory or community-based approach whereby the community plays a central role in project and design and implementation, these programs have been successful in addressing many of the needs and concerns of refugees living in protracted emergency situations. A new wave of thinking about the possibilities for peace education highlights the intervention's capacity to meet the community's needs – ultimately leading to positive psycho-social outcomes.[45]

Areas of debate and discussion

To justify their psycho-social programs, most IOs, INGOs and NGOs underscore the extent of atrocities committed in war-time and point to the widely-accepted view that psychological wounds will fester for generations if they are left untreated. Yet, the strong agreement with respect to the implications of suffering is only rivaled by the disagreement with respect to treatment. The field is characterized by a polemic as to the process of intervention – specifically *how* both to identify and to meet the needs of those suffering from the "trauma of war". The complexity of issues and approaches characterize the debate surrounding this field. To simplify, there are three major, or dominant paradigms[46] that can be drawn from the psycho-social literature and discussion. They are the following:

1. Treatment of pathology;
2. Promotion of well-being/community recovery; and
3. Public health (or something analogous to it more specific to psychosocial issues).

The treatment of pathology (1) is a medical approach where methods of intervention are Western-based. This approach is informed by experience with trauma survivors in Western industrialized countries as well as some experience in the

[43] Also referred to as "Education in Crisis Settings."
[44] LOI on Education for Life Skills, Peace and Conflict Resolution Programme in Kenya.
[45] Lumsden, M., "Breaking the Cycle of Violence." The author highlights the role of peace education in the lives of children who have experienced untold violence throughout the critical developmental stages of childhood and adolescence.
[46] Referred to as "loosely defined perspectives" (Email from Symposium attendee John Williamson sent on March 23, 1999.)

developing world. It is considered "university-based". Its supporters are found within the scientific community, including the fields of medicine and hard sciences.

The promotion of well-being/community recovery paradigm (2) has a very broad focus on the affected population as a whole, utilizing a long-term perspective. The role of aid organizations is considered minimal and short-term, and focuses on building and restoring family and community capacity. Organizations using this approach have faced problems trying to communicate their intervention strategy to the wider community. It focuses its efforts and interventions on meeting current needs with a view to addressing future needs as well.

The public health approach (3), recognizes that the repertoire of potential-need interventions is broad and that all sectors of emergency response have impacts on psycho-social functioning and well-being. It acknowledges the need for both community-oriented interventions in all sectors and individual and family-oriented interventions to address acute or chronic psychopathology. Support comes from some academic disciplines in the university setting, government, policy makers, and IOs.

These approaches are not mutually exclusive. In the field, approaches and interventions are sometimes shaded, including elements from each of the three paradigms. John Williamson, following a three-day Symposium held in March 1999 and attended by 85 representatives from more than 60 organizations, highlighted the approaches to assistance above.[47] Information from the Symposium illustrate the wide range of views held by those around the psycho-social "table" and brought to light areas that require further attention – those that would benefit from discussion and further collaboration. The Symposium documentation touches on a number of issues that are of central interest and concern to this paper.

The aforementioned approaches reveal a core disagreement on what precisely the major *thrust* of an intervention should be – in order to be most appropriate and, simultaneously, effective. The medical approach concentrates on treating pathology among traumatized individuals, while the community-recovery model aims to address an individual's needs at the time of intervention (through community-based and participatory strategies). The latter, however, has a future-oriented focus – and is

[47] Ibid.

arguably a more *preventive* intervention than the former. For example, the latter approach might focus on setting up programs and games to assist the community in increasing its capacity to better limit or cope with psychological distress in the future.

Finally, the public health approach is a synthesis of the other two. It is treatment- and future-oriented. It is, to an extent, curative through medical interventions (when necessary) and preventive through community-oriented interventions (where possible and pathology is not acute).

These approaches also signify variations among individuals from these camps as to the *role of culture and intervener* in an individual's experience of, and therefore, recovery from trauma. That these core beliefs and tightly-held views lie at the crux of the debate explains, in part, the polemic character of it. Each above-mentioned approach is characterized by differing views on the *universality* of a traumatic experience and its manifestation or expression and similarly, in the way in which it can – and therefore should be most effectively addressed.

The approaches find their roots in two diametrically opposing views of psychological suffering and its connection to culture, and therefore diagnosis and treatment. The first maintains that "whatever their race, people have a common physiology, physiopathology, and mental functioning and any remedies are therefore of a universal nature…" Any differences in the experience or expression of suffering are "particularities…(that) are only "local flavour" variations of these syndromes that do not call into question the validity of the diagnostic methods nor of the therapeutic approach."

The second camp believes that "mental pathology cannot be separated from its social and cultural context, in which reside not only the illness but also the cure. For Westerners, mental illness concerns the neuro-physiological/psychiatric process, whereas for people of other cultures it may fall within the realm of the spiritual or the supernatural."[48]

One example that illustrates the complications of applying one culture's diagnosis to another is found in the analysis of depression in Chinese culture where a Western diagnosis is inappropriate and, as such, would be of limited value in developing an effective treatment. *The Psychosocial Problems of Refugees* highlights these cultural

[48] Nyffenegger, E. et al, p. 2

differences: "Depression is only a pathological reaction when it is characterized by excessiveness and inappropriateness for the situation and the culture. The Chinese would consider problems which we (Westerners) call depression or anxiety as due to a physical, moral or cosmological origin and they would expect to be treated along these latter lines."[49] In line with the "labeling theory of mental illness is founded on the idea that what are 'called symptoms of mental illness' can also be conceptualized as a certain kind of nonconformity: the violation of residual rules. Every society has myriad explicit rules and understandings about appropriate behavior, perceptions, feelings, and thoughts."[50]

Much of the polemic is as a result of the fact that psycho-social interventions are led or supported by Western-based organizations, or organizations funded primarily, if not solely, by Western donors. Simply put, it becomes a situation whereby Western organizations are, in effect, *treating* individuals from non-Western societies. There is some, and perhaps, warranted concern that interventions are adopting not only a top-down (as opposed to vertical and community-based) approach but will have a propensity to impose a Western-based model, founded primarily on Western theory (developed in a Western cultural context) to explain a phenomenon. The explanation is then coupled with the use of a Western framework to provide treatment.

Some of the of interventions in this field have argued that this is precisely what has happened in the effort to address the psychological wounds of war. In *"Concerning Psychiatry in Conflict Areas"*, the authors write that "psychiatric programmes in war zones (in a different cultural environment) have attracted harsh criticisms because, for the most part, they have been modeled on western therapeutic methods considered inappropriate, useless in best cases and harmful in most others."[51]

Discussion surrounding the applicability of the Post-Traumatic Stress Disorder (PTSD) diagnosis – a Western-based diagnosis found in DSM IV[52] – has been a sore of contention and illustrates the very nature of on-going debate within this field. It has been argued that it is "unknown whether the construct validity for PTSD is meaningful in

[49] The Psychosocial Problems of Refugees, p. 59
[50] Scheff, T., p. 27
[51] Nyffenegger, E. et al.
[52] Diagnostic and Statistical Manual of Mental Disorders

societies unfamiliar with its definition and therapeutic usefulness."[53] And a Western-based or informed approach is viewed as antithetical to a community-based one and as critics argue, it is culturally insensitive, unaware and invalid:

> "The danger of superimposing Western European approaches which clash with what refugees know and expect is all too obvious and there is high potential for mis-communication, raised anxiety, and conflict when 'their ways' and 'ours' are not clearly distinguished or appreciated. Such information is not readily available or widely disseminated but ought to be all those dealing with refugees."[54]

Critics argue that the medical approach focuses too much on the individual, rather than the system in which they live and the context in which their lives are based. In "Rethinking the Trauma of War", the authors write that:

> "Rethinking the trauma of war means a shift away from projects targeted at individuals or specific groups…It involves a concern to help rebuild, or invent anew, the social structures through which lives are lived and found to have meaning. Normalisation and recovery, from this perspective, touches all aspects of social and economic survival, for children, it involves the context in which development and learning takes place, and for all people, it involves notions of justice, reconciliation and breaking cycles of impunity."[55]

In part, the growing severity and rapid onset of suffering on a wide-scale has led to a response that is often not grounded in cultural expertise. This is not, however, the result of ill intent on the part of interveners. It is more a result of the rapid rush to provide assistance, while lacking knowledge of the larger social and cultural factors involved. Maynard articulates this predicament:

> "Because of the rise of complex emergencies and the accompanying number of civilians personally affected by war has been so rapid, the experience of international organizations in psychosocial recovery is also brief. Understandably, many of these recently unveiled programs are not based on extensive research of the broader country-wide picture, specific local conditions, or other ongoing efforts in complex emergencies."[56]

The critics have brought to light the implications and risks of not giving adequate consideration to cultural expressions and meanings of trauma as well as the cultural diagnosis and treatment. The following diagram illustrates the existing "tensions":

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[53] Richard Mollica (2) p. 135
[54] The Psychosocial Problems of Refugees, p. 73
[55] "Rethinking the Trauma of War," p. 190
[56] Maynard, pp. 217 – 218.

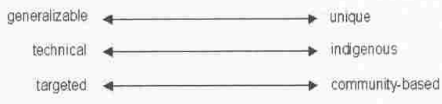

Figure 1: Tensions in the discourse of psychosocial programmes

And organizations are heeding the call to adjust their programs to be developed and implemented with greater cultural sensitivity. A review of programs in the field shows their growing commitment of organizations to adopt a more informed and culturally sensitive approach.

A meeting place

In light of the above discussion and existence of numerous approaches, it is useful for this paper to analyze the on-going debate and to lay the groundwork for cooperation. Frequently, as can be gleaned from the above, some organizations are criticized for approaching war-affected populations and seeing and treating their suffering utilizing a Western lens. It is critical, however, for critics not to mistake the medical model for a Western one – they are not entirely the same. Clarity on the distinction is critical.

If an organization adopts a Euro-centric approach drawing entirely on Western framework for diagnoses and treatment without attention to culture, it merits criticism for culturally insensitivity. And allegations that some interventions have taken such a narrow approach are likely warranted and valid. Organizations, however, can support the use of medical assistance, and thus a medical approach, without being culturally insensitive and narrow in focus. For the medical approach can, and often is, utilized and applied in non-Western societies. Organizations that work closely with a community's medical professionals and traditional healers to strengthen their role or to assist them in service provision are hardly doing the harm that the community-based camp might assume that they are. Much can – *and should* – be gleaned from and based on an indigenous medical approach.

While preventive and non-medical interventions are able to prevent, address and limit the impact of psychological distress, it is shortsighted for critics to ignore the highly biological component of mental illness—where medical treatment is critical and necessary. Although a recreation activity may address the refugee children's feelings of

boredom and hopelessness, such an intervention is thoroughly inadequate—if not altogether useless—in addressing the needs of individuals with suffering from acute psychiatric illness (e.g. clinical depression, psychosis and schizophrenia). The causal factors and symptoms of mental illness are both biological and physical. Recognizing this distinction is critical in order to provide applicable and effective assistance.

It is, furthermore, erroneous to assume that the West possesses the only existing medical approach. Indeed, most, societies have relied on medical assistance, provided by traditional healers. The roots of Chinese medicine date to nearly 4,000 years ago. And in Cambodian society, the subject of significant research in this field, traditional healers have played a critical role in the diagnosis and healing process. Some of the existing interventions to assist Cambodian refugees who have experienced the trauma of conflict and displacement look to the work of traditional healers to provide insight and information – and to develop models for appropriate diagnosis and treatment. The question is not – and should not be— how to supplant one system with another, but rather how to support the community's own traditional approaches and how to provide the providers with ideas and information that may be useful from western medicine.

Consideration for the biological factors linked to medical illness –need not supplant the spiritual or cultural explanations of mental illness or psychological distress. In non-Western cultures, suffering is frequently viewed as the result from many areas – frequently having spiritual, biological, and ancestral explanations. A holistic approach to treatment is then likely to be the most logical and effective. The interplay of these domains in an individual's traumatic experience – and the necessity to incorporate them in any approach to initiate the healing process was highlighted by Jane P. Mocellin in *"Psycho-social Consequences of the Somalia Emergency on Women and Children"*.[57]

Mocellin's research reveals the various types of coping strategies employed by Somali women studied in her research. The author highlights the importance of "building trust between traditional healers and scientific medicine." Mocellin argues that the "interactive effect of religion and medical approaches must not be overlooked… Women take spiritual comfort in reading the Koran when they face problems." She, in turn argues that "specific guidelines on the interface between traditional healers and scientific

[57] Mocellin, J.P.

medicine should be incorporated in a training package for mental health interventions." Context- and culturally –sensitive medical approaches do not overlook these linkages and adopt or support a holistic approach to mental health and psycho-social well-being.

Simply put, the medical approach and its adherents, should not be erroneously categorized or criticized. This is likely to lead to further polarization and further, sets limits on the provision of what may be, in some cases, greatly needed assistance. Often, those in the medical profession are interested in understanding how traditional medicine or non-Western medicine would diagnose and treat pathology. Many aim to support indigenous medicine and traditional healing, while incorporating Western medicine as either a complementary input or even as a last resort.

Recommendations

The above discussion and review of the psycho-social field highlights the complexity of issues that warrant further attention and consideration of organizations hoping to relieve psychological distress and injury resulting from conflict and displacement. Consensus exists within and across organizations that such widespread suffering cannot co-exist with anything more than a quixotic hope for rehabilitation and sustainable peace. Yet, despite the justification of psycho-social interventions and their quick employment, organizations must commit more of their time and patience to enhancing collaboration in this field. The effective contribution of organizations is contingent on taking steps both together and separate from other actors.

Collaboration

The seeds of collaboration are sewn through international forums, information-sharing and an open and non-threatening environment fostered whereby individuals and organizations can share their views and experiences. From a review of programs, literature, and communication with HQ and field workers, the lack of coordination and collaboration is an obstacle to ensuring effective assistance provision.

As the field is marked by confusion, and a lack of agreement among and within organizations – organizations forfeit an opportunity for information-sharing, lessons learned and best practices exchange – while project duplication becomes a likely and expensive likelihood. So long as the field is one of "many different things to many different people," the provision of appropriate assistance is thwarted. This paper argues

that just as other sectors of assistance follow an intervention framework, for example assigning roles to organizations, the field warrants the same operating procedures. A lead agency should be determined collaboratively and inter-agency working groups possessing clear objectives should be set up.

WHO held an *"International Consultation on Mental Health of Refugees and Displaced Persons in Conflict and Post-Conflict Situations: From Crisis Through Reconstruction,"*[58] in October 2000 which had for an objective to set the foundation for and solidify inter-agency collaboration in this field. The initiative, however, lasted for only two days and was marked by minimal inter-agency participation and collaboration prior to the meeting. While symbolically significant, such efforts do not allow for the achievement of inter-agency collaboration, which is usually the result of a difficult, lengthy and arduous process, particularly given the disagreement across organizations.

The polemic character of debate can be minimized if organizations adopt a more holistic approach to health-focused interventions. Baker's Biopsychosocial model, found in the *Psychosocial Problems of Refugees*, illustrates the complex linkages between an individual's physical, psychological and biological needs. This fundamental tenet of assistance provision warrants and requires the multi-sectoral approach to assistance. In this light, each organization with a different mandate or approach is not then an obstacle to another's assistance interventions, but rather a component that will open the way for learning and a truly integrated approach. One organization might set up recreation activities for children, as it is their area of expertise, while working to establish a medical referral system for severely traumatized children. A second-tier approach, such as this, provides a place where the expertise of both the medical and the promotion of well-being/community intervention approaches work in collaboration. Individuals are contributing according to their skills and knowledge base and assistance is better tailored to individual needs. The flames of commitment and expertise among individuals should not be stamped out – but rather brought together – where each is playing a role in facilitating the healing process.

[58] For further information, see: http://www.whomsa.org/it/text8/03_refugees.html

Research

Power lies in knowing which interventions are effective – and why they are or are not. Determining causality between project input and project outcome is critical in ensuring effective operations. Only research and hard data can provide this valuable information. Without it, claims of effective interventions and components are largely weighted on anecdotal evidence and powers of persuasion. It is research that provides the foundation and weight in addressing critical issues in inter-agency discussions and project documents as it also plays a pivotal role in donor funding appeals. In the literature, there is significant reference made to the dearth of hard data to substantiate intervenors arguments either for or against interventions. Dr. Mollica, in an article entitled *"Invisible Wounds"*, asserted that "few longitudinal studies have been done" to measure the effects.[59]

While many assert that massive trauma will have long-term individual and societal implications, there is some evidence that a society, without outside assistance, heals over time. Organizations, in the face of this debate, find themselves cornered. Their argument that their work is effective and needed is challenged, yet they can only point to anecdotal evidence, relying on the empathic response of the listener, to acquire support or to obtain funding for their programs. Organizations cannot determine as they cannot truthfully know whether psycho-social interventions are the most effective use of diminishing financial and human resources. They cannot know where they should fall in the triage exercise. Without determining causality between project input and outcome, there can be no certainty that the approach utilized is the most expedient, appropriate or effective response to suffering.

Furthermore, as many of the organizations are fervent believers in the guiding principle *"to do no harm"*[60] – this requires consideration of the alternative approaches – including the course of non-intervention. Yet, if organizations decided to take that course and it is, in the end, not the most appropriate or most effective, were organizations justified in taking the risk? Until these questions are answered with clear and valid data

[59] Mollica, R. (1)
[60] Anderson, Mary B.

from various cultures and contexts, arguments on both sides are derived from limited data and will, and most certainly should, be considered speculative and subjective.

The lack of data also poses serious problems in targeting assistance most effectively. For example, there are variations throughout a child's development warranting tailored interventions, quite difficult seeing that "longitudinal studies of war-traumatized children followed through crucial developmental nodal points are in short supply."[61] A recent proposal put forth in "Psychosocial Implications of Complex Emergencies and Forced Migration" produced by ICMH and Columbia University underscores the problematic nature of designing interventions:

> "Little is still known about the true size of the problem…we do not have sufficient information about who is most vulnerable, to what they are vulnerable and what form their psychosocial problems take. For example is it the entire population that is at risk or is it just a proportion. If it is the latter, can we estimate what that proportion is likely to be and how can we arrive at such an estimate."[62]

This "gap" in knowledge has existed since the psychological impact of war on civilians was a topic of research and study:

> "The absence of systematic and cumulative research into the refugee experience, and the effectiveness of programmes created for refugees, represents a crucial gap in our knowledge about what works, with whom and why, and what has proved unsuccessful."[63]

Such limitations are dually attributable to the relatively new focus on this field and the difficulty in undertaking research of it. Research is "plagued by methodological problems, including difficulty obtaining adequate controls and getting pre- and post-measures, and by many intervening variables."[64] Regardless of these justifications, the lack of research, in light of the huge obstacles it poses, warrants further attention and investment from all of those involved.

Monitoring and Evaluation (M&E) Mechanisms[65]

As previously mentioned, making assertions without supportive data limits their power. In the same way, it is impossible to develop a valuable knowledge bank or to apply lessons learned without information that is provided by Monitoring and Evaluation mechanisms (M&E). This is true in all areas of assistance. In health, much of existing

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[61] Sack, W.
[62] Psychosocial Problems of Refugees, p. 5
[63] Ibid., p. 9
[64] Flynn, B, p. 100 in Leaning, J. et al (Eds.)

knowledge in primary and secondary prevention is that a specific reaction will lead, or is likely to lead, to a specified outcome. For example, studies have determined that the cessation of cigarette smoking diminishes an individual's chances of getting lung cancer. And it is this formula that directs assistance and the data that prevention programs draw on to justify and support their work. Guidelines in other sectors including nutrition, education and maternal health are derived from – and usually rely on – hard data to develop and design interventions that are appropriate and, ultimately, most effective.

Interventions to ease psychological distress merit the same attention and warrant the same mechanisms. Yet, although there are some exceptions, often the design and approach of interventions are not founded on research findings and hard data. Additionally, there are few frameworks to determine effectiveness. Some have been put forth (Mimica, 1995). Yet, if the international community has no guidelines for determining the effectiveness of interventions, how can it determine which components of intervention or non-intervention are having an impact on populations targeted by assistance programs?

Community participation

Organizations approach this issue – or ensure community inclusion in different ways. UNHCR shows its adherence to including the community in the design, set-up and implementation of projects through its expressed adherence to a *community-based* approach. This is highlighted through the work of the Community Services section (CS) and is made explicit in the *UNCHR Handbook for Emergencies*[66]:

> "Refugee community participation (including both men and women) should be promoted in all sectors, by building on the community's own resources as much as possible and encouraging individual, family and group self-reliance; and special services for the vulnerable should, as far as possible, be provided by the refugee community itself."

Such community involvement ensures that a project is tailored to the needs of individuals and their communities, *as the community defines them*, and rests on the work of community members. As such, it is argued they are likely to be more effective and sustainable. It also ensures the culturally sensitive character of an intervention. This is deemed effective by many for a number of reasons, "in part because of the large

[65] Diagram Evaluation Design, Mimica, 1995.
[66] UNHCR Handbook for Refugees

numbers, but also because this approach is meaningful and acceptable, and emphasis (is placed) on the importance of collective identity."[67] This is becoming a widely-accepted approach to psycho-social assistance. The importance of a "community-based approach that encourages self-help and is context sensitive" is a tenet of any intervention to provide assistance by Save the Children.[68]

The question remains as to whether or not the principles translate into reality on the ground and, as such, deserves further analysis. Some argue that CS should further adapt its approach away from considering refugees as beneficiaries of an intervention or recipients of assistance towards considering them, first and foremost as "key participants" in the processes of decision-making and follow through processes.[69]

Listening to all voices: not just the loudest or the closest

Setting up effective interventions requires not only the inclusion of the community – but requires truly listening to the community. This, in turn, requires that UNHCR staff,

> "Get to know the players present, i.e. refugees, the staff of various international and national agencies and local government personnel… and community development workers should then meet with the refugees, preferably in appropriate groups such as elders, women, youth, etc. to get from them a sense of their priorities as far as needs and interests are concerned as well as what contributions they themselves may be able to make to address the needs and concerns."[70]

And Jane Gilbert asserts that a better understanding is critical before an intervention is designed: "it is crucial that, if help is to be given, there is a very clear understanding beforehand of normal coping strategies within a particular culture."[71] Interventions have failed when the voices of those targeted for assistance were not heeded. One example of this is found in the context of programmatic decisions made to assist former child combatants in Sierra Leone. When children were asked, they

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[67] Rethinking the Trauma of War, pp. 181-182

[68] Promoting Psychosocial Well-Being Among Children Affected By Armed Conflict and Displacement. For further information or details on selected interventions refer to report by Laura McDonald.

[69] "The concept of service continues to objectify the refugees -- making them into 'objects something is being done for'…whereas we would like to think that we aim to involve refugees in conceptualizing, planning and being involved in the implementation of programmes and services, which they help us to determine as necessary for their well-being as refugees. But which will also support their rehabilitation into their home environment upon repatriation." "Strategy for the Re-orientation of Community Services – Towards a Community Development Approach", page 5.

[70] Community-Services, p. 7

[71] Gilbert, p. 16

identified education, employment opportunities and economic security for their families as priorities. In spite of their request and feedback, trauma programmes that have been popular with agencies and donors were set up. And the interventions then failed as they did not "respond to the needs and priorities" as defined by those they aimed to assist.[72]

And reports from others tells of the implications of not listening carefully:

> "…Older people spoke of not being seen and of agencies not having ears as they failed to consult older people on their needs and priorities. Age specific issues, such as chronic health problems, mobility and psycho-social needs were not understood or given priority in most emergencies although they are specific factors that make it difficult for older people to support themselves through a crisis."[73]

Seeing beyond the framework of "Special Needs"

The programs most frequently considered in the psycho-social field are those addressing the vulnerabilities, or needs, of special groups. As mentioned, these groups include, according to UNHCR and a number of organizations: women, children, elderly and disabled individuals. Often within these groups there are specific characteristics of an individual's experience that will manifestly requires specific attention and assistance tailored to their needs. For example, interventions among children often target those who are "unaccompanied" – who have lost their primary caregiver. Among women, assistance is often targeted to meet the needs of those who have survived sexual and gender-based violence (SGBV). This is a result of both the readily identifiable nature of their trauma (facilitating the speed of intervention, fitting into an existing rubric for providing assistance) and the triage process – an unfortunate reality of providing relief and assistance in emergency situations.

An approach such as this, adopted for logical and perhaps necessary reasons, is sub-optimal. Each individual possesses unique coping mechanisms and background and moreover, they have often undergone traumatic experiences that vary significantly (varying degrees and extent of loss, etc.) Therefore, by having clearly delineated groups, organizations must be careful not to assume that individuals outside the defined parameters are not suffering greatly – or to an even greater extent. A review of the literature on women shows the standard approach in providing assistance to focus only on

[72] Community- Services, p. 4
[73] HelpAge paper, p. 4.

women who have experienced sexual violence – or women in the context of their role as mother.[74] Women do, however, have needs that fall outside the above-mentioned realms.

Heeding criticisms as impetus for change: the importance of cultural sensitivity

Critics have been quite forthcoming in putting forth their opinions pertaining to psycho-social interventions, particularly their claims of a blanket imposition of the Western models (diagnostic, treatment, delivery of services). One of the recent publications from this camp, *Rethinking the Trauma of War*, takes the view that assisting traumatized individuals in the context of conflict and displacement should not adopt a narrow western approach. The authors warn that by promoting a western solution as a "truth" it is imposing a solution from the outside that runs the risk of "being inappropriate and will in most cases, remain and unsustainable solution."

Rethinking the Trauma of War draws on mistakes made by organizations wherein cultural context was not given adequate consideration – or did not hold sufficient weight in the design and implementation of the intervention. Some of those interventions mentioned were set up in Mozambique and Somalia.

Their criticisms should be utilized as a catalyst for constructive change – whereby culturally appropriate interventions are a major objective of assistance. And culturally appropriateness does not mean taking interventions that are, or have been used, for one culture and group and adapting them to "fit" another culture. Rather, it means designing and implementing programs specifically designed for the community in need. It requires reflection on the part of the person from outside the culture – analysis and reflection on both the culture possessed by program participants – and of the interveners own culture (norms, standards – and biases). Cultural sensitivity means sensitivity for another culture, but also "implies sensitivity to features of Western culture including our understanding of the person, of autonomy and the personality, and the influence this has had on concepts of emotional disturbance."[75]

Whether the critics are justified in the content or extent or their criticisms, as the field is characterized by the difficulty of interventions, diminishing resources and growing need, culture is an issue that should have a significant place in project design.

[74] In the course of this research, not one guide focusing on the psycho-social needs of women was found.
[75] Rethinking the Trauma of War, p. 183.

De Vries addresses the interveners' dilemma, while stressing the importance of doing the best and most we can to restore the culture:

> "As care providers, we generally appear on the scene after a trauma has occurred. Culture at this point may be fully in place or may have been disrupted by the trauma. Whatever cultural structure remains should be employed to help victims manage the horror…The goal should be to bring order and continuity into the posttraumatic period…"[76]

Organizations must heed the challenge, listen to the critics, hold their work up to their views – to ensure that the interventions undertaken will not live up to their claims.

Timing

Timing is critical. Ensuring an intervention's efficacy requires good timing – and timing, as the adage goes, "is not everything". More precisely, effective assistance requires that the right (or best) intervention be implemented at the right (or most appropriate) time. Again, ensuring this rests on the adoption of a participatory and community-based approach. It is, however, difficult to ensure this in light of the power that donors hold in determining interventions to be funded and in the timeline for funding. The most appropriate psycho-social intervention (at a specific time) and the one that might find more support among the donor community are not necessarily in sync. Interventions in Bosnia reveal the real and deleterious implications of the often 'uninformed' funding cycle.

> "In Bosnia, the first major response to the psychological dimensions of the war came with widespread reports of rapes early in the war (1992-1993), which broadened after that into a concern with war trauma, and then moved from there as the war ended to the current programmes in reconciliation and conflict resolution."[77]

While this donor-driven response seemed acceptable to those on the outside (and maybe to some of the intervenors themselves), this was contrary to knowledge that a trauma intervention for a survivor can be needed most after the war (rather than during). In this light, a number of people interviewed for the "Critical Review of UNICEF's work in the Former Yugoslavia", felt that the shift "from psychosocial projects on trauma to reconciliation projects" after the war was a "mistake".[78] As addressed in further detail below, educating donors will ensure more time-sensitive programs.

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[76] De Vries, p. 140
[77] A Critical Review, UNICEF
[78] Ibid, p. 7

Addressing secondary problems: Alcohol and substance abuse

Psychoactive substances, their use and abuse among war-affected populations, do not receive adequate attention in assistance programs. Views shared by UNHCR colleagues and research showed the role that psychoactive substances often have in the lives of individuals traumatized by war. Yet, there seems a blatant lack of acknowledgement of this issue, similarly, in the psycho-social literature.

This is surprising in light of current knowledge of coping mechanisms employed by those who suffer from psychological distress or disorders even outside the context of conflict and displacement. In light of the critical losses of loved ones, support systems, and identity – individuals often see themselves with no other choice to cope with unbearable pain than to numb it with psychoactive substances. Organizations, however, do not have a framework for addressing it. And although aid workers and organizations can understand their pain – and even why they turn to these substances – such issues should not be seen as "untouchable" or outside the scope of interventions.

The use of psychoactive substances, moreover, aggravates the already difficult situation in which war-affected populations find themselves. An individual who consumes alcohol, although they will often find temporary relief from suffering and boredom, continual use of alcohol prevents them from addressing underlying causes, leading in turn to the development of poor coping mechanisms and problems within the family, including neglect, domestic abuse and sexual and gender-based violence. Often it is the unique combination of frustration, boredom, the breakdown of traditional structures and the accompanying feeling of powerlessness and the availability of alcohol and drugs that may contribute to aggression and sexual violence within camps.[79] Finally, there is a correlation between the use of alcohol and an increase in unprotected sexual intercourse. This, in light of the high prevalence of HIV/AIDS among refugees and war-affected populations, the use and abuse of psychoactive substances may lead, directly or indirectly, to illness and even death.

As normal – or as understandable – such use of psychoactive substances might be in light of their suffering and coping mechanisms frequently adopted in western societies – it should not be a given of their experience or accepted as a simple correlate of their

[79] Reproductive Health in Refugee Situations: An Inter-Agency Field Manual.

pain. The consequences of inadequate attention and assistance along these lines are significant.

Duplication

In light of the broad scope of the psycho-social spectrum, the term is used indiscriminately in describing several types of interventions. The prevailing disparate understanding of interventions (with respect to similarities and differences) and clearly delineated operational mandates and a foggy understanding of the field's terms and roles, leaves open the possibility of redundancy on the ground. Communication with individuals involved in assistance operations showed this to play out in the field.

One specific example that highlights this was a situation relayed to me by a CS Officer who addressed work undertaken by the Center for Victims of Torture (CVT) with refugees in Guinea Conakry. He writes, with regards to their work, that there is a strong "resemblance of programmes to other existing community development projects (IGA…sports, theatres, etc, could be ARC, IRC, ERM, etc.)…" Specifically, he argues that, "they're [CS Officers and CVT workers] all doing the same thing."

Redundancy among personnel, or the "multiplication of community resource people – psycho-social workers resemble at times community health workers, community development workers, monitors, RH field workers…." is sub-optimal, and particularly in light of the existing limitations of resources available within an emergency situation. Each aiming to achieve specific objectives, "don't seem to be working together." That this confusion exists was further confirmed by the individual's response when asked to discuss how the interventions of his organization were different. The email states, "...the fellow we spoke to… couldn't give a substantial difference in intervention/outcome".

Educating donors

The funding cycle and its implication on the type, strength and effective interventions has been an issue sounding alarm among humanitarian workers, journalists, and academics to name a few. Donor-driven interventions, as they are, lead to a top-down, culturally insensitive and whimsical approach. While the funding cycle will remain linked to donor discretion and concession so long as the funding is drawn from their banks, there are ways in which to increase donor sensitivity. One way is through education and awareness-raising activities. This, too, is a symbiotic process. By

educating donors on existing interventions and approaches, and providing them with information and scientific data on the impact of trauma and showing the possibilities for intervention based on lessons-learned, donors will be better prepared and more-informed when participating in the debate surrounding interventions and funding – and more comfortable addressing critical issues and raising questions.

The broader picture: Community Healing

Providing assistance in the context of CHEs requires more than one-type of intervention: just as an individual's health is defined on varying lines including physical and mental health, and as an individual is part of the larger community, assistance must be multi-sectoral in character. It is the positive health of the individual and his or her community in the short- and long-term that must be the overarching objective of any assistance interventions. While psycho-social interventions might provide critically needed assistance to traumatized individuals, they are only one intervention to be considered in the larger macro-picture of "community healing".

Psycho-social interventions should be considered as one intervention among others – as they are most effective when implemented in concert with other needs-based interventions. Maynard criticizes organizations involved in psycho-social work for not considering the larger picture. She writes:

> "Very few of these organizations [working in the psycho-social sector] take into account the full spectrum of the healing process and the implications of each phase on the others. For example, the need for a secure environment is not widely considered to be a component of healing programs. Therefore, as interest in psychosocial recovery intensifies, future international assistance should expand into other possible areas. The following are illustrations of new or underutilized programs supporting the five-phase recovery."[80]

Interventions must be considered in the context of other interventions and programs being implemented within the community and it must be developed based on the needs of the community – *as the community defines them*. Ensuring effective delivery of assistance and optimal outcomes depends on their development outside a HQ-based or removed vacuum.

> "Accordingly, the multidimensional nature of complex emergencies and of psychosocial injuries in particular, requires a multifarious approach to recovery. At a minimum, methods design for healing psychosocial wounds calls for input from public health,

[80] Maynard, pp. 217 - 218

> psychology, sociology and conflict studies. The implementation of resulting programs requires the expertise of relief and development professionals and specific country experts. In addition, country nationals play a critical partnership role in advising on cultural practices and implications, explaining historical roots and pinpointing critical locations, populations or trouble spots."[81]

This is consistent with the critical support behind psycho-social interventions that they are by their very definition, founded on the integration of components that address the psychological and the social implications of trauma and the healing process.

A Symbiotic Process: The Way Forward

This paper highlights the complexities that characterize the field of psycho-social, the approach of intervenors, their philosophies and on-the-ground realities of intervention. The flourishing interest in this field is a result of psychological traumatization and displacement on a scale never before witnessed – and a growing certainty that peace and stability are unlikely to flourish within societies that have directly suffered from horrific violence – and who are left to pick up the pieces. The objective of humanitarian organizations to provide needed assistance to individuals would be disingenuous if it were to ignore – or to overlook – psychological wounds. Yet, while the commitment of organizations to assist is explicit, the psycho-social field is problematic, characterized by debate and confusion. As such, it warrants further attention and consideration from those responsible for its on-the-ground implementation.

Operationally speaking, progress along these lines requires attention to each above-mentioned consideration both separately and as part of a larger symbiotic process. Organizations must continue to address the macro-issues: supporting research, fostering cross-sector collaboration both at HQ and on-the-ground, and developing inter-agency guidelines and evaluation mechanisms. They must also simultaneously address issues that have real implications, right now, for suffering populations. They must ensure culturally- and context-sensitive interventions that make community participation a cornerstone of the framework for program design and implementation. The challenge is even greater insofar as moving forward requires addressing each of these issues in a sub-optimal context of growing need and limited financial and human resources. Only in taking on these challenges both internally and as part of a larger system can the well-

[81] Ibid, p. 209

intentioned efforts of individuals and organizations to help ease the trauma of war be meaningful to those who are suffering.

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