FMO Thematic Guide: Psychosocial Issues
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6. Interventions

7. Research methods

8. Resources

1. Overview

A web-based study of psychosocial resources and documents reveals that there is not a balanced representation of different positions and approaches to the issues on the Internet. While there is a large amount of literature on post-traumatic stress disorder (PTSD) on the web, very few documents and resources that present a cultural or community-based approach to psychosocial issues are available on the Internet. One of the reasons for this may be the unequal access to electronic resources and publications available to scholars who work within a trauma approach and those who do not. In order not to replicate the trauma bias that currently exists on the web in this guide, a number of articles, books, and papers that are not electronically available are reviewed here.

1.1 The study of war and mental health issues in psychology and psychiatry

People have known for a long time that war can have a negative effect on people's emotional, mental, spiritual, and social well-being. In many communities around the world rituals have existed for centuries that are specifically intended for combatants returning from battle to help them reintegrate into communal life. It is only in the past 150 years or so, however, with the development of psychological theories and knowledge, that this has become the concern of psychologists in the West[1]. Summerfield (2000) points out that prior to the development of psychology as a discipline the suffering, distress, and illness caused by armed conflict had been considered primarily spiritual or religious affairs rather than medical or psychological issues.

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[1] The term 'West' refers to the countries of western Europe and North America and 'Western' refers to ideologies and approaches to psychological knowledge that originate in these countries.

Psychological practitioners[2] became interested in alleviating the effect that exposure to and participation in armed conflict has on people from the late nineteenth century onwards. In World War I many soldiers suffered from symptoms that could not be explained by physical injury. This illness came to be known as 'shell shock', as the doctors believed that the shock from exploding shells was responsible for the illness (Leys 1996). Later on, with the development of psychological theory and greater attention to the emotional and mental problems of the soldiers in World War II and of survivors of the Nazi concentration camps, doctors concluded that there were psychological reasons for why people became ill after very distressing experiences.

It was the Vietnam War veterans, returning from the Vietnam War to the USA from the 1970s onwards, who focused attention on the issue of the psychological consequences of armed conflict on people (see PTSD). Since then it has become generally accepted by psychological practitioners that the experiences of war can have a negative impact on the emotional and mental well-being of people and that it is the duty and responsibility of mental health workers to address these (Young 1995). How this has been done has varied greatly and will be discussed below.

In communities around the world it has long been recognized that participation in warfare can cause difficulties and problems for the combatant and his or her family. These difficulties are, however, different from the ones presented by psychology and psychiatry and may include having to appease restless and vengeful spirits of civilians unjustly killed in warfare, or the reincorporation of a soldier into a community. In Angola and Mozambique, for example, purification rituals are performed for returning soldiers so that they may be reincorporated into their communities. In Native American communities returning soldiers underwent sweat lodge rituals which are seen both as spiritual and physical purification ceremonies but also as opportunities for personal growth and healing (Wilson 1989).

Historically, there are thus many different understandings and conceptualizations of the social, personal, and health-related consequences of participating in warfare. These will be explored in the following sections.

Websites:
Honwana 1991
http://ccrweb.ccr.uct.ac.za/two/8_1/p30_collective_body.html

Leys 1996
http://www.uchicago.edu/research/jnl-crit-inq/v20/v20n4.leys.html

Summerfield 2000
http://bmj.com/cgi/content/full/321/7255/232

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[2] This includes all people who work in the area of mental health, for instance social workers, psychologists, psychiatric nurses, counsellors, psychiatrists, community mental health workers, etc.

2.1 Development of psychosocial assistance as part of the humanitarian aid regime
Over the last two decades humanitarian agencies providing assistance to war-affected populations have increasingly paid attention to the psychological and social impact of violent conflict and displacement on communities. The physical and material conditions of displaced groups have always been considered the mandate of humanitarian agencies but it was only from the mid-1980s onwards that organizations began to see the provision of forms of psychological assistance to large-scale refugee displacements as part of their agenda as well.

There are several reasons for this. One is the way in which psychology has become popular in the media and public conversations in the West. Psychological explanations are frequently used in relation to people's problems and experiences in television talk shows, movies, and in newspaper advice columns. The word 'trauma' in particular has become part of everyday language in many Western countries, where people talk about experiences as having been 'traumatic' or someone having been 'traumatized' as a consequence of death, divorce, illness, or accident (Bracken *et al*. 1995). In the wake of the attacks on the USA on 11 September 2001, 'traumatization' has become a household word in that country as information is provided to the public about what symptoms they and their children may expect to have as a result of the 'trauma' they have experienced (Ehrenreich 2002).

A related reason for the popularity of the concept of trauma in the West is the idea of post-traumatic stress disorder (PTSD) and the way in which psychologists and psychiatrists use it not only to explain the behaviour of the Vietnam veterans, but also the reactions of people to distressing life events or natural disasters such as hurricanes, earthquakes, and fires (see, for instance, the International Society for Traumatic Stress Studies).

Another reason is that as more refugees came to European and North American countries after World War II, attempts were made to integrate them into the host societies. Medical centres providing medical services to the refugees and asylum seekers noticed that some of their clients had long-term illnesses that seemed to be caused primarily by emotional pain rather than by physical illness or injury (Eisenbruch 1992). These long-term illnesses made it difficult for the refugees to adjust to life in their new countries. Medical practitioners tried to provide psychological help to some refugees who not only were suffering from 'culture shock', but who were also trying to cope with the memories of what they had left behind as well as experiences of death and suffering.

These experiences contributed to humanitarian agencies becoming concerned about the emotional and psychological well-being of forced migrants. They argue that focusing on the priorities of human survival such as safe water, food, and shelter should not mean that mental health is of less importance (Marsella *et al*. 1994). The international aid community has a responsibility to address the psychological and emotional dimensions of the refugee experience.

This thinking led to a proliferation of psychosocial projects in conflict zones in the early 1990s, particularly in response to the wars in the former Yugoslavia and the genocide in Rwanda in 1994. Summerfield (1996) states, for instance, that 185 psychosocial projects were operating in areas of the former Yugoslavia in 1995. The implementation practices of such projects are diverse, with some focusing predominantly on providing psychological services, for instance counselling for individuals or groups, while others placing more emphasis on social assistance through community development (Strang and Ager 2001).

Some critics argue that the popularity of psychosocial work with war-affected communities and displaced people has led to the growth of a 'psychosocial industry', similar to the humanitarian aid industry, relying on professional 'experts' from the West to develop trauma programmes for populations in the south (Parker 1996). These and other criticisms will be discussed in more detail in some of the sections below.

Websites:
Bracken *et al.* 1995
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3YS8BF9-6-1&_cdi=5925&_orig=browse&_coverDate=04%2F30%2F1995&_sk=999599991&wchp=dGLbVzz-lSzBA&_acct=C000010360&_version=1&_userid=126524&md5=9bc23bf57f1c99751856f292dbabc81a&ie=f.pdf.

Eisenbruch 1992
http://216.239.35.100/search?q=cache:lzCNbuJucm8C:www.dinarte.es/salud-mental/pdfs/Eisenbruch-From%2520PTSD%2520to%2520cultural%2520bereavement.pdf+Maurice+Eisenbruch+cultural+bereavement&hl=en&ie=UTF-8

International Society for Traumatic Stress Studies
http://www.istss.org/

Strang and Ager 2001
http://www.ishhr.org/conference/articles/strang.pdf

1.3 Definitions: what is psychosocial work?
What exactly does the term 'psychosocial' mean and what is meant by psychosocial assistance or work? Are these substitutes for mental health and providing psychological help? Or does the term 'social' mean that anything that improves the general well-being of war-affected communities can be counted as being psychosocial?

It seems that every organization answers these questions differently, depending on which approach it takes. As has been said, psychosocial projects vary greatly and include anything from therapy sessions to building communal structures where people can meet and conduct their community affairs. Ahearn (2000) notes that there is little agreement in the field as to what psychosocial assistance is or should be: different organizations

emphasize either the psychological or the social aspects, but also have different understandings of what each of these terms mean. Many different psychological theories exist about how to help people who have had distressing experiences. For example, cognitive psychologists believe that influencing thinking processes is important, psychodynamic psychologists believe that reactions are caused by unconscious impulses, and system theory psychologists believe that the social environment of the person is the most important aspect of how they cope with experiences. More information about these different psychological approaches can be found in Loughry (2001).

It has been suggested that the concept of 'psychosocial' should be linked with 'well-being', in other words that people's psychosocial well-being is part of their general health (Ahearn 2000). The World Health Organization (WHO) defines health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity' (Ahearn 2000: 4). Most definitions of the term 'psychosocial' are based on the idea that a combination of psychological and social factors are responsible for the well-being of people, and that these cannot necessarily be separated from one another. The term directs attention towards the totality of people's experience rather than focusing exclusively on the psychological aspects of health and well-being, and emphasizes the need to view these issues within the interpersonal contexts of wider family and community networks in which they are located. Ager (2001), for example, describes psychosocial interventions as the integration of social and psychological approaches to the prevention of mental health problems and social difficulties.

The definition used by Baron (2002) is one that was agreed in the 1997 Regional Workshop in Kenya and states: 'The word 'psycho-social' simply underlines the dynamic relationship between psychological and social effects, each continually influencing the other.' Baron points out that this suggests that each person is made up of an integration of the following:
- the mind, thinking, emotions, feelings, behaviour are the psycho or psychological components
- the social world which creates the context through the environment, culture, economics, traditions, spirituality, interpersonal relationships with family, community and friends, and life tasks.

Websites:
Ager 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/video/toc_tr.htm

Loughry 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/brief/paradigm/par_p1.htm)

2. The trauma debate
When they think of psychosocial work with war-affected people many assume that this involves working with trauma or with traumatized people. The word has become so popular that assumptions are very quickly made about experiences of war leading to

trauma automatically. 'Trauma' is used to talk about the resulting state of distress in an individual, a group, a community, or a nation.

There has been a lot of debate about the concept of trauma and how it has been applied. While trauma remains a dominant model used by many psychological practitioners who seek to provide assistance to war-affected populations, the voices of criticism have been growing louder. It is important briefly to outline the basic lines of argument.

First the issues will be presented from the perspective of those practitioners who make use of the concept of trauma and find it useful.

2.1 The concept of PTSD
Central to the notion of trauma is the concept of post-traumatic stress disorder (PTSD). The experiences of the Vietnam War veterans were important in developing this diagnosis (Marlowe 2000). The veterans had difficulties adjusting to civilian life after they returned, many becoming alcohol dependent, committing criminal offences, and displaying aggressive behaviour in public. There was a high rate of divorce. The returning soldiers experienced a number of symptoms associated with their experiences, such as flashbacks to extremely distressing situations, sleep disturbances, avoidance of situations that triggered memories of distressing events, difficulties in feeling emotional responses, and, occasionally, memory loss. These symptoms occurred so frequently amongst this group that a new psychiatric disorder was developed by the American Psychiatric Association which was included in the third edition of their *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published in 1980 – PTSD. It consists of a number of symptoms related to:
- the re-experiencing of the distressing event
- the avoidance of things that remind one of the event, and
- increased physical problems such as not being able to concentrate or difficulties with sleeping.

If these symptoms affect the person to such a degree that they are no longer able to function in social, vocational, or other important areas of their life, and if they persist for more than one month, a person may be diagnosed with having PTSD.

PTSD is a term now commonly used when some psychological practitioners talk about the effects of distressing events such as displacement, witnessing or participating in armed conflict, bombings, torture, rape, or attacks. For an example of such research, see Krinsley and Weathers (1995). Researchers use PTSD checklists in countries around the world such as Sierra Leone, Sri Lanka, and Columbia, on the basis of the belief that this is a universal concept that can be applied to everyone regardless of cultural, ethnic, religious background, age, gender, or context. They assert that the same symptoms will appear in anyone who has been traumatized, whether they be an American war veteran or an Angolan adolescent displaced by war.

Using PTSD as a diagnosis means that people who suffer from its symptoms can be diagnosed as having a mental disorder. While this was the initial 'clinical' intention behind the development of this diagnostic category, it has also been used:

- to conduct research in order to understand better the effects of war on different populations
- to conduct needs assessments among affected populations in order to argue for the allocation of resources for mental health or psychosocial programmes
- to conduct evaluations of the impact of psychosocial programmes. This is usually done by measuring the numbers of symptoms before and after a psychosocial intervention, to see if there has been a decrease in symptoms.
- to identify specific individuals or groups in a population that have been particularly negatively affected and who need additional support.

Websites:
Krinsley and Weathers 1995
http://www.ncptsd.org/research/rq/rqpdf/V6N3.PDF)

Marlowe 2000
http://www.rand.org/publications/MR/MR1018.11/MR1018.11.ch9.html)

2.2 Other aspects of the concept of trauma
The concept of PTSD is central to understanding trauma and has become the 'gold standard' for understanding the effects of armed conflict and displacement on people. Many people equate war-related distress with trauma, and equate trauma with PTSD. However, the concepts of trauma and traumatization are broader than PTSD. For example, some psychological professionals are of the opinion that PTSD is just one of many mental health problems that can arise as a consequence of traumatization (Newman *et al*. 1996). Depression and anxiety are the two other most frequently diagnosed psychiatric disorders, and research is being conducted into the frequency with which they occur amongst war-affected populations (Friedman and Marsella 1996).

While the symptoms of PTSD are 'found' and diagnosed in individuals, some scholars argue that psychological practitioners should focus on the traumatization of whole communities where they have been subjected to large-scale displacement, genocide, or constant attacks from armed groups (International Trauma Research Net Conference 2002). This results in the breakdown of social relations, and can lead to an increase in interpersonal conflict, domestic violence, and alcohol and drug use (see Weisaeth and Eitinger 1991).

Some psychologists have argued that trauma can be transmitted from generation to generation (Danieli 1997). Research was first conducted by scholars studying trauma symptoms in the children of Holocaust survivors (Kestenberg and Brenner 1996). The central idea here is that, unless some intervention takes place, parents will transmit to their children their unresolved feelings about the distressing events they have experienced, resulting in the traumatization of the next generation.

Websites:
Danieli 1997
http://www.ncptsd.org/research/rq/rqpdf/V8N1.PDF

International Trauma Research Net Conference 2002,
http://www.traumaresearch.net/con_xx.htm

Weisaeth and Eitinger 1991
http://www.ncptsd.org/research/rq/rqhtml/V2N3.html

Key readings and psychological studies:
Danieli, Y., Rodley, N., and Weisaeth, L. (eds), *International Responses to Traumatic Stress*. New York: Baywood, 1996.
Marsella, A., Friedman, M., Gerrity, E., and Scurfield, R. (eds), *Ethnocultural Aspects of Posttraumatic Stress Disorder*. Washington, DC: American Psychological Association, 1996.
http://www.ncptsd.org/research/rq/rqpdf/V3N2.PDF
Mollica, R. 'Assessment of Trauma in Primary Care. *MSJAMA*, vol. 285, 2001.
http://www.ama-assn.org/sci-pubs/msjama/articles/vol_285/no_9/jms0307012.htm
National Institute of Mental Health
http://www.nimh.nih.gov/publicat/violence.cfm
Van der Kolk, McFarlane, A., and Weisaeth, L. (eds), *Traumatic Stress. The Effects of Overwhelming Experiences on Mind, Body and Society*. New York: Guilford Press, 1996.
Yule, W. (ed.), 'Post-Traumatic Stress Disorders. Concepts and Therapy'. Chichester: Wiley, 1999.

2.3 Criticism of the trauma concept
The concept of trauma has come under criticism in the past few years. Critics have focused on several key issues:

1. Aid agencies and funders have focused on trauma and traumatization as the 'flavour of the month'. This means that they frequently arrive in post-emergency situations with a preset agenda of providing psychosocial assistance where communities may actually identify other issues and concerns as more important (Bracken and Petty 1998). The material conditions and economic needs may be neglected by aid agencies who have received funding to implement psychosocial projects. Bracken *et al.* (1995) believe that this reflects a Eurocentric agenda rather than the expressed needs of war-affected populations themselves. Political and historical issues are also ignored in favour of emotional and mental health issues (Summerfield 1999).

2. Trauma is a Western concept that cannot be applied to non-Western populations. Trauma and PTSD arise out a Western psychiatric diagnostic system and are inappropriate to different cultural contexts, where people not only have different diagnostic systems but also different understandings of distressing events and how to survive them (Boyden and Gibbs 1997). People make sense of their experiences in reference to cultural frameworks and local cosmologies, and their reactions are, to a great extent, influenced by their perceptions of the meaning of those events These meanings may not be psychological or medical but may be spiritual, cultural, or political. By imposing this Western trauma framework on other populations, psychological

practitioners have largely ignored the role that culture plays in issues of distress and mental health, instead focusing on interpreting the suffering of people by means of pre-determined psychiatric categories and PTSD symptom checklists. Where attempts have been made to implement culturally sensitive programmes, these have often been guided by the notion that cultural factors are potential barriers to be overcome in the provision of psychological services, rather than resources. The distress and suffering caused by war cannot, therefore, be captured in universal concepts, and are instead related to context and local culture. At times, Western models of trauma may be in direct opposition to local cultural understandings of distress, or fit poorly with local cosmologies, norms, and values (Wessells 1999).

3. Interventions that aim to alleviate trauma are often inappropriate and ineffective. A consequence of point 2 is that Western treatment and intervention practices tend to use uniform programmes which are implemented regardless of the cultural context within which they work, thereby failing to acknowledge local diversity in expression, understanding, and treatments (Adjukovic 1997). Psychosocial projects have been described as ineffective at best, and as having a destructive influence at worst when indigenous efforts to cope with the social and material devastation are overridden and undermined by Western 'trauma experts' (Richters 1998).

4. Local resources and systems are ignored. Communities have resources for coping with distress that they draw on in situations of adversity, a fact frequently ignored by psychological professionals, who focus more on what they see as weaknesses and deficits than on strengths and abilities (Summerfield 2001). Recognition needs to be given to the important role of local healing practices and coping strategies, as these are central to strengthening community reconstruction in post-conflict situations, as well to the many ways in which people engage in 'world-making' after events of armed conflict (Nordstrom 1997).

5. Talking about people as traumatized presents them as passive victims. The presentation of people and communities as traumatized implies 1) that they have a mental disorder, and 2) that they are passive victims who need the assistance of wesTern-trained 'experts' (Bracken 1998). In fact, most people are not traumatized in the sense that they become dysfunctional, and only a small minority ever require special help. Claims of vast numbers of 'traumatized' people and generational transmission overexaggerate the percentage of people who may be unable to cope with their distressing experiences.

Websites:
Bracken *et al.* 1995
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3YS8BF9-6-1&_cdi=5925&_orig=browse&_coverDate=04%2F30%2F1995&_sk=999599991&wchp=dGLbVzz-lSzBA&_acct=C000010360&_version=1&_userid=126524&md5=9bc23bf57f1c99751856f292dbabc81a&ie=f.pdf.

Summerfield 1999

http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3WR495S-F-
1&_cdi=5925&_orig=search&_coverDate=05%2F31%2F1999&_qd=1&_sk=999519989
&wchp=dGLbVtb-
lSzBk&_acct=C000010360&_version=1&_userid=126524&md5=2d8665f86190910324
9f2bac6f7c6d59&ie=f.pdf

Summerfield 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/natconf/toc.htm

Key readings from a critical perspective:
Boyden, J. and Gibbs, S., *Children of War. Responses to Psycho-social Distress in
Cambodia*. Geneva: United Nations Research Institute for Social Development, 1997.
Bracken, P. and Petty, C., *Rethinking the Trauma of War*. London: Free Association
Books, 1998.
Gilbert, J., 'Responding to Mental Distress in the Third World: Cultural Imperialism or
the Struggle for Synthesis?' *Development in Practice*, vol. 9, no. 3, 1999.
http://www.developmentinpractice.org/abstracts/vol09/v9n3a04.htm
Summerfield, D., 'A Critique of Seven Assumptions Behind Psychological Trauma
Programmes in War-affected Areas'. *Social Science and Medicine*, vol. 48, 1999.
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3WR495S-F-
1&_cdi=5925&_orig=search&_coverDate=05%2F31%2F1999&_qd=1&_sk=999519989
&wchp=dGLbVtb-
lSzBk&_acct=C000010360&_version=1&_userid=126524&md5=2d8665f86190910324
9f2bac6f7c6d59&ie=f.pdf
—, 'Childhood, War, Refugeedom and 'Trauma': Three Core Questions for Mental
Health Professionals'. *Transcultural Psychiatry*, vol. 37, no. 3, 2000.

http://www.sagepub.co.uk/frame.html?http://www.sagepub.co.uk/journals/details/issue/a
bstract/ab013947.html

2.4 Victims or survivors: the resilience/vulnerability debate
Studies have found that in countries where almost everyone has been exposed to or
witnessed distressing incidents (for instance, Rwanda, Bosnia, Cambodia), people appear
to be remarkably resilient. In a survey of 3,000 residents of Sierra Leone, where a ten-
year civil war has brought suffering, death, and displacement to most of the country's
population, 59 per cent of the respondents described themselves as 'generally a happy
person'. Ehrenreich (2002) points out that these figures are comparable to findings in
similar surveys in North America and Europe, where people were not experiencing armed
conflict.

The debate to what extent war-affected people can be described as being vulnerable or
resilient in relation to their experiences and how they cope with these has been a constant
feature in psychology since World War II (Cairns 1996). Some psychologists are
interested in the question why some people suffer more serious psychological
consequences than others, while other psychologists seek to identify the factors that
promote resilience in children and adults affected by adversity. Some of the commonly

described factors that may play a role in how well people cope with distressing experiences are:

- social environment such as emotional, moral, and practical support from family, friends, neighbours, and support groups
- individual factors such as age, personality and previous experiences, and coping strategies
- ideological factors such as political commitment or religious faith
- cultural resources and collective coping strategies such as mass funerals, rituals and ceremonies.

It has been argued that studies of the psychosocial effects of armed conflict have concentrated too much on vulnerability at the expense of neglecting people's strengths and abilities to cope (Boyden 2000). While there have been reasons for this, for example placing the psychological well-being of forced migrants on the international agenda, the consequence has been to present war-affected people primarily as victims. Victimhood is frequently a disempowering position, in that it implies helplessness and the need for someone to intervene and assist. It should not be assumed that people want or require psychosocial assistance. Summerfield (2001) discusses findings by Somasundaram (1996), who asserts that large numbers of Sri Lankans suffer from PTSD following aerial bombings, but that none of them considered themselves psychiatrically ill and just saw their symptoms as an inevitable part of the war. The majority of Sri Lankans were able to adjust to their symptoms and function in their social and vocational lives. The help they asked for was primarily economic.

Placing the emphasis on resilience does not mean that people who are resilient do not experience symptoms of distress. It does, however, take as a starting point people's abilities and capacities to deal with their experiences, and necessitates – at the very least – providing assistance that they themselves need and want.

Websites:
Boyden 2000
http://www.rsc.ox.ac.uk/casocialhealing.html

Summerfield 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/natconf/toc.htm

3. Cultural and anthropological studies
The study of armed conflict distress has not only been the concern of psychology and psychiatry but has also been researched by anthropologists and sociologists. Their approach has been to take local understandings and perspectives as a starting point, based on the belief that the political, historical social, cultural, and economic contexts play a central part in how armed conflict is perceived and how subsequent distress is dealt with.

Understandings of distressing events vary between situations, and these variations are very important as to how people themselves perceive and cope with these events. For example, experiences of young people in armed conflict in the DRC (Democratic Republic of Congo) will differ from those of young people involved in armed conflict in

Palestine, which in turn differ from the experiences of young people in Kosovo. The political situations differ; the historical reasons for the conflict differ; the social and communal situations differ; economic factors play different roles; and cultural understandings of the situations differ. These will all affect how young people view themselves and their communities, and how they view their own actions and those of people against whom they are fighting. This in turn will influence how they and their communities deal with the distressing events. Most scholars advocating for a cultural approach to war-related distress are therefore sceptical of the claims of trauma professionals that trauma is a universal phenomenon, and question whether Western systems adequately reflect experiences of people in other cultures.

3.1 Culture: definition

People use the word 'culture' in many ways and to mean very different things. In the West, researchers have in the past viewed 'culture' as referring to something that other people have in other parts of the world, without taking into account that every society and community is influenced by culture or cultures (Chakraborty 1991). As Clifford Geertz observes: no human community is 'culture-free' (1973).

The term has often been understood to refer only to specific customs, practices, food. or ways of dressing. However, this definition is too narrow. Culture is about ways of thinking and living. Culture influences the meanings we attach to issues and events, relationships, and interactions, ways of feeling and being in the world.
A useful definition is given by Helman (1994: 2–3), who defines culture as a

> set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relations to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual.

3.2 Culture and distress

This section briefly describes some of the central concepts that have been used by medical anthropologists, and cultural psychologists and psychiatrists to understand how culture influences how people understand and respond to distressing events such as armed conflict and displacement.

3.2.1 Etic and emic perspectives

These refer to whether one adopts an 'outsider' or 'insider' view of an illness or problem.

The etic perspective imposes a way of viewing the world on the illness. Usually this is a Western, biomedical view that tries to make an illness fit a prescribed biomedical category. Behaviour and illnesses are examined from a position outside the social or cultural system in which they take place.

The emic approach is the 'insider' perspective, in which the world-view of the people who are ill or distressed is adopted. The cultural and social system in which the people find themselves is seen as central to understanding the illness (Berry *et al*. 1992).

3.2.2 Explanatory models
Arthur Kleinman (1978), psychiatrist and medical anthropologist, uses the term 'explanatory model' to explain that the patient and the healer may have very different conceptual understandings of the nature of the illness, its cause, and its treatment. For example, the experiences of a returning soldier may be seen by a psychiatrist as symptoms of PTSD. To the soldier and their family, these symptoms may be signs that vengeful spirits of civilians they have unjustly killed may be disturbing them. Whereas the psychiatrist may recommend some form of therapeutic intervention, the family may believe a purification ritual to appease the spirits to be the most effective remedy. The psychiatrist and the family hold different explanatory models of the problem and conflict may arise when communication across these different models does not occur.

3.2.3 Somatization and idioms of distress
Distress is not expressed in the same way in all cultures or communities. Some symptoms seem to be common to people who have experienced or witnessed armed conflict (sleep disturbance, concentration problems, disturbing memories). Other symptoms vary and are frequently complex. Some have argued that the imposition of a PTSD framework results in the loss of important variations in the way in which distress is expressed.

A common way in which distress is expressed in many parts of the world is somatization: people complain of physical symptoms which are mainly caused by emotional or mental worry, anxiety, or stress. Common complaints are vague aches and pains, headaches, palpitations, dizziness, and weight loss (Swartz 1998).

The term 'idioms of distress' has been used to describe specific illnesses that occur in some societies and that are recognized by members of those societies as expressions of distress. An example that illustrates both 'somatization' and 'idioms of distress' is the term 'nerves'. It is used in many parts of the world to describe bodily pain and emotions: insomnia, fatigue, restlessness, etc., as well as feelings of sadness, tension, and weepiness (Scheper-Hughes 1992). In South Africa people suffering from nerves associated it with poor economic conditions, worries, bad feelings, and interpersonal conflicts (Swartz 1998). Nerves refer to matters of mind, body, and spirit ,and no one medical explanation can ever convey the multiple meanings of this illness.

One of the main functions of idioms of distress and somatization is that they convey a wide range of personal and social concerns in a way easily recognizable by other people, who are then alerted that the sufferer may need help.

3.3 Local resources and strategies
All communities have resources for dealing with difficulties, illness, and distress. Practitioners who place culture at the centre of their work with war-affected communities believe that the starting point for any intervention or assistance offered must be an

understanding of what these resources are. Efforts by 'outsiders', i.e. people who do not belong to he communities they seek to assist, should be aimed at

- establishing the resources available
- determining to what degree they have been disrupted
- providing assistance to re-establish these, or facilitating processes for strengthening these.

Local resources and strategies for dealing with distress may vary. One of the most common ways in which people around the world respond when they are distressed is to turn to those around them for advice (Kleinman 1980). Practical advice will often be given about how the problem or illness can be resolved, for example by seeking out a healer, priest, or nurse. Moral support may be given to the person and practical help for overcoming periods of illness may be provided.

Other resources that people draw on may be indigenous healer, diviners, priests, or prophets. Honwana (1999) describes how healers and diviners are consulted by people in Mozambique troubled by spiritual problems related to the killing of innocent civilians and to the neglect of the performance of proper burial rites. Reynolds (1996) reports that children who were disturbed by nightmares following the civil war in Zimbabwe were taken to indigenous healers by their parents, and Eisenbruch (1992) observed similar ways of coping with distress amongst Cambodian refugees in the USA. In Angola the churches play an important role in helping people with distress, with priests of independent, prophetic, charismatic, and established churches providing prayers, advice, and faith healing (Eyber 2001).

Rituals form an important part of healing in some communities. Wessells and Monteiro (1999) provide examples from Angola where communities use rituals to reintegrate young returning soldiers who were demobilized during a brief period of peace in the country. These rituals were effective in helping most of the youngsters make the transition to civilian life and in facilitating community acceptance of the youth.

Practitioners and scholars who study the local resources and strategies of war-affected communities report that people deal with the realities of their experience in a dynamic way, constantly negotiating their survival and simultaneously rebuilding their lives. Nordstrom (1997: 189), researching the way in which Mozambicans responded to the destruction of their homes and lives, calls this engagement in 'world-making', where people 'seek new sources of survival; they seek to understand what it is they need, and how they are to go about getting it', creatively and actively forging new identities, reinventing homes, and revitalizing the world with significance. Nordstrom reported that during her extensive research in many parts of Mozambique over a period of many years she saw no community that had succumbed to chaos, inertia, or destructiveness. Some individuals had, but they were in the minority.

Websites:
Eisenbruch 1992
http://216.239.35.100/search?q=cache:lzCNbuJucm8C:www.dinarte.es/salud-mental/pdfs/Eisenbruch-

From%2520PTSD%2520to%2520cultural%2520bereavement.pdf+Maurice+Eisenbruch
+cultural+bereavement&hl=en&ie=UTF-8)

Honwana 1999
http://ccrweb.ccr.uct.ac.za/two/8_1/p30_collective_body.html

3.4 Criticism of the cultural approach
Criticism has been expressed of the cultural approaches to providing psychosocial
assistance:
- *Cultural approaches provide information about one specific community which cannot
  be generalized to other communities.* It has been argued that this approach has limited
  practical value as the information gathered cannot be applied to inform a broader
  approach.
- *There is a danger that local culture and local resources may be romanticized and
  seen as the solution to all problems.* This is often not the case as resources have been
  destroyed, healers may not be available, and the performing of rituals may not be
  possible in locations to which people have been displaced. There is a need to be
  aware of not romanticizing local culture.
- *Some advocates of a cultural approach view 'culture' as static entities rather than as
  constantly changing dynamic systems.* There is a danger that people seek to identify
  certain characteristics of cultures (e.g., 'Cambodians believe in spirit possession')
  without taking into account variation within the population, as well as the changing
  nature of beliefs, lifestyles, and ways of thinking.
- *Issues of power between individuals and groups are present in all communities.* The
  emphasis on taking local practices as a starting point may contribute to maintaining
  unequal power structures in communities.

Key readings on cultural and anthropological studies:
Honwana, A., 'Non-western Concepts of Mental Health'. In M. Loughry and A. Ager
(eds), *The Refugee Experience. Psychosocial Training Module* (rev. edn). Oxford:
Refugee Studies Centre. 2001.
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/nonwest/toc.htm
Nader, K., Dubrow, N., and Stamm, H., *Honoring Differences: Cultural Issues in the
Treatment of Trauma and Loss*. Philadelphia: Bruner/Mazel, 1999.
Nordstrom, C., *A Different Kind of War Story*. Philadelphia: University of Pennsylvania
Press, 1997.
Swartz, L., *Culture and Mental Health. A Southern African view*. Cape Town: Oxford
University Press, 1998.

4. Women in situations of armed conflict
(See also the thematic guide on Women/gender)
Gender issues cut across all sectors of society, regardless of political, economic, or social
context, and this is no different for situations of political violence and armed conflict
(Moser and Clark 2001). Discussions of gender issues in situations of war often present
women as victims, in particular of sexual abuse and forced abduction, while men are

presented as perpetrators or defenders of their nation and communities. 'Women and children' are frequently classified together as one category – that of civilians – while men are often classified only as combatants.

In the psychosocial and other literature this simplistic representation has often meant that women are seen as passive and vulnerable while men are associated with active aggression. More recently, these stereotypes have been challenged by authors such as Moser and Clark (2001) and Lentin (1997).These authors argue that this presentation has denied women the role of social actors, who have the ability to shape their environment and events. As a result women's involvement and participation in armed conflict, both deliberate and coerced, is not recognized. However, arguing for the recognition that women are more involved in situations of armed conflict than just as passive recipients of violence does not imply that no differences in experience and in power relations exist between men and women, nor that the experiences of men and women may not be profoundly different from one another.

4.1 Gender relations
Mary Diaz (2001) identifies three main ways in which gender differences are manifested in all societies:
- gender roles: the activities and behaviours which are expected of women and men in social and economic life, for example the division of labour between women and men
- social institutions: the family, marriage, the state, and other institutions that ensure that people comply with these roles
- cultural institutions and practices such as religion, the media, language, literature, history, etc.

In situations of armed conflict and political violence these gender differences may be reinforced, or may be changed in some way. Understanding power relations between women and men is important when trying to investigate how gender relations are changed in such situations. Cockburn (2001) identifies four 'moments' of conflict where power relations need to be considered: before armed conflict breaks out; in times of war and repression; in processes of peacemaking; and in post-war periods. Different dynamics may operate at such times: in El Salvador, for example, the needs of women combatants were not considered in the demobilization process although they had participated alongside men in the armed struggle (Ibáñez 2001). In other situations women who suffer discrimination and human rights abuses during peacetime may become actively involved in changing these situations in post-conflict situations and rebuilding their communities.

Changes in women's traditional roles can occur in situations of social upheaval. Armed conflict can create large numbers of female-headed households when men are detained, displaced, have disappeared, or are dead (Lindsey 2001). Traditional protection and support mechanisms may no longer be operating which heightens the insecurity and danger for the women left behind. However, the situation may also mean that women are forced to take over responsibilities and activities traditionally carried out by men. This may lead to the development of new skills and confidence as they become involved in rebuilding the lives of their own families as well as their communities:

Before the war women were taken into consideration. Women were only
working in the home. But when war came women came out of the house to
demonstrate their capability. In part it was the war which meant that women
could be taken seriously and they could do a lot of things. It made people
realise that women are capable of changing society.
(A woman from El Salvador, quoted in Lindsey 2001: 31)

Such changes can be seen as reflecting the empowerment of women. They take place,
however, in the context of poverty, loss, and deprivation, all of which strongly impact on
women's lives as well as on whole communities. Nevertheless, he changes that take place
in wartime may not be permanent and can be reversed in post-war situations, when
women are expected to withdraw to the home again (Lindsey 2001).

Websites:
Diaz 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/gender/toc.htm)

Lindsey 2001

http://www.icrc.org/Web/eng/siteeng0.nsf/d268e7e7eea08ab74125675b00364294/5bd09
56e8c9593cfc1256b66005efee9?OpenDocument

4.2 Experiences of women in situations of armed conflict
There is clear evidence that women suffer severe forms of abuse during, and often after,
armed conflict (Moser and Clark 2001). Such abuse includes An example is sexual
violence. In Mozambique and Rwanda mass rape was used as an instrument of war;
women were abused both by their rapists and by their husbands, families, and
communities who afterwards rejected them (Turshen 2001). Sexual violence occurs
frequently in all phases of armed conflict and may be carried out by armed forces,
military groups, or civilians. Here are three further examples:
• The rape of Somali women in refugee camps in Kenya while they were gathering
firewood (Diaz 2001)
• Refugee women forced to exchange sex in return for being allowed to cross a border
into South Africa (Dodson 1998)
• The abduction of girls in northern Uganda by the Lord's Resistance Army. The girls
were forced to work as domestic and sex slaves (Waliggo 1999)
Sexual violence against girls and women may result in pregnancy. Children born of
forced maternity are more likely to suffer infanticide, stigma, neglect, and discrimination,
and their mothers may be rejected and ostracized by their communities (Carpenter 2000).
Domestic violence affects women during peace and war, but may be increased in
situations of general poverty, disempowerment, and frustration, which frequently occur
following displacement (Kumar 2001).

Unequal access to essential services and goods, such as food, water, shelter, and health
care, is a problem faced by many displaced women. Female-headed households may
encounter discrimination when access to services and goods is controlled by men.
Decisions about food distribution in refugee camps, for example, are often made by

international organizations in consultation with male leaders who may have little understanding of the needs and circumstances of the women who prepare the food (Forbes 1992). Women may find it difficult to access general or reproductive health care in situations of armed conflict: services (e.g., gynaecological services) may be absent, inappropriate (e.g., only male medical staff is available where this is culturally or religiously unacceptable), or inadequate. In some situations women may have to seek permission from male relatives before they can access health services (Lewis and Kieffer 1994).

Widowhood is one of the consequences that many women face in situations of armed conflict. Widowhood frequently changes the social and economic roles of women in the household and community. While the impact varies widely between communities and societies, widows may struggle to gain access to basic goods and services, may have their rights to inheritance and land challenged, and may be relegated to a position of lesser social status in their community. In some communities, widows may not be allowed to keep their children or may have to care for dependants in the deceased husband's family. Lindsey (2001) points out that many women have organized themselves into groups to fight for their recognition and rights.

Other issues affecting women are lack of freedom of movement due to harassment and attack; access to education and training for girls and young women; and the challenges of becoming involved in income-generating activities (Diaz 2001).

Websites:
Diaz 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/gender/toc.htm)

Dodson 1998
http://www.queensu.ca/samp/publications/policyseries/policy9.htm

Lindsey 2001

http://www.icrc.org/Web/eng/siteeng0.nsf/d268e7e7eea08ab74125675b00364294/5bd09 56e8c9593cfc1256b66005efee9?OpenDocument

Waliggo 1999

http://www.uhrc.org/publications/%5B1008660606%5DThe%20plight%20of%20women %20and%20children%20in%20areas%20of%20armed%20conflict%20in%20Uganda.do c

4.3 Psychosocial issues
Issues of women's health and well-being are frequently linked to one of two categories: maternal and child health, or reproductive health. This has led to the criticism that a woman's health is primarily considered from the point of view of her reproductive or maternal functions and not in its own right (Desjarlais *et al*. 1995). The World Mental

Health Report (Desjarlais *et al*.,1995) argues that such a traditional approach should be broadened to incorporate mental and physical health across the life cycle:

> A woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by the effects of workloads, nutrition, stress, war and migration, amongst others.
> (Van der Kwaak *et al.* in World Mental Health Report 1995: 179).

Understanding the sources of ill health for women relates to understanding how cultural and economic forced interact to undermine the social status of women.

Women and men share many of the same losses, deprivation, and threats of armed conflict (e.g., the destruction of homes and the killing of family members). Some experiences of violence and difficulty, however, affect either women or men, or have more severe consequences for women. Sexual violence is one example. Similarly, the loss of a spouse may alter a woman's life and status in ways that affect her ability to survive. Does it follow from this that women are more vulnerable in psychosocial terms?

The international community has responded by viewing women as more vulnerable and in need of special assistance. In Bosnia and Rwanda many agencies sought to set up programmes specifically targeting women who had been raped. Richters (1998) points out that these initiatives were not always welcomed by the women concerned: they felt that they were only of interest to the agencies and the media because they were survivors of sexual violence, and that their own opinions of the type of assistance they wanted were not taken into account.

Lindsey (2001) and Turner (2001) discuss the effects of the identification of women as particularly vulnerable, pointing out, on the one hand, that this sometimes leads to more problems for women, and, on the other, that it can lead to neglect of the suffering experienced by men. The vulnerability of any group (men, women, the elderly, children) differs according to its exposure to a given problem and its capacity to tackle it. The type of action necessary to respond to the needs of women depend on circumstances (Lindsey 2001).

It is vital that the women themselves are asked about the issues they would like addressed and the manner in which they would like to receive assistance. Involving women in the planning, design, implementation, and evaluation of psychosocial programmes is crucial to their success. In addition, programmes that seek to address general psychosocial issues in a population need to be gender-sensitive by taking into account the situation of women, the particular problems they face, and the ways in which they deal with them (Diaz 2001).

Women have different coping mechanisms from men and these need to be recognized and strengthened. In many situations of armed conflict women have organized themselves to address the issues they face (Kumar 2001). In Rwanda, for example, women's organizations such as Pro-Femmes were actively involved in shelter projects as they saw housing as an important first step for women to rebuild their lives (Newbury and Baldwin 2001). 'Capacity building' is a much-used term but in the context of

empowering women to face the challenges of post-conflict or post-emergency societies, it should form part of psychosocial programmes whose aim it is to help people cope.

Websites:
Diaz 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/gender/toc.htm)

Lindsey 2001

http://www.icrc.org/Web/eng/siteeng0.nsf/d268e7e7eea08ab74125675b00364294/5bd09
56e8c9593cfc1256b66005efee9?OpenDocument

Turner 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/vind/toc.htm

Website of the Women's Commission for Refugee Women and Children:
http://www.womenscommission.org/

Key readings on women and armed conflict:
Agger, I., 1992 *The Blue Room. Trauma and Testimony Among Refugee Women. A Psycho-social Exploration*. London: Zed Books. 1992.

Diaz, M., 'Gender and Forced Migration'. In M. Loughry and A. Ager (eds), *The Refugee Experience. Psychosocial Training Module* (rev. edn). Oxford: Refugee Studies Centre, 2001.
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/gender/toc.htm)

Kumar, K. (ed.), *Women & Civil War. Impact, Organisations and Action*. Boulder, Colorado: Lynne Rienner, 2001.

Lindsey, C., *Women Facing War. ICRC Study on the Impact of Armed Conflict on Women*. Geneva: ICRC, 2001.

http://www.icrc.org/Web/eng/siteeng0.nsf/d268e7e7eea08ab74125675b00364294/5bd09
56e8c9593cfc1256b66005efee9?OpenDocument

5. Children in situations of armed conflict
(See also the thematic guide on Children)
5.1 Experiences of children in armed conflict
The experiences and circumstances of children in armed conflict are diverse and cannot be easily generalized. Children may live in areas where they are exposed to and may participate in low-intensity warfare for many years (as in Sri Lanka); they and their families may be displaced suddenly and may lose their possessions and land; they may be separated from or remain with caregivers; they may be abducted by armed groups (as in northern Uganda); they may experience sexual exploitation and torture; and they may witness death, killing, and injury of family members, friends and neighbours. Bombings,

and the threat of land mines may be among the experiences that children and their families are confronted with.

In many situations the health of children may be endangered through malnutrition, insufficient food intake, and a lack of access to basic health care. An example that illustrates all of these different aspects is Palestine, where the situation of children has seriously deteriorated since the start of the last *intifada* in September 2000. A 2002 report by Johns Hopkins University and partners found that children were experiencing severe levels of malnutrition in Gaza and the West Bank (http://www.usaid.gov/wbg/reports/Nutritional_Assessment.pdf). Children and their families are also frequently being prevented from reaching clinics in hospitals during periods of occupation by Israeli troops (Save The Children US 2001a), and school attendance has dropped as children are either unable to attend school due to road blocks, closures, or military attacks by Israeli troops.

What are the psychological and social effects of these diverse experiences on children? There has been a tendency for psychologists to make blanket statements about vast numbers of 'traumatized' children who have suffered forms of psychological 'damage', and at times it has been claimed that these are irreversible and permanent wounds inflicted on the psyche and spirit of children. There can be no doubt that situations of armed conflict have negative consequences for children's well-being and that they often interfere negatively with children's development. However, such statements are based on particular Western notions of childhood, development, and trauma, which will be discussed in the next section.

There has also at times been a narrow focus on the psychological or mental and emotional effects of armed conflict *per se*, without a recognition that the social effects of armed conflict have a severe impact on the overall well-being of children. To take the example of Palestine above: it is not only the experiences of attacks and occupation by Israeli troops that affect children, but also the impact of economic stagnation in Gaza and the West Bank, which results in severe malnutrition for children, as well as the dangers and difficulties of gaining access to health care and schooling. It is not possible to separate out the impact of the actual attacks from the social, economic, and political consequences of armed conflict, nor to identify particular events such as deaths or bombing as the only experiences that cause distress and negatively affect children's development.

Websites:
Save the Children US 2001a
http://earlybird.qeh.ox.ac.uk/cgi-bin/ps/saxon.pl?psychsoc.7.xml?copyright.xsl

5.2 Childhood, development, and trauma
Conventional Western perspectives on children and childhood have tended to view children as vulnerable, passive, and dependent, and they should therefore be protected from work, hardship, and misfortune (Boyden 2000). Western scholars have presented these views of children as 'truths' that apply to children everywhere. Boyden points out,

however, that such notions are socially constructed and context-specific and vary across cultures, class, and historical time periods. Great variation exists of how children, their capacities, roles, and needs are viewed in different societies, and the notions of passivity and dependency are not necessarily shared. Children in many societies take care of siblings and work in and outside the household, learning skills and competencies that are valued by the children themselves, as well as by their communities.

Another challenge to Western notions of children as passive and vulnerable is that these perspectives deny children's agencies and resilience (McCallin 2001). Children are active social agents, who engage with the environment around them and participate in and influence events. The assumption that children are passive recipients to whom negative things happen, as opposed to actors who are resilient and who cope with the difficulties they face, is pervasive in psychological discussions of the effects of armed conflict, and may result in a lack of recognition of children's rights to make decisions about issues that affect their lives. It also has implications for perceptions of the 'psychological damage' done to children in situations of armed conflict: statements about large numbers of traumatized children assume that emotional and mental wounds are inflicted on children, who respond with symptoms of trauma. This 'pathologizes' the experiences of children and ignores their status of subjects, rather than respondents, in situations of adversity. Evidence has clearly shown that the majority of children do not become traumatized or suffer severe long-term psychological problems, but that they cope with their experiences and suffer no long-term psychological consequences (Cairns 1996). Of course children do experience distress in the form of nightmares or fear, for instance, and a minority of children do react with severe disturbances, but it is wrong to assume that all children are automatically traumatized or permanently damaged.

Developmental psychologists have sometimes presented a universal notion of child development that is based on the idea that all children pass through specific developmental stages in which they need to negotiate specific tasks, for instance the development of trust, self-confidence, or certain age-specific competencies. This approach assumes that children need certain conditions for optimal development and that the lack of these conditions will impede or delay their development. This linear, generalized model has been challenged by scholars who view development as a dynamic and evolving process during which multiple forces interact to shape a child's physical, emotional, social, and cognitive maturation (Ahearn *et al*. 1999). The notion of conditions for optimal development also operates as a Western standard of ideal conditions for children's development against which other conditions are unfavourably compared, a problematic concept (Burman 1994). Again, these criticisms of developmental psychology do not imply that developmental psychology has no role to play in discussions of the effects of armed conflict on children, and the significance of child development will be discussed in the next section. It is, however, important to understand that a purely needs-focused approach, based on Western understandings of what these needs are, is contested.

Websites:
Boyden 2000

http://www.rsc.ox.ac.uk/casocialhealing.html

McCallin 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/children/toc.htm

5.3 Child development and child rights

The two dominant approaches to understanding the situation of children affected by armed conflict and providing assistance to them have been oriented around child development and child rights. These two approaches are not necessarily in conflict with one another, and complement each other even as they place different emphasis on various aspects of children's situation.

The child development approach emphasizes the age- and stage-related developmental needs, vulnerabilities, and capacities that must be addressed in order to further healthy and holistic development in children (Ahearn *et al.* 1999). The aim is to minimize risks and prevent further harm while reinforcing protective factors that facilitate children's physical and psychosocial well-being. Cultural influences and contextual factors such as patterns of socialization, education, and care can have a profound influence on a child's developing attitudes, values, and beliefs, and should be considered when adopting a developmental approach. For example, while it is clear that babies and toddlers depend on adults for their physical survival, the way in which attention, care, and nurture are given to them may vary within different social and cultural contexts. While participating in cultural and social activities is also a developmental need of children, the way in which this happens will be diverse. The main aim is to allow children to reach their fullest potential in a holistic manner.

The rights-based approach focuses on the fact that children have not only needs, but also the right to have these needs met, as well as other rights such as survival rights, protection rights, and participation rights. The Convention on the Rights of the Child (CRC), which was launched in 1989 and widely ratified by governments around the world, and the African Charter on the Rights and Welfare of the Child (1990) set international norms for the recognition and observance of children's rights. The three key principles of the CRC are (1) the best interests of the child must be observed; (2) non-discrimination is to assure that all children have the right to be treated equally; and (3) children must have the right to participation. This last principle is important for a number of reasons: first, it acknowledges that children are individuals with thoughts and feelings; second, it emphasizes the right of children to have their views not just heard but also taken into account when decisions are made; and third, it recognizes that children are participating members of their communities (McCallin 2001).

Both child development and child rights approaches place primary importance on the protection of children from violations, maltreatment, injury, and exploitation. Both approaches also emphasize the provision of services to children, for instance the right to food and health care, the right to education, and the right to enjoy social security. The rights approach places additional importance on the right to participation.

Websites:
Convention on the Rights of the Child
http://www.unicef.org/crc/crc.htm

McCallin 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/children/toc.htm

5.4 Some key issues in the provision of psychosocial assistance
5.4.1 Focus on children and focus on families
Over the past years, attention in psychosocial work has shifted from providing assistance to children directly to working with families. The family has the most significant influence on a child's development and is the child's greatest resource (Action for the Rights of the Child 2002). The physical and emotional well-being of caregivers (defined as individuals involved in providing care to children, including parents, siblings, grandparents, relatives, or neighbours) is important for the well-being of children, and this recognition has led to more programmes for caregivers. Strengthening the capacities of parents, families, and communities better to assess and respond to the abilities and needs of their own children is perhaps the most effective and sustainable means of achieving positive, long-term developmental impact for children

Websites:
Action for the Rights of the Child 2002
http://www.unhcr.ch/cgi-
bin/texis/vtx/home/+DwwBmVeoNxpwwwwnwwwwwwwhFqA72ZR0gRfZNtFqrpGdB
nqBAFqA72ZR0gRfZNcFqmE2gDzmxwwwwwww/opendoc.pdf

5.4.2 Separation
Research has shown that keeping children with parents or caregivers during emergencies usually provides children with the emotional support they need, and reduces the negative impact of the events and the risk of developing severe reactions of distress (Richman 1993). This has led to a general principle in humanitarian work that aims to keep children together with their caregivers where this does not directly endanger the lives of the children, and to reunite children who become separated from their caregivers as quickly as possible in the post-emergency phase (Uppard *et al*. 1998). Institutionalization of orphans and children who cannot easily be united with their families is usually only undertaken when no possibilities exist for finding fostering places or peer groups that can fulfil the role usually filled by other caregivers.
Richman (1993) points out that the emotional well-being of children will remain reasonably intact when the caregivers with whom the children remain offer a stable presence and have not themselves become severely distressed, anxious, or depressed. If it is the case that the caregiver is anxious and distressed for long periods of time the child's emotional well-being may deteriorate rapidly.

5.4.3 Establishing a sense of normalcy and predictability
It has generally been accepted that one of the important issues for the psychosocial well-being of children is how quickly and how well a sense of normalcy and predictability can

be established in the lives and daily routines of children (UNHCR 1994). Establishing educational and leisure activities such as sports, as well as the continuation of religious and cultural activities, are seen as important means of providing this normalcy. It has recently been questioned whether the idea of 'going back to what was before' is always appropriate or desirable, given that communities may have spent considerable time before the present emergency living in situations that were unpredictable and marked by intermittent episodes of violence. In addition, elements of what may be sustaining the conflict in a certain area may be part of the previous normalcy, and it may be that communities wish to change those factors and engage their children in different activities. However, these considerations of what type of 'normalcy' the lives of children should be returned to does not detract from the idea that structured activities are beneficial for children, as they provide children with some predictability and routines that may otherwise be absent following displacement and severe disruption to their communities.

Websites:
UNHCR 1994
http://www.unhcr.ch/cgi-bin/texis/vtx/home/+TwwBmetFMl_wwwwrwwwwwwwwhFqA72ZR0gRfZNtFqrpGdBnq
BAFqA72ZR0gRfZNcFqOt1omncoDn5aqrocmGnDaWKK6Dzmxwwwwwww1FqhRl20
0/opendoc.pdf

5.4.4 Education:
The early provision of educational activities is seen as vital to the psychosocial well-being of children (Action for the Rights of the Child 2002). Not only do schools provide a daily structure, purpose, and meaning for children, but they may also lead to children gaining greater insight into understanding the events that have occurred. In addition, teachers who have been made aware of possible problems and difficulties that may occur with the children may be in a position to identify particularly distressed children so as to monitor their progress.
Voices of criticism of the importance accorded to education in the form of schooling have been growing. Parents may see school as irrelevant for their children, as no jobs are available upon graduation, and they may see vocational training as more important. In many countries schools are inadequate, and the regimentation and bureaucratization in schools is contrary to the ways in which children live and learn in traditional communities (Desjarlais *et al*. 1995). Corporal punishment and the authoritarian relationships of teachers with their pupils may make experiences of schooling a source of distress for children. Blanket statements about the psychosocial benefits of schooling need to be made with caution.

Websites:
Action for the Rights of the Child 2002
http://www.unhcr.ch/cgi-bin/texis/vtx/home/+DwwBmVeoNxpwwwwnwwwwwwwwhFqA72ZR0gRfZNtFqrpGdB
nqBAFqA72ZR0gRfZNcFqmE2gDzmxwwwwwww/opendoc.pdf

5.4.5 Importance of play

The notion that play is an important part of children's lives which promotes their overall well-being is central to many psychosocial programmes. Tolfree (1996) discusses the reasons for this. Children's play often reflects the experiences they have undergone, for example attacks or bombings, and may serve as an expression of feelings as well as a way of integrating difficult experiences. In this sense, play can be seen as having 'natural healing properties'. Play can also serve as a barometer of children's well-being: the absence of play among children can be taken as an indication that something is wrong. Many programmes thus concentrate on providing opportunities for children to play, meet together, and socialize with one another (Tolfree 1996).

5.4.6 Adolescents

A recent report by the Women's Commission for Refugee Women and Children, entitled *Untapped Potential*, draws attention to the fact that adolescents are subsumed under the category of children, but are usually overlooked in programming, as resources are directed towards younger children who are perhaps perceived as more worthy recipients of aid. Not only are the needs of adolescents overlooked, but their strengths and their potential as constructive contributors to societies also remain unrecognized. Adolescents are affected by armed conflict in particular ways that expose them to increased risks such as recruitment into armed groups, sexual abuse, the contraction of sexually transmitted diseases, and economic exploitation. They may assume adult responsibilities such as heading households, yet are frequently not accorded decision-making powers in communities. Adolescents may thus be faced with particular problems and may have specific psychosocial issues that they want to address. In a participatory research study with young people in Kosovo (Lowicki 2001), adolescents identified psychosocial problems as their second most important concern, superseded only by security concerns. The loss of family and friends, and uncertainly about the future and feelings of hopelessness were mentioned as issues with which they needed help.

Websites:
Lowicki 2001
http://www.womenscommission.org/reports/reports.html

Women's Commission for Refugee Women and Children, Untapped Potential
http://www.womenscommission.org/reports/womenscommission-adolescentstudy.pdf

5.4.7 Especially vulnerable groups of children?

There has been a tendency to identify specific groups of children as being especially vulnerable, for example orphans or disabled children. While such groups may need particular forms of assistance, such as economic help, it has been debated whether identifying such children as especially vulnerable is useful or beneficial. Boyden (1994) suggests that focusing on 'spectacular groups of children' such as soldiers or children on the street often occurs at the expense of the larger child populations affected by conflict. In addition, the experiences of children are not fixed and categorical; they may move in and out of categories and definitions.

5.5. Approaches to intervention
Four broad approaches to psychosocial programmes with children can be identified.

5.5.1 Clinical approaches
These approaches are based on a recovery or rehabilitation model that assumes that some form of psychological damage has been done to a child. Common interventions may include individual or small-group counselling and talk therapy in which children are asked to draw, act out, or talk about the distressing experiences. Rehabilitation with former under-age soldiers or with child survivors of land mine accidents are typical examples of this, as are programmes focusing on children with severe behaviour problems, depression, or anxiety. Clinical programmes usually work with small numbers of children and require a certain level of training in psychological theory and practice..

5.5.2 Preventative approaches
These approaches are usually orientated towards people in the community who work with children directly, for instance parents and other caregivers, teachers, health workers, religious leaders, or other social service providers. Training programmes may be instituted that provide information about the needs of children in general and about possible reactions that children may have to experiences of war, and how the adults can respond to these. These programmes are usually large-scale and are based on the assumption that if caregivers understand and respond to the needs of children, more serious reactions of distress will be prevented. Peace education, life skills training, and youth leadership programmes may also form part of such programmes.

5.5.3 Community-based approaches
These approaches are orientated towards strengthening community relationships and networks through community mobilization around issues that affect the entire population. This indirect and long-term approach is based on the belief that a shared community vision and involvement in projects that reduce the dependency on outside resources will lead to an overall improved environment for children to live and participate in.

5.5.4 Local cultural approaches
These approaches are based on the notion that communities have their own resources and strategies for helping children deal with difficulties and problems. Reynolds (1996), for instance, found that children troubled by events of the war of independence in Zimbabwe were taken to traditional healers. Churches, diviners, and communal ceremonies and rituals may be other ways in which people help their children to cope. Political commitment may be a further source of strength for dealing with the effects of armed conflict. The role of 'outsiders' to a community may thus be to help facilitate these activities, rather than to try and institute others.

* * *

The process of developing and implementing interventions has to involve the community itself. The provision of services to children is frequently a point on which community members can agree despite other differences and the development of a programme can be

a unifying factor. The communities and the children need to define what priorities for improving the well-being of children exist, and should be consulted on acceptable methods for achieving this.

Key readings on children and armed conflict:
Action for the Rights of the Child (ARC), A Rights Based Training and Capacity Building Initiative. Geneva: UNHCR/Save the Children/UNICEF.
http://www.unhcr.ch/cgi-
bin/texis/vtx/home/+DwwBmVeoNxpwwwwnwwwwwwwhFqA72ZR0gRfZNtFqrpGdB
nqBAFqA72ZR0gRfZNcFqmE2gDzmxwwwwwww/opendoc.pdf

Apfel, R. and Simon, B. (eds), *Minefields in their Hearts: The Mental Health of Children in War and Communal Violence*. New Haven: Yale University Press, 1996b.

Tefferi, H., *Psychosocial Needs of Children in Armed Conflict and Displacement. A Module for Training Teachers and Caregivers*. Stockholm: Radda Barnen, 1999.

Tolfree, D., *Restoring Playfulness. Different Approaches to Assisting Children who are Psychologically Affected by War or Displacement*. Stockholm: Radda Barnen, 1996.

UN Study on the Impact of Armed Conflict on Children (the Machel Study)
http://www.unicef.org/graca/)

Women's Commission on Refugee Women and Children, *Untapped Potential: Adolescents Affected by Armed Conflict. A Review of Programs and Policies*. New York: Women's Commission on Refugee Women and Children, 2000.
http://www.womenscommission.org/reports/womenscommission-adolescentstudy.pdf

6. Interventions
The above discussions have highlighted some of the differences that exist between conceptualizations and theories of psychosocial work with war-affected populations. These differences are also expressed in practice and in the types of interventions that are implemented. A particular rhetoric has developed around psychosocial interventions which glosses over some of these differences: almost all interventions claim to be culturally sensitive and community-based. A closer examination of actual programmes reveals important differences, however, in implementation. Some of these differences centre on the following issues.

6.1 Different understandings of the 'psychosocial needs' of a population
Some organizations assume that any group affected by armed conflict will be in need of psychosocial assistance. Such an assumption may lead to situations where no or only very superficial needs assessments are conducted, as the organizations see the 'psychosocial need' as self-evident, requiring no exploration or justification.

Other organizations use needs assessments that are based on the trauma model, for instance questionnaires that assess to what and how many distressing events individuals

were exposed, and what symptoms of trauma are found in individuals. The assumption here is that counting the number of distressing events and the number of trauma symptoms gives an accurate reflection of what the psychosocial problems and needs of a population are.

A major criticism of these approaches is that they are based on a deficit model of communities and individuals. They assume that the community is lacking something. In the first case, where no or only a superficial needs assessment is done, it is assumed that the organization already knows in advance what the needs of the communities are. In the second case, a specific understanding of the effects of armed conflict, the trauma model, is used as a filter or lens through which a community's needs are viewed. In both cases, the strengths and resources of the community are not assessed or taken into account. In addition, the people themselves are not asked how they understand the experiences and events, or how they have affected their lives – only specific questions are asked that may not relate to the important aspects of people's' experiences.

A further issue is the debate around assumptions of vulnerability. Summerfield (1999) points out that many organizations assume *a priori* that certain categories of especially vulnerable people exist, and these are frequently orphaned children, women who have been raped, and widows. He takes issue with this: the focus on particular events (such as rape) may exaggerate the differences between people or particular population groups (e.g., children), running the risk of disconnecting them from others in their community and from the wider context of their experiences and the meanings they give to them. Ager (1997) describes the tension that exists between developing programmes targeted at specific groups within a community, and programmes designed for the whole population. He suggests that vulnerable groups may well exist within populations but that initial phases of a programme should be directed first towards the general population, and that later phases should be aimed more specifically at groups that seem to be coping less well with the difficulties they face. Vulnerability should thus not be assumed, but should be established through thorough needs assessment.

Websites:
Ager 1997
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3WR495S-F-1&_cdi=5925&_orig=search&_coverDate=05%2F31%2F1999&_qd=1&_sk=999519989&wchp=dGLbVtb-lSzBk&_acct=C000010360&_version=1&_userid=126524&md5=2d8665f861909103249f2bac6f7c6d59&ie=f.pdf

Summerfield 1999
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3WR495S-F-1&_cdi=5925&_orig=search&_coverDate=05%2F31%2F1999&_qd=1&_sk=999519989&wchp=dGLbVtb-lSzBk&_acct=C000010360&_version=1&_userid=126524&md5=2d8665f861909103249f2bac6f7c6d59&ie=f.pdf

6.2 Different understandings of 'culturally sensitive' or 'culturally relevant'
While the vast majority of psychosocial interventions claim to be culturally sensitive, vast differences exist between how they are implemented. Some programmes conduct group or individual therapy sessions with refugees, and because these sessions open with a prayer or a song they are presented as being culturally appropriate. Other programmes seek to find appropriate or similar words for trauma and stress in local languages, and believe that therefore they too are being culturally sensitive. Such programmes sees culture as an addendum to 'what is really going on', i.e. traumatization. They are based on a Western psychological approach to understanding distress, and view culture and context as 'external variables' that affect the particular local expressions of distress but do not change its basic form. The interventions based on such an approach frequently 'extract' a few cultural practices and attempt to incorporate these into existing programmes, for example through the incorporation of purification rituals into programmatic interventions or the promotion of 'cultural' activities like dancing and singing. The 'cultural' elements are seen as supplementing psychological methods (counselling, psychoeducation, etc.), but not as principal resources for dealing with distress. Such an approach does not do justice to local ways of understanding and expressing distress, nor does it recognize that context and culture permeate every aspect of suffering and the range of treatment options available.

This contrasts with programmes that perceive their role primarily as accompanying communities in the ways in which the communities have chosen to deal with the difficulties they face: rather than imposing outside solutions these programmes try to assist by facilitating local strategies through a variety of ways.

While most programmes lie somewhere in between these two approaches, it is important to be aware and critical of the current rhetoric around cultural issues in psychosocial programmes. The main issue is to what extent organizations see cultural and local understandings as central to their interventions (Wessells 1999). Practitioners argue that only when local culture is taken as a starting point for needs assessments, planning, and implementation, and monitoring and evaluation can programmes be said to be culturally sensitive.

6.3 Different understandings of 'community-based'
Again, there are vast differences between programmes in this respect. Some programmes assert that they are community-based programmes because the activities take place within the geographical area of the 'community', for instance in a refugee camp or in a suburb of a town. These programmes may bring in psychosocial counsellors who do their counselling sessions within the camps, and this is seen as sufficient to label the intervention as a community programme.

Being community-based is not about the physical location of programmatic activities, however. It refers to the extent to which the community itself is involved in decision making with regard to the programme and in implementing the activities, and the degree of control the community has over the programme as a whole. Issues of conflict may arise where organizations have developed models for psychosocial interventions in their

headquarters in the north, and seek to implement these in communities regardless of the specific local cultural and political contexts. Such organizations may expect community members to participate in these projects through volunteering (or payment) and may find that there is a lack of interest and a low up-take of services. Many times these failures are explained away on the basis of organizational factors, when in fact an examination of the fundamental approach to working with communities is needed.

The word 'community' is itself controversial, as it implies some kind of imaginary or physical boundary that separates a specific group of people from others. In post-emergency situations it may be difficult to determine what is or is not a community, for example amongst self-settled refugees who live alongside members of the host society in urban cities. Some humanitarian workers prefer to use the word 'population' to refer to groups of displaced people.

The central issue here is to distinguish rhetoric from implementation: to what extent are the displaced themselves involved in decision making, and the planning, implementation and evaluation of programmes intended for them? Community participation is central to effective psychosocial programming and Segerstrom (2001) provides some guidelines for achieving this.

Website:
Segerstrom 2001
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/commpart/toc.htm).

6.4 Tensions between the local population and outside experts
Ager (1997) identifies the tension between the value placed on indigenous knowledge and the technical knowledge of outside experts as central to current debates in the field. Most agencies describe their programmes as an integrated approach that draws on the knowledge of both local and outside psychosocial 'experts'. Dawes and Cairns (1998) point out, however, that asymmetrical power relations between local and foreign systems and actors will continue to affect psychosocial interventions even when these seek to incorporate local approaches. A concerted effort is needed to prevent these unequal power relations, which may often be related to access to resources, from relegating local actors to a status of lesser importance in planning and decision making.

Website:
Ager 1997
http://www.developmentinpractice.org/copy_of_dip_new/abstracts/vol07/v7n4a07.htm)

6.5 Some example of types of programmatic activities
A few examples of common programmatic activities are briefly described here.

6.5.1 Primary mental health care approach
This approach is based on the notion that all psychosocial programmes should form part of existing health care systems, and that they should be incorporated into general health care delivery (Boothby 1996b). Many developing countries who are affected by armed

conflict have limited resources allocated to mental health care systems, and health care staff may not be trained or equipped to deal with mental health problems (World Mental Health Report 2001). A primary mental health care approach is usually implemented through one of two routes: either through the training for health care personnel at institutional level, for instance in nursing colleges, or through the training of community health workers in psychosocial issues. The rationale for such an approach is:

- that mental health should form part of general health care, as mental and physical well-being cannot be separated form one another
- that mental health care is the right of all people living within a country, and efforts should thus be directed at the overall lack of provision in this area and not just at refugees or internally displaced people
- that access to and delivery of these services is most effective when they are part of basic health care and not confined to specialized psychiatric institutions that require trained doctors and expensive drugs.

This approach is often implemented in displaced populations through networks of community health workers who are already involved in providing health education about common illnesses to the population. In Angola, for example, community health workers visit households, refer people to the clinic, and hold small meetings about issues such as diarrhoea, feeding practices, and water purification. As they themselves are part of the community, they know the households in their areas well enough to discern who is not coping with their experiences and who may be facing particular difficulties. When such community workers are provided with information about primary mental health care, they may initiate appropriate action which can range from starting mutual help groups to referrals to indigenous or biomedical services.

Websites:
World Mental Health Report 2001
http://www.who.int/whr/

6.5.2 Counselling approach
This approach involves training local people as counsellors who then work in the communities providing individual or group counselling to those identified as being in need of support. The training approaches and the types of counselling technique vary greatly, but most are based on the assumption that it is helpful for someone who has been identified as being distressed to verbalize his or her memories of events, and the emotions and thoughts the memories provoke (Van der Veer 1998).

In some programmes the counsellors are not from the displaced community itself, but may be from the host community or may be living outside the area in which they are working. This may lead to friction and misunderstandings between counsellors and the displaced populations, as differences in educational background, language, culture, and political orientation may be pertinent.

6.5.3 Psychoeducation
Psychoeducation has been described by Van der Veer (1998) as a technique that involves explaining the cause of symptoms, and placing the person's experiences within a

conceptual framework, which can lead to a reduction in feelings of helplessness and powerlessness. One of the main aims of psychoeducation is to assure people that they are experiencing emotions, thoughts, and behaviours that can be expected under conditions of war. This has the effect of 'normalizing' reactions to distress. The emphases placed on specific aspects of psychoeducation and ways of implementation vary, depending on what each programme regards as important to convey. Some programmes are public information projects that aim to provide information to the public about mental health issues, based on the assumption that such knowledge leads to insight, earlier detection of severe psychological problems, and possible prevention amongst the population. Most programmes place emphasis on informing people about reactions to distress and violence amongst adults and children, often with the aim of reassuring people that their reactions are normal. Psychoeducation may include guidelines on how to distinguish between normal and pathological reactions, or information about developmental psychology that will give parents and caregivers insight into the normal and abnormal developmental processes their children undergo.

The assumptions that guide the decision to use psychoeducation as an intervention strategy relate to the importance attached to particular information, its potential recipients, and the manner in which the information is conveyed. For instance, seminar-type situations may be used to train participants, as opposed to public gatherings, or the design of pamphlets, posters and the use of theatre to convey the information may be considered relevant. The term 'psychoeducation' is thus used to encompass a range of activities intended to communicate psychological knowledge, the content of which has frequently been decided upon *a priori* by service providers. Bracken *et al*. (1995) warn against an approach that aims to educate populations about the 'real' effects of violence, i.e. symptoms of trauma, as this may undermine local expressions and ways of dealing with distress. The manner and intention with which psychoeducational messages are delivered thus seem to be important.

In conclusion, some scholars continue to argue that the trauma model is the most appropriate way of conceptualizing the effects of war and of providing psychological assistance (Danieli *et al*. 1996), while others call for a complete disengagement of the international aid community from this area of work (Summerfield 1996). The most commonly expressed position, however, is that psychosocial work needs to engage critically with the concept of culture and with local contexts in order to avoid inappropriate and ineffective programme implementation (Wessells 1999).

Agencies implement psychosocial programmes in war-affected areas around the world. There is thus a need to advance knowledge in this field, specifically in relation to the conceptualizations of distress, suffering, and trauma, and how these guide implementation practices.

Website:
Bracken *et al.* 1995
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3YS8BF9-6-1&_cdi=5925&_orig=browse&_coverDate=04%2F30%2F1995&_sk=999599991&wchp

=dGLbVzz-
lSzBA&_acct=C000010360&_version=1&_userid=126524&md5=9bc23bf57f1c997518
56f292dbabc81a&ie=f.pdf

6.6 Monitoring and evaluation

The monitoring and evaluation of psychosocial interventions has been notoriously inadequate, with many project reports asserting the beneficial effects of their programmes purely through reference to a few anecdotal reports from beneficiaries. The need to develop more systematic and effective approaches to monitoring and evaluation has recently received attention, and several initiatives are under way to produce guidelines and manuals to help agencies undertake this task (e.g., MandENews, a website on monitoring and evaluation).

At present, few resources aimed specifically at evaluating psychosocial programmes are available, and practitioners have usually drawn on more general evaluation toolkits such as the one developed by Save the Children (1995) for assessment, monitoring, review, and evaluation of their programmes, or that for the evaluation of community programmes written by Feuerstein (1986). Major differences in approaches to evaluation are evident and centre around the following themes:

- outsider versus insider evaluations: is it always necessary or indeed desirable to bring in outside 'experts' to evaluate projects, or can project staff conduct their own evaluations?
- methods: what are the most appropriate methods to answer questions of output, effects, and impact? What constitutes reliable data?
- tools: what tools are the most appropriate for implementing the different methodological approaches to evaluation?
- involvement of beneficiaries and participants in the project: to what extent are monitoring and evaluation participatory processes that involve community members themselves? How are results of evaluations reported to the communities?
- monitoring and action research: to what use are monitoring and evaluation results put? Do they feed back into the project cycle or do they end up on office shelves?

Websites
MandENews
http://www.mande.co.uk/news.htm

Key readings on interventions
Ager, A., 'Tensions in the Psychosocial Discourse: Implications for the Planning of Interventions with War-affected Populations'. *Development in Practice*, vol. 7, no. 4, 1997.
http://www.developmentinpractice.org/copy_of_dip_new/abstracts/vol07/v7n4a07.htm

Boothby, N., 'Mobilising Communities to Meet the Psychosocial Needs of Children in War and Refugee Crises'. In R. Apfel and B. Simon (eds), *Minefields in their Hearts: the Mental Health of Children in War and Communal Violence*. New Haven: Yale University Press, 1996b.

Dawes, A. and Cairns, E., 'The Machel Report: Dilemmas of Cultural Sensitivity and Universal Rights of Children'. *Peace and Conflict: Journal of Peace Psychology*, vol. 4, no. 4, 1998.

Save The Children Alliance, *Promoting Psychosocial Well-being among Children Affected by Armed Conflict and Displacement: Principles and Approaches*. International Save the Children Alliance, 14, 1996.

Wessells, M., 'Culture, Power and Community: Intercultural Approaches to Psychosocial Assistance and Healing'. In K. Nader, N. Dubrow, and B. Stamm (eds), *Honoring Differences. Cultural Issues in the Treatment of Trauma and Loss*. Philadelphia: Bruner/Mazel, 1999.

7. Research methods

The field of research into the mental health and psychosocial well-being of forced migrants has drawn on various social science and medical disciplines: psychology, anthropology, sociology, psychiatry, and public health, amongst others. Within these disciplines great variation exists between the approaches adopted towards research and the types of research aims to be achieved. For instance, psychologists have used methods such as narrative analyses to investigate the experiences of one or two people and how they have coped with the impact of these experiences – while other psychologists have adopted a 'survey approach' to gathering information about large numbers of people. Medical anthropologists have investigated local conceptualizations of distress, loss, and death, while some social anthropologists have focused on social networks and support systems that facilitate coping among refugees. It is clearly not possible to categorize research approaches based on the type of discipline researchers are trained in or work in, as decisions about methods depend on the questions the research sets out to answer.

Over the last two decades a vast amount of research has been conducted based on the concept of PTSD, with approximately 400 new publications on this topic appearing every year for the past few years. This research has predominantly relied on questionnaires, checklists and structured interviews to gain information about the type of events people have experienced, their frequency and intensity, and about the reactions to these events. As discussed in the section on the trauma debate, this approach has increasingly come under criticism for being culturally inappropriate and producing results that have limited value because it provides no information about the meaning people themselves attach to the events and responses (Summerfield 1999).

Ahearn (2000) differentiates between approaches that are quantitative and those that are qualitative. Common quantitative research methods are, for example, psychometric measurements such as depression scales or symptom checklists, surveys, or structured interviews. The emphasis in quantitative research is on answering questions such as 'what?' and 'how many?', as well as on testing suppositions (hypotheses) and correlation between factors that researchers suspect are relevant to the issues under investigation. For instance, a quantitative researcher may be interested in the levels of anxiety refugees are

experiencing, and the causes of these anxieties. She may develop a structured interview in which questions of that nature are presented to refugees, as well as questions related to other factors such as age, sex, economic background, or religious affiliation. During analysis, the researcher may investigate if levels of anxiety are related to age, religious affiliation, or other factors by conducting statistical analysis on correlation between these factors.

Common qualitative research methods are ethnographic approaches that include participant observation, semi- or unstructured interviews, and focus-group discussions. The emphasis in qualitative research is on answering questions such as 'why?' and 'how do people themselves understand certain issues?'. Qualitative researchers are interested in relationships, understandings, beliefs, values, and world-views. An example of qualitative research is an investigation of local understandings of death and the way in which death is understood from a political or religious perspective. The researcher may engage in conversations with local people about these topics, may observe funerals and burial rites and may conduct focus-group discussions with community members or leaders in order to understand the significance attached to these rites.

Both quantitative and qualitative approaches have been criticized on a number of accounts, for instance for being culturally inappropriate or for not producing results that can be generalized (Ager 2000). Ahearn (2000) makes recommendations for how both quantitative and qualitative researchers can improve their research methods, for instance by ensuring that local, culturally appropriate definitions are used, and that a shift from focusing on the individual as a unit of analysis to incorporating a perspective on families, groups, and communities is important.

Website:
Summerfield 1999
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3WR495S-F-1&_cdi=5925&_orig=search&_coverDate=05%2F31%2F1999&_qd=1&_sk=999519989&wchp=dGLbVtb-lSzBk&_acct=C000010360&_version=1&_userid=126524&md5=2d8665f861909103249f2bac6f7c6d59&ie=f.pdf

7.1 Ethical issues
Punamäki (2000b) writes about her research work in Palestine over more than twenty years. She describes some of the ethical dilemmas she faced in her research when the people she talked to felt angry at being asked what they felt to be obvious questions, or questioned what benefit they would derive from the research. She suggests that action research is one of the ways to overcome some of these dilemmas. An example of such action research conducted with displaced populations is described by Demusz (2000) and conducted with Tamil internally displaced people in northern Sri Lanka. The methodology of this project involves various stages in which researchers from the displaced communities, together with other researchers, investigated past and present problem-solving skills of the communities in order to develop ways of facilitating these.

Findings were implemented and assessed by community members so that further changes could be made.

Other ethical considerations are described by Sluka (1995), who points out that the researcher's primary responsibility is not to endanger the life of the participants and not to cause harm. Both these principles are highly relevant when working in war zones where peoples' lives may be put at risk merely by being seen talking to outsiders or for revealing information considered to be damaging to a particular group. The principles of not causing harm is, of course, standard for any kind of research ethic, but is particularly important when working with people who have experienced distressing events. Not re-traumatizing children and adults by asking them questions about events of war and then leaving them distressed is crucial, and requires that researchers develop the appropriate skills and insight to know when, who, and what to ask, and how to provide the necessary emotional containment.

Key readings on research methods:
Ahearn, F. (ed.), *Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research*. London: Berghahn Books, 2000.
Demusz, K., *Listening to the Displaced. Action Research in the Conflict Zones of Sri Lanka*. Oxford: Oxfam, 2000.
Jensen, P., 'Practical Approaches to Research with Children in Violent Settings'. In R. Apfel and B. Simon (eds), *Minefields in their Hearts: The Mental Health of Children in War and Communal Violence*. New Haven: Yale University Press, 1996.
Sluka, J., 'Reflections on Managing Danger in Fieldwork'. In C. Nordstrom and A. Robben (eds), *Fieldwork Under Fire*. Berkeley: University of California Press, 1995.
Richman, N., *Communicating with Children. Helping Children in Distress*. London: Save the Children UK, 1993.