

“WAR IS NOT THE ONLY TRAUMA:”¹ RETHINKING PSYCHOSOCIAL HEALING IN COMPLEX EMERGENCIES

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War inevitably leads to a degree of psychological trauma among affected populations. This paper critiques Western-based, clinical interventions as detrimental to an already demoralized population. Ager’s (2002) framework of psychosocial intervention – human capacity, social ecology, and culture and values – is appropriate in the context of complex emergencies. Building upon an ecosystems perspective, Ager’s framework considers the whole individual and promotes strengths and resiliencies. Social workers are ideal facilitators of this type of community-based, culturally-salient, psychosocial programming, due to its application of the field’s core principles and its commitment to empowering community members to participate in their own recovery.

War is experienced both collectively and individually. War deliberately destroys established social infrastructure, creating an environment of fear and chaos and a loss of community identity. Furthermore, dislocation and a “loss of place” result in mental distress (Fullilove, 1996), often expressed internally within the individual or externally among communities. Affected individuals and communities need culturally-salient, psychosocial interventions that aim to address a population’s particular needs at the appropriate time. This paper presents a critique of Western-based interventions in the context of an increasingly medicalized humanitarian aid community, which sees Post Traumatic Stress Disorder (PTSD) as an obvious and convenient diagnosis, while eclipsing strengths and resiliencies. Ager’s (2002) framework of psychosocial intervention – human capacity, social ecology, and culture and values – should be used as a guideline for effective psychosocial programming during complex emergencies and in post-conflict rehabilitation. Social workers are a valuable resource in the field of humanitarian aid due to their understanding of the ecosystems perspective, in which a holistic approach is taken, with equal emphasis placed upon the individual and his environment (Allen-Meares & Lane, 1987).

A Critique of Western-Based Interventions

Humanitarian workers focusing on psychosocial interventions during complex emergencies commonly rely on Western-based models of treatment, such as discursive talk therapy, medication management, and explanations that tend to pathologize experience (Psychosocial Working Group, 2005; Summerfield, 1999). These approaches may be in direct opposition to the cultural norms of the community affected by trauma. For example, Englund (1998) notes that Western therapists address nightmares as a mode of symptom management, whereas within specific cultures, nightmares are often seen as an element of the indigenous healing process.

Summerfield (1999) views the imposition of Western-based therapies as an example of power and privileged knowledge being unduly forced on disenfranchised, war-ravaged communities. A Western-based approach tends to focus on the problems located within the individual, rather than focusing on the wholeness of the individual (Psychosocial Working Group, 2005), including the social systems within which the individual interacts. Western-based interventions have increasingly replaced the traditional mechanisms that communities have always utilized for support and healing, such as religious gatherings and community centers.

Western-based therapies cannot and should not replace local, cultural, and spiritually-based healing processes within a community, and interventions must be tailored to a population's needs. Narrative and discursive therapies may sometimes be appropriate modes of treatment, but there should be efforts within the humanitarian field to develop therapies that do not completely rely on discursive communication (Englund, 1998) and are responsive to the community's current circumstances.

Moving From PTSD Towards a Strengths-Based Approach

Humanitarian aid agencies commonly diagnose victims of trauma with PTSD, despite the diagnosis's potentially detrimental effects on a community's perception of its strengths and resiliencies. Categorizing displaced populations as affected by PTSD may further reinforce the definition of victim, pathologizing and trivializing a normal reaction to extraordinary circumstances (M. Grady, personal communication, December 4, 2004)^{II}. The categorization of PTSD renders an individual victimized and disordered rather than resilient and active, diminishing his ability to contribute to capacity-building activities. Considering the status of an internally displaced person (IDP) or a refugee, one

must recognize the increasingly passive circumstances for a once independent individual. Merging this idea with the label of a PTSD diagnosis, there is a combination of demoralizing factors where “the lack of autonomy engenders hopelessness” (Van Damme, 1995, p. 361).

Social work embraces the holistic workings that circumscribe individuals that insular Western models may neglect. Social work practice interventions ideally focus on strengths and resiliencies rather than focusing solely on deficits or challenges. The experience of trauma is not the sum total but rather a part of the individual’s life experience (H. Smith, personal communication, December 2, 2004)^{III}. Interventions should aim to empower and build upon communities’ present capacities. Communities have the ability to define their own difficulties and consequently design their own solutions. Interventions should be aimed at uncovering these abilities and then collaborating with affected individuals to provide assistance. Additionally, within program development, the partnering with indigenous professionals is a priority if sustainability is the goal of the psychosocial interventions (Ager, 1997). The most effective way to empower communities is to enable them to shape their own recovery.

Cross-Cultural Meanings Applied to Psychosocial Healing

In some African languages there is no word for “stress” or “trauma” (Gourevitch, 1998; Summerfield, 1998). In other words, what is known in one culture may not be understood within the same context in another culture. When developing psychosocial programming, it is imperative to examine whose knowledge is being used to create the program – the indigenous knowledge or knowledge brought by the humanitarian community. Knowledge from both can be combined. Historically, however, the latter has often dominated relief efforts. Humanitarian workers must remember to work within the cultural framework of the population being served to understand how communities interpret their own specific, cultural knowledge. It is also critical to recognize the priorities within a particular emergency, allowing the programming to be specifically geared towards a population’s needs.

However, without evidence of the generalizability or comparative efficacy of psychosocial programming, it is not likely to be used in other communities and less likely to have effects on large-scale policy changes (Psychosocial Working Group, 2005). This presents a problem for, “a degree of generalizability must be assumed, if lessons learned in one setting can be seen to benefit planning in another” (Ager, 1997, p. 403). Furthermore, any

attempt to reproduce the same program in another community brings up issues of sustainability. Sustainability can be found in the general conceptual design of psychosocial programming, with the accepted notion that all programs will have to be adapted for the population's needs. A psychosocial intervention that does not pay heed to the community's indigenous mechanisms will inevitably be ineffective and unsustainable (Ager, 2002).

The individual is a part of his environment just as the environment is a part of the individual, and the individual's experiences are tied up in the experiences of the community (Turner, as cited in Englund, 1998). Community healing and rebuilding cannot be managed by outsiders (Summerfield, 1999); however, the humanitarian aid community can be catalysts and enablers. Humanitarian workers should evaluate whether indigenous or Western-based processes are exerting influence on programming, to what degree, and whether or not the two are compatible.

A New Framework for Psychosocial Healing

A mantra of modern social work practice is "to start where the client is" (Goldstein, 1983). Goldstein continues: "Starting where the client is assures that the client's values, needs, and individuality will take precedence, and that his or her rights will prevail" (p. 268). Social work values suggest that helping can only be achieved when the helper truly has a sense of who the client is and what the needs of the client are. Humanitarian aid must also go where the needs of the communities are and address urgent concerns, while not eclipsing the dignity and worth of these populations (Summerfield, 1999, p. 1461). In addressing the needs of individuals affected by complex emergencies, Ager (2002) proposes three areas to be restored to pre-conflict functioning in order to restore psychosocial well-being: enhancing human capacity such as technical skills and knowledge, maintaining or increasing social connections within communities, and encouraging the reinstatement of culture and values such as places of worship and traditional ceremonies.

Human capacity involves community development, vocational training, and skills building. Populations affected by complex emergencies often (and understandably) direct their efforts outwards towards their damaged communities, rather than inward, towards their mental processes (Summerfield, 1999). An important goal of all humanitarian aid programming should be community input and ownership of the work being facilitated within their community. Developing the population's human capacity is a way to accomplish this goal. Humanitarian aid must not ignore the human resources available within communities, as utilizing community

members serves a two-fold purpose: identifying patterns of community strength and weakness and building and reinforcing local capacities.

Social ecology is another key component to psychosocial recovery. In Gourevitch's (1998) account of the Rwandan genocide, he notes:

...once the threat of bodily annihilation is relieved, the soul still requires preservation, and a wounded soul becomes the source of its own affliction; it cannot nurse itself directly...when it comes to soul preservation, the urge to look after others is often greater than the urge to look after oneself (p. 228).

From a programming perspective, Englund (1998) concurs that social engagement within an individual's community is an essential way for refugees to regain or maintain psychosocial well-being. Summerfield (1999) notes that death rates are two to three times higher for individuals who lack social supports; therefore, addressing individuals' social needs should be a priority in humanitarian response. Ager (1997) comments on the importance of maintaining social systems during conflicts, referring to the role that "protective or ameliorative influences" such as family members, social systems, and personal beliefs (p. 404) play in psychosocial interventions.

As for Ager's (2002) third area of psychosocial resources, the mental health of individuals affected by complex emergencies may depend on their ability to carry out culturally significant practices, such as religious prayer and cultural rituals. These rites allow individuals to continue to evolve spiritually, and in many instances, signify an intense transformative process (Englund, 1998). Informal and anecdotal evidence abounds regarding the positive effects of the reestablishment of cultural norms within communities. Eisenbruch (as cited in Summerfield, 1999) notes the positive use of traditional healers among Cambodian refugees affected by the Khmer Rouge regime. Englund also highlights the importance of death rituals, such as exorcisms of the spirits of the dead, as a form of psychosocial healing among Mozambican refugees in Malawi. An indigenous healing program has been developed in Uige, Angola, to provide former child soldiers with an elaborate ceremony when they return to their home villages, symbolically representing psychological healing and community acceptance (Green & Honwana, 1999). Ager (2002) speaks of other Angolan communities who have utilized traditional medicine and church movements to alleviate suffering and have participated in the reestablishment of community meals ("sewa senbet") around the

community, thereby creating a space for community development and psychosocial support.

Ager (as cited in Summerfield, 1999) suggests there is a place for a targeted clinical response as well, since there will be individuals who do develop severe mental disorders that community-based interventions cannot address. Such targeted therapeutic responses should only be used after intact supportive networks, such as the ones described above, have been employed, ensuring that the voices of the people that the humanitarian world intends to assist are rightly heard. In many cases of war-related mental trauma, however, the individual has not lost his mind, but rather his world (Summerfield, 2003). It is up to the humanitarian community to help the individual rebuild his world.

The Future of Psychosocial Interventions in Complex Emergencies

While there may be friction between psychosocial programming and basic humanitarian assistance, humanitarian aid agencies must define what the top priorities are in a particular emergency. Most experts define water and sanitation, immunizations, food and nutrition, and medical care as priorities in complex emergencies with the overarching goal of reducing morbidity and mortality (Leaning, Briggs, & Chen, 1999; Medicines Sans Frontieres, 1997; Salama, Spiegel, Talley, & Waldman, 2004). Psychosocial assistance providers must carve out a place for mental health interventions, acknowledging that the alleviation of psychological suffering should also be a priority. Nevertheless, such efforts are difficult when there is only anecdotal and qualitative evidence that psychosocial interventions are effective (Palmer, 2002; Psychosocial Working Group, 2005; Salama et al.). In a field where humanitarian assistance is intrinsically dependent upon donor money, it is difficult for indigenous, community-based programming, such as the culturally-relevant, psychosocial programming discussed in this paper, to gain the support it needs without evidence-based proof of its efficacy.

A recent study among children in Afghanistan (Psychosocial Working Group, 2005) attempted to provide quantitative evidence that community-based psychosocial interventions were effective. Researchers aimed to identify and reduce threats to war-affected children's well-being and encourage the development of social systems and individual capacities. The study was designed to compare the effects of the implementation of psychosocial programming ("child centered spaces") with the implementation of a water-sanitation project (the construction of water

wells) on the well-being of children in various communities throughout Afghanistan. Although the results did not show that either program had a greater impact, the study data proved that both interventions had value to the study participants. Furthermore, this study provided a template for future quantitative research.

The ways in which psychosocial interventions can be applied to everyday humanitarian activities within a refugee community are limitless. Psychosocial services do not have to be a separate entity from other services provided by humanitarian agencies. Mothers can be trained at therapeutic feeding centers to educate others in their community about malnutrition. Members of the refugee community can assist with local water and sanitation projects. The development of “child-friendly spaces” in IDP camps can help alleviate the tedious, toxic atmosphere that surrounds children daily (G. Martone, personal communication, September 22, 2004)^{IV}. Mobilizing educators and children into schools within resettlement camps serves a two-fold purpose for the children and the adults working with them. It is essential that humanitarian aid support the rituals that war-affected populations go through to complete the mourning process: providing burial materials for families, assistance for funeral arrangements, and additional food for funeral parties (Englund, 1998).

Effective social workers employ an ecological systems theory in their work with individuals and communities, conceptualizing individuals as participants within a number of social structures. Furthermore, social workers promote self-determination, help develop individual agency, and build upon the understanding that individuals and communities have the capacity to address their own needs (National Association of Social Workers, 1996). These social work values are consistent with effective, community-based, and culturally-salient psychosocial practice. With this in mind, social workers should assist in the development of all sector objectives during complex emergencies, utilizing their ability to conceptualize appropriate psychosocial interventions throughout all levels of humanitarian relief.

Every step away from war brings its own difficulties, as communities struggle to rebuild and heal. The detrimental effects of war among culturally rich communities cannot be ameliorated by Western-based models, which can overlook resiliencies and strengths. To meet the needs of communities, collective capacities, social connections, and cultural values must be cultivated. Social workers play a vital role in addressing the consequences of war among affected populations by assisting in the rebuilding of infrastructures, tangibly and emotionally, at the individual level and at the community level.

Endnotes

^I In DeVries, 1998, p. 1580.

^{II} Dr. Martha Grady is a psychotherapist based in New York City's White Institute, who works with children affected by war-related trauma. This reference is from a December 4, 2004 lecture entitled, "Psychotherapy with Refugees of Trauma."

^{III} Hawthorne E. Smith is a psychologist and the Co-Director of Clinical Services at Bellevue/NYU's Survivors of Torture program, which provides multidisciplinary treatment and case management services to survivors of political torture and their families residing in New York City. This reference is from a December 2, 2004 lecture entitled, "Therapeutic Work with African Victims of Torture."

^{IV} Gerald Martone is the Director of the Emergency Response Unit for the International Rescue Committee, a global non-governmental organization that provides humanitarian assistance to those affected by complex emergencies. This reference is from a September 22, 2004 lecture entitled, "Current Operational Issues in Humanitarian Efforts: Sudan's Silent Tragedy."

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