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Aid from without, healing from within : an examination of the use of target population cultural knowledge of mental health and healing in refugee camp mental health programs

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ABSTRACT

This qualitative survey of reports is an examination of the use of target population

cultural knowledge of mental health and healing in refugee camp mental health programs.

The data for this study came from a survey of reports from completed refugee camp

mental health programs. The survey was designed to examine how refugee camp mental

health workers use the target refugee population's cultural knowledge of mental health

and healing throughout the process of needs assessment, program implementation and

evaluation and how the use of the target population's cultural knowledge coincides with

UNHCR and affiliated NGO operating procedures regarding the participation of refugees

and incorporation of target population cultural knowledge in all stages of operations.

Fifteen reports from refugee camp mental health programs in eleven countries

were surveyed and analyzed for content. In addition, an extensive review of literature

was conducted on the topics of refugee mental health theory and practice and UNHCR

and affiliated NGO operating procedures with regard to refugee involvement and cultural

integration in refugee camp programming.

The major findings of this study were that target population cultural knowledge of

mental health and healing in refugee camp mental health programs is often present but is

piecemeal, not present throughout programs and inconsistent across programs. I also discovered that there is no connection between UNHCR and affiliated NGO policy on cultural integration and ground level operations. The final section of this report examines this discrepancy. Recommendations for future studies and implications for social work are discussed.

AID FROM WITHOUT, HEALING FROM WITHIN:

AN EXAMINATION OF THE USE OF TARGET POPULATION

CULTURAL KNOWLEDGE OF MENTAL HEALTH AND HEALING

IN REFUGEE CAMP MENTAL HEALTH PROGRAMS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

The man leading the tour of the Killing Fields just outside of Phnom Penh, Cambodia kept his head down when he spoke and walked with a defined limp in his left leg. He was middle aged, a survivor of a massive human slaughter recent enough in history that the air around the capital city still hangs heavy with the energy of it; bones protruding from the hard ground as if the force of brutality that sent them into the earth was now wrenching them back up, shouting, "Remember us." Tourists shuffled in the heat, tested the air in shallow, wary breaths and surveyed the grounds with the glazed expressions of people trying not to be swallowed up by the sorrow of what their eyes were seeing.

The guide had been one of the hundreds of thousands of Cambodians who fled the capital after its fall to the Khmer Rouge in 1975; seeking refuge at ever expanding camps on the Thai border (Rowat, 2006). He recalled the overcrowding in the camps, the constant sense of fear and uncertainty as first Khmer Rouge troops, and later the Vietnamese army, mounted approaching attacks; killing asylum seekers or forcing them to scatter, camps being destroyed and reforming as the Thai government and international aid community struggled to keep up. Even when the camps were relatively secure, the man recalled that there was never enough food or potable water, that camp dwellers were violent and restless, the men sometimes only utilizing the camps as a refueling point before returning to battle the Khmer Rouge army in the bush. And of the humanitarian

assistance provided by the international aid workers, he offered an impression that spoke

to the reality of the often haphazard provision of services in crisis settings. He said that

they were always struggling to provide enough, that malnutrition and illnesses were

rampant and that there was never sufficient training for the adults or educational support

for the children. "People were in the camps for many years with nowhere to go," he said,

"We didn't want to play games or talk about what was going on. What we needed was

education and job training. We needed the tools to rebuild our lives!" (Guide at the

Killing Fields, Phnom Penh, Cambodia, personal communication, January 18, 2005).

This man's story remained in my mind long after the Killing Fields disappeared

from view in a cloud of red dust. I was also given cause to recall another account, similar

as it was though the source was a different man from a vastly different part of the world.

This account came from another guide's story, told a few years before at a genocide

memorial in the hills southwest of Kigali, Rwanda. There stood what had formerly been

a technical college campus, a scenic open space atop a cliff accessible on only one side

by a narrow land bridge. In 1994, thousands of Tutsis were told by the Rwandan

government to flee there to escape being slaughtered by marauding hoards of Hutus

during a massive nationwide outbreak of ethnic violence. But this was really a ploy to

get many Tutsis in the same place, where they could be easily killed. The escapees were

trapped on the hilltop where they became weak with starvation. The Hutu militia

blanketed the area with grenade fire, then went in with guns and machetes, brutally

murdering all who were left. The college dormitories now house approximately one

thousand of the dead, exhumed from a mass grave and preserved in lime to serve as a

ghastly reminder of the genocide that the world largely tried to ignore. The man who

now led student tours at the memorial had narrowly escaped with his life, crawling away the night after the massacre with a bullet in his head. He made his way to a camp in Burundi where he got medical treatment but left quickly to search for his family. They were never found.

The guide recalled that later in the year, after the killings had finally ceased, aid agencies began providing health services in Kigali and in the temporary camps along the borders in Uganda and Burundi. He said that he had stayed away, however, after hearing stories of the temporary hospitals drugging people with sleeping pills and anti-anxiety medications. He said that people would be put to sleep but when they woke up, all of their problems would still be there. They didn't want to be put to sleep, he said, and they didn't want to forget (Emmanuel, Guide at Gikongoro, Butare, Rwanda, personal correspondence, May 11, 2002).

Years later a very similar story was told by another Rwandan genocide survivor who attended a talk on the Smith College campus. He said that most people stayed away from the NGO-run hospital in Kigali because they were prescribing psychotropic medications. According to his assessment, Rwandan people weren't looking for medications or pills to make them sleep, they were looking to find ways to heal their society and rebuild their lives (Lecture participant, Smith College, Northampton, Massachusetts, personal correspondence, June 20, 2007).

I have prefaced this report with the above three accounts because they serve as both the impetus and background for the study contained herein. I wanted to know what had kept these people, and possibly many others, from accessing sufficient refugee camp services, particularly in the sector of mental health. I learned through research that

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mental health services were being provided at refugee camps around the world (Allison, Szewczyk & Pouwels, 2006; Drumm, Pittman & Perry, 2003; Ingleby, 2005). Yet I gathered from the three accounts from refugees that there had been some discrepancy between the mental health services provided and the needs of the people they were aiming to help. In considering this discrepancy, I was lead to question how refugees were being involved in the planning, implementation and evaluation of programs aimed to promote their welfare following a crisis and how program facilitators were incorporating refugees' beliefs about what constituted healing.   In considering mental health programs specifically, the question that I reached was as follows: How are facilitators from aid agencies contracted with The United Nations High Commissioner for Refugees using the target population's cultural knowledge of mental health and healing in refugee camp mental health programs?

In order to address this question I conducted a qualitative survey of reports from completed refugee camp mental health programs. I began with the supposition that a vast majority of refugees in refugee camps face significant mental health stressors and are in need of comprehensive mental health programs (Fong, 2004; Robben & Suarez-Orozco, 2000). I also assumed that cultural competency, as it is defined and discussed in this report, should be considered in all professional therapeutic settings and thus should be present in mental health programs in refugee camps. Upon this basis I formed a survey guide that would test reports for the presence of culturally competent practices at each point in a mental health program; assessment, intervention and evaluation. My goal was to create a picture of how cultural competency is being used in refugee camp mental

health programs, to what extent, how well it is being reported and built upon and what implications this has for the future of refugee mental health.

From the stories that preface this report, a hypothesis could be drawn that in the rush to provide emergency aid, specifically mental health services, to groups in crisis, a deficit has occurred between the services provided and the target population's needs. One explanation for this possible phenomenon can be found in Andrew Kaplan's (1964) book *The Conduct of Inquiry: Methodology for Behavioral Science*. He wrote about the "*law of the instrument*" wherein when the only tool in one's possession is a hammer, there is a tendency to see everything as a nail in need of hammering (Kaplan, 1964). Could refugee camp mental health facilitators, armed only with the tools of Western psychotherapeutic methods, be missing the actual needs of the refugee populations they were trying to serve? Or were culturally competent practices being implemented throughout programs as they ought to be? I wanted to seek to find out.

Thus the objective of this study was to explore the nature of hammers and nails, providing within, a view of the mental health issues that affect a growing number of populations in refugee camps around the world. In specifying the current responses to refugee camp mental health issues, this report sought to shed light on the specific plight of this population and the options that NGO mental health service providers have for creating programs that fit the needs of the communities they serve. My hope is that through more focus on this topic, refugee camp mental health programs will begin to more closely match the needs of refugees by providing hammers forged by the same groups who hold the nails.

CHAPTER II

REVIEW OF LITERATURE

The following review of literature will provide a brief history of the refugee crisis in the 20th century, the creation of the UNHCR and sanctioned refugee camps, and finally, refugee camp mental health programs. I will also present an overview of specific topics related to the field of refugee mental health such as collective trauma theory and posttraumatic stress disorder (PTSD). Next, literature on the concept of cultural competency will be presented including the argument for and against the inclusion of cultural competency into all fields of social work practice. In the final section of the review I will present the small body of published works on the intersection between refugee mental health and cultural competency. I will also summarize NGO policy documents pertaining to the inclusion of culturally competent practices in refugee camp programs. Gaps in research, such as the dearth of literature on the specific topic of cultural competency in refugee camp mental health programs, will be identified.

The goal of this chapter is to provide the reader with a comprehensive picture of mental health issues affecting refugees, the refugee camp mental health programs that have responded to these issues and the current published work detailing the use of culturally competent practices in these mental health programs. This literature review will give the reader a sufficient background for considering the topic of cultural competency in refugee camp mental health programs and will prepare the reader to approach the findings of this study with informed consideration.

Refugees

The United Nations High Commissioner for Refugees (UNHCR, 2007a) provides

the following as the legal definition for *refugees*: "Refugees are defined as people who

are outside their countries because of a well-founded fear of persecution based on their

race, religion, nationality, political opinion or membership in a particular social group,

and who cannot or do not want to return home." This definition was first established by

the United Nations 1951 Convention Relating to the Status of Refugees, which is

considered the most important document to date concerning refugee rights (UNHCR,

1998). First developed to protect European refugees in the aftermath of World War II,

the convention was expanded in the 1967 Protocol to include refugees across the globe.

The Convention and Protocol stipulated that host governments, comprising 147 (or

approximately three quarters of all) countries worldwide including all of the First World

nations, must afford refugees basic rights including freedom of religion and movement,

freedom to work and education and accessibility to travel documents. In addition,

refugees cannot be forced to return to their home countries while there is still threat of

danger (UNHCR, 2007a).

The 1951 Convention was written with enough fluidity in language to be adaptive

to the changing face of refugee welfare. However it has come under significant criticism

for failing to include specifications on such issues as time limits on refugee status and the

nature and required proof of threat necessary for a refugee to claim asylum in a host

country (Afzal, 2006). Arguments have also been put forth to include more consideration

for refugees displaced by natural disasters and environmental degradation. One

consideration involves the inclusion of people forced to leave their land due to

development projects, which have recently created significant strife for China's farming

class, and what are termed environmental refugees; people who no longer gain a secure

livelihood in their traditional homelands because of what are primarily environmental

factors of unusual scope (Meyers & Kent, 1995, as cited in Black, 2001). The connection

between refugees and environmental degradation was also touched on in a recent article

in *The Atlantic Monthly* magazine which suggested that global warming, specifically the

depletion of arable land due to drought, led to the genocide and subsequent refugee crisis

in Darfur, Sudan (Faris, 2007).

The UNHCR also provides aid and asylum to internally displaced persons (IDPs)

who have been uprooted from their homes by acts of violence, persecution or disaster but

are relocated within the borders of their countries of origin. With a population estimate

exceeding 25 million, the UNHCR recently termed IDPs the world's largest group of

vulnerable people (UNHCR, 2007b). Even these numbers are considered gross

underestimates because IDP groups tend to be migratory and difficult to track. It is

known however that their numbers are vast and their proximity to conflict settings often

puts them at even greater risks than refugees (UNHCR, 2007b). Yet as individuals or

groups falling into this category have not crossed outside their home country, they are not

protected under the 1951 Convention. Much debate has occurred recently in the

international community around including IDPs in a new Protocol to the Convention or

establishing a separate charter to specify this population's rights (Black, 2001; McAdam,

2006; Steiner, Gibney and Loescher, 2006; UNHCR, 2006a). Thus we may envision that

as global humanitarian crises broaden in scope and definition, the international

community will soon see a complete renovation of the 1951 Convention which will reclassify those protected under its charter and redefine their rights therein.

The United Nations High Commissioner for Refugees (UNHCR)

The Office of the United Nations High Commissioner for Refugees was established on December 14, 1950 by the United Nations General Assembly (UNHCR, 2007a). Prior to that time the League of Nations, the organization that preceded the UN, assigned Norwegian scientist and explorer Fridtjof Nansen to the post of High Commissioner for Refugees (2007a). The UNHCR's first mandate was to take up the former International Relief Organization's (IRO) mission to resettle the remaining 1.2 million European citizens who had been left homeless following World War II (Steiner, Gibney, & Loescher, 2003). Since that time the agency has been charged with leading and coordinating international action to protect refugees and resolve refugee problems worldwide. According to its website, the agency's primary purpose is to safeguard the rights and well-being of refugees (UNHCR, 2007a). The UNHCR strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another place, with the option to return home voluntarily, integrate locally or to resettle in a host country.   In more than five decades, the UNHCR has helped an estimated 50 million people restart their lives. Today, a staff of around 6,689 people in 116 countries continues to help over 30 million persons. The current High Commissioner, Mr. António Guterres of Portugal, took office in 2005, becoming the tenth person to hold this position (UNHCR, 2011).

UNHCR Refugee Camps

Statistics on the number of legally defined refugees and IDPs in the world today vary between agencies but the UNHCR states that at the start of 2011, the refugee

population had reached 10.4 million with a further 4.7 million looked after by a sub-agency for Palestinian refugees and 26 million IDPs (UNHCR, 2011). Half of the refugees of concern to the UNHCR are in Asia and twenty percent are in Africa. The countries with the largest numbers of IDPs are Sudan, Colombia and Iraq (UNHCR, 2011).

According to the UNHCR global trends report for 2006, UNHCR seeks to protect, assist and seek durable solutions for refugees through the following three scenarios (1) voluntary repatriation to the home country; (2) local integration in the country of asylum and (3) resettlement in a third country (UNHCR, 2007a). This study focused on refugee and IDP populations who have relocated to temporary or semi-permanent refugee camps either within the borders of their home countries or in a neighboring country. For the purpose of this study, both populations are referred to as "refugees" or as the "target population." Refugees who have either repatriated or resettled in another country were not considered because studies have shown that the mental health stressors that they face are significantly different from those faced by refugees in temporary camps (Drumm, Pittman & Perry, 2003; Fong, 2004; Pérez Foster, Moskowitz & Javier, 2004). This study instead focused specifically on the immediate mental health concerns of refugees in refugee camps and the mental health programs that occur therein.

There is no specific estimate on the number of people currently living in refugee camps worldwide. The UNHCR tracks areas of interest and gives date-specific and general estimates on the number of people of interest to the organization but does not give specific data on the number of refugee and IDP camps that it is currently overseeing

or an estimate of the number of people in those camps. This may be because camps form quickly, evolve or dissolve as refugees repatriate or immigrate into host countries, and change focus as immediate crises give way to long-term stabilization and development goals. The UNHCR website does specify areas of recent interest including the following: the Japanese earthquake and tsunami crisis, ongoing unrest in North Africa, flooding and violence in Northern Kenya, the ongoing crisis in Lebanon, the 2005 earthquake in Pakistan, the 2004 tsunami disaster in the Indian Ocean region, the Balkan crisis, Iraq, South Sudan, Chad/Darfur and Afghanistan (UNHCR, 2011). However the UNHCR also maintains a presence in sites of older conflicts or ongoing refugee situations. For instance the UNHCR is present in camps along the Thai border with Myanmar and in the Democratic Republic of Congo as well as many other sites worldwide.

The size, structure and availability of resources in camps can vary greatly depending on accessibility, timeframe and scope of crisis (UNHCR, 2008). The most immediate concerns are the provision of shelter, in the form of large occupancy tents, hygiene facilities, including toilets and clean water, food, medical services and supplies and communication equipment, such as radio or satellite phones with internet capability. Over time tents may become more permanent dwellings and food may be grown and harvested to supplement rations. However in many instances camps do not develop far beyond a vast network of makeshift dwellings offering impoverished, unsanitary and generally substandard living conditions (Miller & Rasco, 2004). (For photos and descriptions of refugee camps currently operated by the UNHCR, visit their website at www.unhcr.org.)

The UNHCR and NGOs

Internationally sanctioned refugee camps fall under the jurisdiction of the UNHCR but much of the work of building and running the camps is taken on by affiliated non-government organizations (NGOs). This partnership has strengthened significantly since the UNHCR's inception and the agency is now affiliated with 649 NGOs worldwide (UNHCR, 2007c). Partnerships between the UNHCR and NGOs fall into two types: implementing and operational. In implementing partnerships, the UNHCR provides funding for the NGO project and the NGO works as a subcontractor. In 2006, for instance, the UNHCR channeled $360 million of its $2.7 billion budget through NGOs (UNHCR, 2007c). In operational partnerships, the NGO provides voluntary support and works alongside the UNHCR. Operational partnerships occur more often during the immediate crisis response phase of a UNHCR program.

Following the immediate provision of basic needs services, UNHCR refugee camp administrators also contract out for other necessary services including education for children, skills training and mental health (UNHCR, 2007c). Mental health programs are implemented by participating NGOs including the World Health Organization (WHO), The Center for Victims of Torture (CVT), The International Committee of the Red Cross (ICRC), the International Rescue Committee (IRC) and others. These NGOs, often working in collaboration with regional and national agencies, are paid contractors of the UNHCR and are responsible for all phases of a program. According to the UNHCR website, NGO service providers in implementing partnerships work closely with UNHCR staff but are in primary charge of identification of program objectives, selection of partners, implementation of the project and evaluation (UNHCR, 2011). Thus NGOs are

governed loosely by the overarching principals and policies of the UNHCR but operate more within their own established guidelines.

Refugee Mental Health

Refugees are a group marked by their status as outcasts and fugitives and the refugee experience is fraught with stress, loss, uprooting, illness, trauma, fear and isolation (Stein, 1986 as cited in Drumm, Pittman & Perry, 2003).   According to Miller and Rasco (2004), refugees face two major groups of stressors that lead to mental health concerns. The first group of stressors deals with the impact of exposure to violence. People forced to flee their homeland as a result of persecution and disaster will likely have faced some of the following scenarios: dismemberment, arbitrary detention, witnessing the death of loved ones, destruction of property, rape, torture (both physical and psychological), humiliation, forced combat, brainwashing and prolonged periods of fear and vulnerability. The second set of stressors deals with the psychological effects of being displaced (Miller & Rasco, 2004).

Firsthand accounts from refugees within camps illustrate the horrors and immense hardships that people often face in the time between disaster and refuge. A woman in a Kosovar refugee camp in South Albania recalled the assault she endured and the ensuing terror during wartime.

> The first night of the bombing we were happy because we thought that we were going to be saved. The next day the Serbs came to the house and beat men, women and children. They beat my arms, chest and legs. We were afraid of the Serbs. We used to go in the   forest during the days and went home at night only. The Serbs came to our village and made threats that they would cut us up. (Drumm, Pittman, & Perry, 2003, p. 82)

A study by Dr. Frank Neuner and colleagues on the mental health of Ugandan refugees revealed that a majority of participants had witnessed brutal beatings and killings including in many cases the killing of relatives, wide scale massacres and mutilations (Neuner et al., 2004). Sierra Leonean refugees in camps in Guinea described war atrocities including the intentional hacking off of limbs, carving the initials of rebel factions into victims' skin, forced cannibalism and public slayings of pregnant women (Stepakoff et al., 2006). Stepakoff and colleagues found that the most prevalent psychological impact of these unspeakable atrocities were feelings of isolation and stigma. These themes were repeated in other mental health studies from Sierra Leone and other post-conflict settings. An adolescent Sierra Leonean boy described his struggle with stigmatization during a camp mental health exercise.

> Before coming here I was made to join the rebels. People in the camp know what I did but they don't know that I was forced to do bad things. I would have been killed if I refused. Now, at night, I remember people I killed. People in the camp won't ever trust me. To them, I will always be unwanted. My family is dead so there is nowhere I can go. No one wants me. What can I do? (Kline & Mone, 2003, p. 327)

Many reports used in this study cited feelings of isolation and stigmatization as common themes in psychological issues affecting the mental health of refugees (Amone-P'Olak, 2004; Amone- P'Olak, 2006; Bower et al., 2004; Stepakoff et al., 2006).

Miller and Rasco (2004) also examined mental health concerns caused by the psychological effects of being displaced. These stressors include social isolation and a loss of traditional social support networks, loss of property, loss of family heritage, loss of closeness to ancestors and sacred burial sites, uncertainty regarding the well-being of loved ones unable to unwilling to make the journey, a lack of income-generating

opportunities and corresponding economic self-sufficiency, loss of valued social roles, stigmatization in the new community and lack of access to proper health, educational and economic resources (Miller & Rasco, 2004). Studies have shown that these stressors have the same level of severe negative effects as exposure to violence and warfare (de Jong et al., 2001; Hollifield et al., 2002). The results of these studies have been correlated with the high levels of depression and dysthymia recorded amongst refugees seeking mental health services. However these stressors have been identified and studied most frequently as they occur in the experiences of refugees who have been relocated to new, foreign environments; such as refugee populations within the United States. In these incidences, the psychological stressors appear to be a culmination of feelings of displacement, loss of a home and culture and alienation/isolation within a new society. This set of stressors may differ from those experienced by refugees in camps who plan to eventually return to their homeland following the end of disaster and warfare.

<div align="center">**Measuring Trauma in Refugee Populations**</div>

Refugees in all different settings experience multiple stressful events that are associated with adverse mental health outcomes. However methodological difficulties—such as translation and cultural differences, and inadequate resources to fully assess symptoms—complicate accurate measurement (Hollifield et al., 2002). In a widespread survey of articles relating to refugee health and trauma, Hollifield and colleagues discovered twelve instruments (i.e. measurement tools such as questionnaires, surveys and interview schedules) specifically designed for a refugee sample population (2002). Their research concluded that none of the instruments met the criteria for reproduction in

the field because they had not been tested with different populations. Most instruments

were created for one specific study with a set population and not reproduced. None of

the instruments were published (Hollifield et al. 2002).

Bolton (2001) posed a new method for measuring trauma in refugee populations

in his study with Rwandan genocide survivors. Bolton and colleagues began by asking

members of the population to identify people who suffered from "*agahinda gakabije*" (a

locally described grief syndrome). The people identified were then asked directly if they

felt that they had this syndrome and were interviewed using the depression section of the

Hopkins Symptom Checklist (DHSCL). Bolton found that there was a similar

relationship between depression and *agahinda gakabije* as between depression and grief

in Western countries (Bolton, 2001). He concluded that this community approach to

measuring trauma would work best for the developing world where standardized testing

criterion did not exist and would lead to more accurate mental health assessments among

refugee populations.

<h3 style="text-align:center">Refugees and Post-Traumatic Stress Disorder</h3>

Mental health professionals have conducted extensive studies and published

numerous works on the relation between the severe stressors faced by refugees and the

diagnosis of post-traumatic stress disorder (PTSD) (Bowen et al., 1992; Naeem at al.,

2005; Neuner et al., 2004; Neuner et al., 2008). The majority of participants in a study of

993 Cambodian adults in a Thai refugee camp reported having experienced multiple acts

of violence, loss and deprivation (Mollica et al., 1993). In this study Mollica and

colleagues found that 55% of the study participants had prevalent symptoms of major

depressive disorder (MDD) and 90% had notable symptoms of PTSD. Studies conducted

in camps in Central America and West Africa had similar findings. Michultka, Blanchard, and Kalous (1998) found a 68% prevalence of PTSD in their study of Central American refugee adults, while Fox and Tang (2000) found that 49% of the Sierra Leonean refugees they studied in a camp in Gambia were in the clinical range for PTSD (Miller & Rasco, 2004). In a 2001 study of trauma symptoms in four refugee communities (located in Algeria, Ethiopia, Gaza and Cambodia), de Jong and collegues found that the percentage of the sample testing positive for PTSD ranged from 15.8% to 37.4%. (de Jong et al., 2001). The authors found that the reported causes of PTSD differed significantly between sites. For example, torture was related to PTSD in Algeria, Ethiopia and Gaza but not in Cambodia. Domestic adverse events during youth, death or separation within the family, and parental alcohol abuse were related to PTSD in Cambodia.

A number of studies have shown that multiple exposures to traumatic events - either to the same type of event or to different types of events - are associated with higher levels of symptoms of PTSD (de Jong et al., 2001, Neuner et al., 2004, Neuner et al., 2006). Findings from these studies suggest that in nonwestern conflict situations, PTSD is associated with a number of lifetime traumatic events (de Jong et al., 2001). A study by Dr. Neuner and colleagues (2004) of trauma amongst West Nile refugees explains the PTSD "dose-effect" as follows:

> There is a clear dose-effect relationship between traumatic exposure and PTSD in the studied populations with high levels of traumatic events. In this context, it is probable that any individual could develop PTSD regardless of other risk-factors once the trauma load reaches a certain threshold. (Neuner et al., 2004, p.1)

Researchers have used a wide variety of screening tools for the assessment of PTSD in refugee populations, including the Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1992), the Impact of Event Scale (IES) (Horowitz,Wilner, & Alvarez, 1979), the PTSD Checklist—Civilian Version (PCL–C) (Weathers, Litz, Herman, Huska, & Keane, 1991), and the Post-Traumatic Diagnostic Scale (PDS) (Foa, Cashman, Jaycox & Perry, 1997). Depression has most commonly been assessed with the Depression section of the Hopkins Symptom Checklist (DHSCL) (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974).

It should be noted that these diagnoses were being made within the framework of Western mental health doctrine and only a minority of organizations providing psychological assistance have tried to adapt scientific knowledge from PTSD research specifically to the conditions of traumatized refugees (Neuner, 2004). Also, while PTSD is widely diagnosed in refugee populations, research on effective treatments for PTSD with refugee populations is still scarce. Notwithstanding the considerable attention war-torn populations have received from psychosocial organizations in recent years, very little clinical research has been conducted on how to adequately support and treat these groups (Neuner, 2004).

Refugees and Collective Trauma

Dr. Kennedy Amone-P'Olak described traumatic events in the refugee context as follows:

> These events are the kinds that threaten the person or relatives in the sense of their existence, or by causing the destruction of things that are essential to their lives, such as the killing of their parents or relatives, burning of their houses and destruction of their property. Such traumatic events include: war, natural catastrophes, accidents, deaths and exposure to violence. The consequences of

these traumatic events include: nightmares, extreme fears of objects that remind them of the traumatic events, intrusive thoughts, anxiety, isolation and withdrawal. (Amone-P'Olak 2004, p. 26)

The phenomenon of collective trauma is also important to consider in relation to the mental health needs of refugees in camps because the traumatic events have occurred with entire communities, ethnic groups or regions (Robben and Suarez-Orozco, 2000). Refugee camp mental health programs are often focused around a healing process that restores faith in the communal environment. This work can lead to the integration of culturally competent models since much of cultural competency revolves around focusing on the strengths of a community.

A report by a group of Center for Victims of Torture (CVT) mental health workers in a camp for Liberian and Sierra Leonean refugees in Guinea details a group therapy process focused on empowering community leaders and restoring a balance within the chaos of displacement (Stepakoff et al., 2006). Stepakoff and colleagues utilized traditional interventions such as narrative, body-oriented work, dance/movement therapy, drama groups and the incorporation of the supernatural, spirit realm. This report emphasized the ideal of incorporating culturally competent models into collective trauma oriented refugee mental health programs.

Refugee Camp Mental Health Programs

Psychosocial organizations usually provide different forms of counseling approaches to assist traumatized refugees (Van derVeer, 1998). These types of treatment plans, often referred to as "trauma-counseling" or "cross-cultural counseling," encompass a large variety of approaches, such as problem-solving procedures (Amani Trust, 1997) as well as group discussions and individual assistance including variants of exposure

treatment (World Health Organization / United Nations High Commissioner for Refugees [WHO/UNHCR], 1996). In most cases, the counseling procedures and duration of treatment are not rigorously standardized. The lack of standardization poses a serious restraint for the evaluation of counseling. Little knowledge about the efficacy of counseling in general exists (Bower et al., 2002), and as of yet there is no clinical trial that examines the efficacy of counseling approaches for traumatized refugees.

Neuner and colleagues (2002) developed narrative exposure therapy as a standardized short-term approach to refugee mental health programming based on the principles of cognitive–behavioral exposure therapy by adapting the classical form of exposure therapy to meet the needs of traumatized survivors of war and torture. In narrative exposure therapy, the patient is requested to repeatedly talk about the worst traumatic event in detail while re-experiencing all emotions associated with the event. In the process, the majority of patients undergo a habituation of the emotional response to the traumatic memory, which, according to Neuner and colleagues, consequently leads to a remission of PTSD symptoms (Neuner et al., 2002). This was the first recorded randomized controlled trial for treatment of traumatized survivors of war living in a developing country.

In a 2004 study, which was surveyed for this report, Neuner and colleagues found that narrative exposure therapy was significantly more effective than supportive counseling, psychoeducation or no treatment in treating posttraumatic stress disorder in refugees (Neuner et al., 2004). This constituted the first study that considered the efficacy of different treatment methods with a refugee population.

Cultural Competency[1] in Refugee Mental Health

Siegel and colleagues (2000) provided a comprehensive definition for cultural competency in their report for *Administration and Policy in Mental Health* entitled "Performance Measures of Cultural Competency in Mental Health Organizations." Cultural competency is the term used to describe the set of behaviors, attitudes and skills, policies and procedures that come together in a system, agency or individuals to enable mental health care givers to work effectively and efficiently in cross/multicultural situations (Siegel et al., 2000, p. 92). As mental health professionals continue to recognize their obligation to adapt their work to a culturally diverse population, the use of culturally competent models for practice has become imperative in the field (Aponte & Wohl, 2000).

There has been a movement, over time, toward more incorporation of cultural competency in mental health (Castillo, 1996; Eshun & Gurung, 2009; Loewenthal, 2009). The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association [*DSM-IV*], 1994) was the first DSM to contain a section on culture-bound syndromes such as "mal de ojo" and "susto"; both of which were described in a mental health report conducted in Mexico (Miller & Billings, 1994) which was used in this study. Though there was much critique of the American Psychiatric Association's treatment of culture-bound syndromes (Mezzich et al., 1999), the creation of the section nevertheless signified a first major step toward including

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[1] In this report, the term "cultural competency" will, in practice, be replaced with the phrase "target population cultural knowledge." This is intended to suggest that refugee camp mental health programmers may not be experts in culturally competent practices but can still practice cultural competency by engaging to the target population.

cultural considerations in mental health treatments around the world. It is predicted that the DSM-5, slated to be released in May 2013, will provide a much more comprehensive inclusion of cultural considerations which will be interspersed throughout the text rather than grouped at the back (American Psychiatric Association, 2010).

Cultural competency is also being considered in the sphere of refugee mental health where Western therapeutic methods have come under scrutiny for their failure to produce measurable positive results (Amone-P'Olak, 2006). Hollifield and colleagues (2002) asserted that the work of Bolton (2001) was a good step toward incorporating community-based, qualitative data gathering techniques into refugee camp mental health programs but that refugee camp mental health providers needed to go further toward not only identifying mental illness, but understanding how illness related to impairment within the population's cultural construct (Hollifield et al., 2002). In Bolton's study, Rwandan genocide survivors were accurately diagnosed with depression and grief symptoms but it was not discovered how this diagnosis informed their function within Rwandan society. A culturally-bound diagnosis would need to be met with culturally-bound healing practices so that all parts of the mental health program fit in with the target population's cultural knowledge of both mental health and healing. Hollifield and colleagues recommended that qualitative techniques, such as in-depth interviews and focus groups, would help identify the range, depth and meaning of mental health responses in a specified population and would lead toward culturally informed interventions (Hollifield et al., 2002).

UNHCR and Affiliated NGO Codes of Conduct and Guides regarding Cultural

Competency in Refugee Camp Programming

The debate over the use of target population cultural knowledge in refugee camp

programming has not been lost on the UNHCR. The UNHCR Code of Conduct

(UNHCR, 2004), which is signed by all staff members, consultants and interns and is

shared with all affiliated governmental and non-governmental organizations and

companies which, through their employees, work for UNHCR, stated the following:

> Refugees, IDPs and returnees must be at the center of decision-making
> concerning their own protection and welfare. UNHCR firmly believes that
> the participation of refugee women and men in the definition of problems and
> the design of programmes for their benefit is crucial to serving, assisting and
> protecting them. (UNHCR, 2004, p. 5)

The Code of Conduct further specified the UNHCR commitment to refugee involvement

in the second of its five Guiding Principles.

> We are committed to supporting the fullest possible participation of refugees and
> other persons of concern – as individuals, families and communities – in the
> decisions that affect their lives. (UNHCR, 2004, p. 27)

In the Code of Conduct's final Guiding Principal, refugee culture was recognized though

the use of cultural knowledge and was met with a qualification.

> We will respect the cultures, customs and traditions of all peoples and will strive
> to avoid behaving in ways that are not acceptable in a particular cultural
> context. However, when the tradition or practice is considered by the
> relevant organ of the United Nations to be directly contrary to an International
> human rights instrument or standard, we will be guided by the applicable human
> rights instrument or standard. (UNHCR, 2004, p. 39)

This caveat to the Code of Conduct was meant to identify the Universal Declaration of

Human Rights as the fundamental constitutive document of all United Nations agencies,

including UNHCR (United Nations, 1948). The Declaration protects the inalienable

rights of the individual over states rights and mandates the protection of culture unless a

cultural practice goes against a basic human right. The Universal Declaration of Human

Rights and the Code of Conduct apply to all UNHCR employees, consultants and

independent contracting affiliates. However the code is not legally binding nor is signing

of the code mandatory for all who are affiliated with the UNHCR. It is instead, a guide to

the kind of personal and professional behavior expected of all staff members and

colleagues (UNHCR, 2004).

Other UNHCR operating manuals designate for the use of local knowledge in

refugee camp programming. The UNHCR Handbook for Self-reliance (2005a) specified

the UNHCR's community development approach to fostering self-reliance in all refugee

camp programs.

> UNHCR's community development approach gets communities involved in
> decision-making and planning (right from the emergency phase), and regards
> refugees as active partners in assistance and protection activities, rather than
> passive recipients. The community development approach uses empowerment to
> enable refugees/returnees to shape their futures, improve their environment and
> overcome limitations in service provision. It is applied from the start of an
> operation and continues throughout, working towards the identification and
> implementation of durable solutions. The approach involves refugees/returnees
> from all population groups in program planning, assessments, implementation and
> monitoring. The use of committees to represent all groups within the community
> enables everyone a voice and acts as an effective and sustainable targeting
> mechanism leading to self-reliance. (UNHCR, 2005a, p. 2)

The Handbook stated that the UNHCR has adopted the self-reliance model because

traditional humanitarian/relief assistance was being increasingly viewed as undermining

the capacities of individuals to cope with crisis (UNHCR, 2005a). The UNHCR designed

the self-reliance model to avoid dependency by refugee groups and deemed the model

appropriate for all stages (from planning and assessment to implementation and

monitoring) of every UNHCR operation.

In concurrence with the self-reliance model, the UNHCR designed a Tool for Participatory Assessment in Operations (UNHCR, 2006c). The introduction to the Tool reiterated the UNHCR's policy of placing refugees, IDPs and returnees at the center of all decision-making concerning their protection and well-being. The UNHCR's rationale for the use of participatory assessment included the following points:

Participatory assessment:

- Minimizes the risk of exclusion of certain groups

- Recognizes the power relations among groups

- Promotes greater respect for the rights of refugee women and gender equality

- Promotes participation by children, particularly adolescents

- Leads to improved accuracy of baseline data

- Improves relations between UNHCR and partners in UNHCR's operations

- Allows for a more holistic, comprehensive understanding and response. (UNHCR, 2006c)

According to the Tool, participatory assessment serves the dual purpose of involving refugees in decision-making and promoting better communication between all affiliated parties. The Tool tied the mandate for refugee participation back to the Universal Declaration of Human Rights.

> [Refugee, IDP and displaced person's] right to participate in decisions on matters that affect their lives is enshrined in human rights instruments and UNHCR policy and guidelines, in particular the Agenda for Protection. (UNHCR, 2006c, p.1)

The Agenda for Protection (UNHCR, 2003a) contains numerous references to the involvement of refugees in program decision-making and implementation. Two examples can be found in Goal 3, Part 4 and Goal 5, Part 7.

GOAL 3: Sharing burdens and responsibilities more equitably and building capacities to   receive and protect refugees

4. Refugee communities empowered to meet their own protection needs:

States, UNHCR and partners to consider ways to enable refugees to use their skills and capacities, in recognition that empowered refugees are better able to contribute to their   own and their communities' protection (UNHCR, 2003a, p. 60)

GOAL 5: Redoubling the search for durable solutions

7. Achievement of self-reliance for refugees:

States, UNHCR and partners should look at relief-substitution strategies, tapping the resourcefulness and potential of refugees (UNHCR, 2003a, p. 80)

The UNHCR's Tool for Development Assistance for Refugees (DAR) (Jallow and Malik, 2005) also specified the use of a community-based approach for programming. The Tool's Guiding Principles included the mandate to utilize a participatory and community-based approach in program design, implementation, monitoring and evaluation in order to empower communities (Jallow and Malik, 2005).

The UNHCR also specifies a community-based approach for programs involving women. The UNHCR Handbook for the Protection of Women and Girls (UNHCR, 2008) defined the community-based approach as a way of working that is based on an inclusive partnership with communities of persons of concern that recognizes their resilience, capacities and resources (UNHCR, 2008). The Handbook stated that a community-based approach is the approach best suited to alter cultural practices that are harmful to women because it will promote greater awareness of the community's shifting cultural norms. The following example was given of a community-based solution within a UNHCR refugee camp female education program.

One of the obstacles to implementing this project was the traditional hijab dress worn by the Somali refugee girls. The clothing made it difficult to participate in sports. UNHCR and community representatives therefore met and decided that a women's group would design and produce clothes that were culturally appropriate but that allowed the girls to participate more freely in sports. Nike sent a team of female designers to work with the refugees on a volleyball uniform that would respect traditional norms but give greater freedom of movement. (UNHCR, 2008, p.33)

The mental health section of the Handbook detailed the integration of target community knowledge into the assessment, intervention and evaluation phases of all refugee camp mental health programs. Guidelines for the implementation of a mental health program for women included the following.

- Spend time with the community identifying and analyzing their responses to mental health challenges and working to understand community dynamics.

- Identify trusted traditional healers and learn about their practices.

- Advocate for and integrate appropriate community-based psychosocial support in programming, emergency preparedness and contingency planning.

- Establish good relations with the community in order to identify the support structures that exist in the community before and after displacement.

- Encourage the reestablishment of normal cultural and religious events and activities in order to support social networks, such as neighborhood committees, youth and women's groups, and recreational activities for children.

- Learn about how communities helped gender-based violence survivors to recover emotionally before displacement. (UNHCR, 2008)

The Handbook recognizes the role that cultural practices can play in promoting gender inequalities and violence but promotes the integration of cultural knowledge and community involvement in order to combat these practices (UNHCR, 2008).

The UNHCR Guideline for the Prevention of and Response to Sexual and Gender-Based Violence against Refugees, Returnees and IDPs (2003b) takes a similar

approach to community involvement and integration of cultural knowledge. The

Handbook's guiding principles included the following.

> Engage the refugee community fully. The refugee community should be central
> to all program activities that address sexual and gender-based violence.
> Community involvement in decision-making is essential. It requires research to
> obtain an understanding of gender power relations and other power dynamics
> at play within the community. (UNHCR, 2003b, p. 28)

The Handbook recommends campaigns that are culturally sensitive and advocates for the

use of traditional courts in trying sexual violence cases (UNHCR, 2003b). The

framework for action included a definitive statement about the efficacy of community-

based programming.

> The programs to prevent and respond to sexual and gender-based violence that are
> most successful are those that have been designed through consultations with
> the refugee community. (UNHCR, 2003b, p. 31)

Recommendations for mental health programming included identifying and engaging

traditional healers and encouraging the resumption of positive traditional healing and

cleansing practices (UNHCR, 2003b).

> The UNHCR Handbook for Emergencies (2006b) also contained guidelines for

the employment of a community-based model for mental health programming.

> Any program dealing with mental health must be community-based with the
> refugees themselves playing a major role. The program must be based on a
> solid knowledge and understanding of the refugees' cultural background and
> integrated with the other services provided to refugees. (UNHCR, 2006b, p.
> 167)

> The Mental Health of Refugees (WHO/UNHCR, 1996), a guide jointly published

by UNHCR and the World Health Organization, contains an extensive section on

traditional medicine and traditional healers. The guide's general rules include learning

the target population's specific terms for emotional distress and mental illness,

understanding population specific manifestations of mental illness and assuring the

longevity of programs through full community participation (WHO/UNHCR, 1996).

Regarding the treatment of refugee children, the guide recommended the full and often

autonomous involvement of the community for the sake of cultural preservation.

> Culture provides identity and continuity for children. The beliefs and values that
> hold people together in families and communities are passed on through
> culture. It is best if those who work with refugee children are from the
> children's own culture and share the   same language. If you are working with
> refugee children who are not of your culture, talk to the community about how
> people care from their children, what rituals and celebrations they have and what
> hopes they have for the future. (WHO/UNHCR, 1996, p. 52)

The guide encourages cooperation with traditional healers in order to provide the best

care for the community and reminds the reader that traditional and scientific medicine

can compliment each other rather than compete.

> The traditional and scientific approaches complement each other. Used together
> in the treatment of mentally ill refugees, they give better results than if just one
> approach is used. (WHO/UNHCR, 1996, p. 67)

The guide suggested that many magical cures and traditional rituals can have a positive

psychological effect and should be promoted. However the guide recognized that a

practice occurring within a community does not necessarily constitute a traditional

practice. It is recommended that incoming staff members learn enough about the target

population's cultural knowledge of mental health and healing to distinguish between

traditional healers and quacks (WHO/UNHCR, 1996).

The World Health Organization has included extensive references to the use of

cultural knowledge in other mental health program operating manuals. In the *Tool for*

Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations

Affected by Conflict and Post-Conflict Situations (WHO, 2001), the requirement for

cultural sensitivity and community involvement is presented on the first page and is

strongly reiterated throughout the document.

> There are a few mental health interventions that are broadly acknowledged as useful to start with even before a mental health assessment is completed. These include training humanitarian aid workers in basic mental health skills including active listening, cultural sensitivity, community-based activities and community empowerment. Aid workers should provide recreational, cultural space in the design of refugee camps including places for religious and cultural ceremonies and other community activities. The community should be involved in all decision-making processes and in all common interest activities. Finally, aid workers should allow for the reestablishment of cultural and religious events, self-help groups and inter-generational mechanisms. (WHO, 2001, p.2)

This *Tool* also stated that a community-based approach to programming, with maximum

correspondence to cultural norms, will be the most successful. It recommends a full

assessment of cultural norms and implications prior to all program implementation and

recommends the involvement of the target population in the assessment, implementation

and evaluation phases of all programs.

The WHO guides *Quality Assurance in Mental Health Care* (1997), *Mental

Health in Emergencies* (2003) and *Clinical Management of Rape Survivors* (2004)

followed similar community-based, culturally sensitive intervention guidelines and

encouraged the reestablishment of traditional mental health practices.

The *Code of Conduct for the International Federation of Red Cross and Red

Crescent Societies* (IFRC, 1994) also included stipulations for the incorporation of target

population participation and knowledge into its programming. Articles five and seven of

the code stated the following.

- 5 – We shall respect culture and custom. We will endeavor to respect the culture, structures and customs of the communities and countries we are working in.

- 7 – Ways shall be found to involve program beneficiaries in the management of relief aid. Effective relief and lasting rehabilitation can best be achieved where the intended beneficiaries are involved in the design, management and implementation of the assistance program. We will strive to achieve full community participation in our relief and rehabilitation programs (International Federation of Red Cross and Red Crescent Societies). (IFRC, 1994, p.4)

The Center for Victims of Torture, which works extensively with refugees both internationally and in the United States, included similar mandates for target population participation and use of cultural knowledge in its operating manual *Healing the Hurt: A Guide for Developing Services for Torture Survivors* (Center for Victims of Torture, 2005). The chapter devoted to psychological services included the following recommendations for honoring and involving the target population's cultural knowledge into mental health programming.

- Learn to articulate one's own cultural beliefs, practices and assumptions. Without this skill, the provider may make culturally based assumptions that are automatic or unconscious.

- Investigate ways to address cultural difference/sameness among therapist, client, and interpreter.

- Assess and address culturally relevant variables such as spirituality and religious practices and family and social roles.

- Use tools designed specifically for cross-cultural dialogue.

- Investigate cultural meanings for individuals as well as for groups. Survivors' experiences and beliefs differ widely within cultural groups.

- Incorporate discussions of the survivor's political context into treatment, particularly as it intersects with culture. Survivors are not removed from the political world that surrounds them. (Center for Victims of Torture, 2005)

The CVT guide includes a list of books that detail psychotherapeutic practices across cultures and also includes suggestions for working with interpreters.

The Inter-Agency Standing Committee, which was established by the United

Nations General Assembly and whose task force members include the American Red

Cross, the International Rescue Committee, Save the Children, ActionAid International,

Médecins Sans Frontières, Oxfam, the International Federation of Red Cross and Red

Crescent Societies, UNICEF, UNHCR, UNESCO, the World Health Organizetion, Aga

Khan Development, CARE USA, Human Rights Watch and War Child among others,

touched extensively on the topic of cultural knowledge in its mental health handbook,

IASC Guidelines on Metal Health and Psychosocial Support in Emergency Settings

(IASC, 2007b). Target population participation and integration of cultural knowledge

were included in the second and forth articles of the Guideline's Core Principles.

- 2. Participation **-** Humanitarian action should maximize the participation of local affected populations in the humanitarian response. Many key mental helaht and psychosocial supports come from affected communities themselves rather than from outside agencies. Participation should enable different sub-groups of local people to retain or resume control over decisions that affect their lives, and to build the sense of local ownership that is important for achieving program quality, equity and sustainability. From the earliest phase of an emergency, local people should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance. (IASC, 2007b, p. 9)

- 4. Building on available resources and capacities - All affected groups have assets or resources that support mental health and psychosocial well-being. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programs often lead to inappropriate mental health and psychosocial support and frequently have limited sustainability. (IASC, 2007b, p. 10)

The IASC Guidelines, comprising some one hundred and seventy pages of specific

processes for needs assessment, implementation and evaluation of mental health

programs in emergency settings, include standards for community involvement and

integration of cultural knowledge during every phase. Minimum response standards from

the Guideline's Matrix of Interventions include the following.

- Build awareness of need for workers who understand local culture and language.

- Develop community-owned and managed social support activities.

- Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices.

- Map existing formal and non-formal practices.

- Map psychosocial skills of community actors including community workers, religious leaders and counselors

- Train staff in culturally appropriate clinical care of survivors of gender-based and other   violence.

- Learn about and collaborate with local, indigenous and traditional health systems.

- Identify and recruit staff and volunteers who understand local culture.

- Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors.

- Conduct assessments in an ethical, culturally appropriate and participatory manner (IASC, 2007b)

The IASC Guidelines also included a number of examples from mental health projects

that incorporated traditional healing methods.

> A former boy soldier said he felt stressed and fearful because the spirit of a man he had killed visited him at night. The problem was communal since his family and community viewed him as contaminated and feared retaliation by the spirit if was not cleansed. Humanitarian workers consulted local healers, who said that they could expel the angry spirit by conducting a cleansing ritual, which the boy said he needed. An international NGO provided the necessary food and animals offered as a sacrifice, and the healer conducted a ritual believed to purify the boy and protect the community. Afterwards, the boy and people in the community reported increased well-being. (IASC, 2007b, p. 109)

The Sphere Project, developed in 1997 by Care International, the International Community of the Red Cross, Save the Children, Oxfam and Médecins Sans Frontières among others to establish minimum standards for humanitarian assistance, set defined standards for community involvement and integration of cultural knowledge similar to the IASC Guidelines. Recommendations from The Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response (2004) included the following.

- The participation of disaster-affected people, including vulnerable groups, in the assessment, development, and implementation and monitoring of responses should be maximized to ensure the appropriateness and quality of any disaster response.

- Programming should be designed to maximize the use of local skills and capacities.

- Disaster-affected populations possess, and acquire, skills and capacities of their own to cope and these should be recognized and supported.

- Normal cultural and religious events should be maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People should be able to conduct funeral ceremonies.

- Interventions should be based on an assessment of existing services and an understanding of the socio-cultural context. They should include use of functional, cultural coping mechanisms of individuals and communities to help them regain control over their circumstances. Collaboration with community leaders and indigenous healers is recommended when feasible. (The Sphere Project, 2004)

Humanitarian Accountability Partnership International (HAP International), whose members include CARE International, Oxfam, Save the Children UK and World Vision International, is the humanitarian sector's first international self-regulatory body, "dedicated to making humanitarian action accountable to its intended beneficiaries: those people whose lives are at risk due to armed conflict or other calamitous events" (HAP International, 2008). Its governing document, *The Guide to the HAP Standard* (2008),

which was designed for use by humanitarian practitioners, researchers and donors,

included the following statement regarding target population participation.

> Members must involve beneficiaries in the planning, implementation, monitoring
> and evaluation of programs and must report to them on progress, subject only to
> serious operational constraints. (HAP International, 2008, p. 13)

The HAP Standard is unique among this list of guides in that it focuses on accountability

and meeting specified goals with regard to target population participation at all points

within a humanitarian program.

The Active Learning Network for Accountability and Performance in

Humanitarian Action (ALNAP), whose members include the UNHCR, UNDP, UNICEF,

WHO, USAID, International Red Cross, CARE International, Catholic Relief Services,

Oxfam, Save the Children and World Vision, has provided tools and analyses for

improving the quality and accountability of humanitarian action (ALNAP, 2006). In

2003 the ALNAP research team created the handbook *Participation by Crisis-Affected*

Populations in Humanitarian Action (Groupe Urgence Réhabilitation Développement

(URD), ALNAP, 2003) which was meant to guide humanitarian practitioners in

transferring the need for target population participation into actual practice. The

foreword to the handbook stated its aim as follows.

> Humanitarian agencies have long believed that increased consultation and
> participation of people affected by crises should improve accountability and the
> quality of humanitarian assistance. The thinking, language and policy of
> humanitarianism have reflected these aspirations but, in reality, there has been
> little impact at field level. There are undoubtedly real barriers to participation: the
> lack of time to consult in life-threatening situations, the lack of coherent social
> structures within displaced populations or fear of putting people at risk, to name
> just a few. In the face of these difficulties, the humanitarian community has been
> hesitant to translate ideas into practice. This handbook provides the most detailed
> road map to date for field workers to find practical approaches for involving
> affected communities in the design and implementation of humanitarian

interventions. It offers a deeper understanding of what participation in humanitarian assistance involves, and how in conflict situations and disaster environments participation can be given a more prominent role (Groupe Urgence Réhabilitation Développement. (URD), ALNAP, 2003, p. 7)

This handbook, the first to bridge the gap between international humanitarian policy and practice, was created following six in-depth studies of humanitarian programs in crisis affected areas around the world. It provides specific instructions for ways to involve the target population at every point of a humanitarian program, gives arguments for why a participatory method will be the most successful, and gives examples from past successful programs that involved target populations. The guide does not contain a section specific to mental health programs but Chapter 11, entitled Participation and Health Programs, provided general recommendations for target population involvement in all health programs. The handbook stated that any health program must begin with an understanding of local health beliefs and practices.

> One of the most common weaknesses of health assessments in the humanitarian sector is the tendency to construct a purely epidemiological picture of the situation. Certainly, the epidemiological assessment is fundamental, but it often masks social and cultural specificities pertaining to the affected population. Throughout the assessment process, you can ask yourself: Am I paying sufficient attention to the social and cultural dynamics that affect health? (Groupe Urgence Réhabilitation Développement (URD), ALNAP, 2003, p. 316)

This point considered, recommendations for assessment, design, implementation, monitoring and evaluation of a health program included the following:

- Form focus groups to establish a community profile. Determine how the society is organized, how the population is distributed geographically, what health services and practices exist and how they are distributed between traditional and "Western" models.

- Make contacts with all involved parties, including doctors, nurses, social workers, traditional healers, Ministry of Health personnel and community health workers, to determine what roles each group fill in the provision of health services.

- Conduct a participatory analysis of needs. Involve representatives from groups identified in the community profile as either being involved in the provision of health services or in need of some form of health services.

- Define the program objective based on the participatory analysis of needs. Define what parties will be involved in the program and how.

- Determine what members of the target population have the capacity to participate. Increase participation by addressing issued that have diminished members' capacity to participate.

- Establish strategies to ensure sustainability.

- Expand monitoring procedures to involve more than quantitative assessments. Incorporate participatory monitoring methods including focus groups, supervision, follow-ups and interviews.

- Take a "top up" approach to evaluation, focusing on the impressions of the target population on the positive and negative impacts of the program. Assure that all members who were involved in the program are involved or represented in the evaluation. (Groupe Urgence Réhabilitation Développement (URD), ALNAP, 2003)

When combined, all of the guides reviewed in this section produce a step-by-step instruction manual for facilitators in refugee camps to incorporate the use of target population cultural knowledge into every single step of a program. If these guides are being followed by employees of the agencies they represent and affiliated partners, there should be evidence of the use of cultural knowledge throughout the entirety of every refugee camp program, including mental health programs.

Critiques of the Use of Cultural Methods

Some scholars have warned that the use of cultural knowledge must be handled appropriately lest it become detrimental to some portion of the target population (Neuner, 2008; Okin, 1999; UNHCR, 2003; Werner et al., 1992). Mental health program facilitators must conduct a comprehensive survey of the target population in order to determine what constitutes cultural knowledge. Traditional healers who come forward

during an NGO mental health program may be respected in the community or may be opportunists seeking material gains (Amone-P'Olak, 2006; WHO, 1996). Facilitators must also be wary of "witch doctors" who may be accepted in a community but are more entrepreneurs than healers and may do more harm than good if brought into a mental health program (Werner et al., 1992).

Facilitators must also be aware of the intersection between cultural practices and women's rights. Okin (1999) gave the following commonly found example of how aligning with a population's cultural norms would serve to further subjugate women:

> Suppose that a culture endorses and facilitates the control of men over women in various ways (even if informally, in the private sphere of domestic life). Suppose, too, that there are fairly clear disparities of power between the sexes, such that the more powerful, male members are those who are generally in a position to determine and articulate the group's beliefs, practices, and interests. Under such conditions, group rights are potentially, and in many cases actually, antifeminist. (Okin, 1999, p.12)

To compensate for culturally embedded male dominance, NGO program facilitators are often advised to hold special focus groups for women in order to protect their rights and understand their particular cultural knowledge within the larger population (United Nations Population Fund, 2004; UNHCR, 2003b; Jallow and Mallik, 2005).

Evaluating Cultural Competency in Refugee Camp Mental Health Programs

Though much has been written about refugee mental health and there are extensive NGO guides and working papers containing suggestions for the incorporation of cultural knowledge in refugee camp programs, there has not yet been a comprehensive study of the use of cultural knowledge in refugee camp mental health programs. I could not find any measures for the use of cultural knowledge or reviews of the efficacy of incorporating cultural practices specifically into refugee camp mental health programs. It

appears that at the time of this writing, there is not yet a study that connects published policy and recommendations regarding the use of cultural knowledge with practice in refugee mental health. This study sought to merge policy with practice by identifying the presence of cultural competency within refugee camp mental health programs.

CHAPTER III

METHODOLOGY

This qualitative survey of documents was designed to examine how mental health

workers have used the target population's cultural knowledge of mental health and

healing in refugee camp mental health programs. The study was exploratory in nature

because not enough current research on the topic of the use of target population cultural

knowledge of mental health and healing in refugee camp mental health programs exists to

form a hypothesis. The aim of the study was to fill the gap between literature on the use

of cultural knowledge in refugee mental health and refugee camp mental health

programs. In order to bridge the gap between literature, policy and practice, I conducted

a fixed survey of reports from completed refugee camp mental health programs. My

hope was that this survey would provide a snapshot view of the current use of target

population cultural knowledge of mental health and healing in refugee camp mental

health programs. The information gained from this study can help to inform future

refugee camp mental health program administrators in forming operating policies that

better serve the specific needs of target populations. This chapter presents the methods of

research used in this study and describes the sample data, method of collection and

analysis procedures.

Sampling Method

The sample population for this study was completed reports from refugee camp

mental health programs. The inclusion criteria for the reports were that they included a

mental health program that occurred in a refugee camp and that the reports were

accessible online. Reports that did not describe a specific mental health program and

reports from mental health programs conducted with refugees outside of refugee camps,

such as in resettlement countries, were ruled out. There was not a set start or end date for

reports collected for the sample. Five reports were ruled out because they did not meet

the sample criteria. The final sample for this study was fifteen reports.

The sampling method for this study was purposive, "the research participants are

chosen primarily because they meet the selection criteria and they are easily available"

(Anastas, 1999, p. 279). I collected reports using a snowballing method of internet

research. I began by using the UNHCR website (see Table 1) and its partner website

Refworld; a database for information on refugees. I also searched NGO websites and

used academic search engines. I used reference lists from reports and used bibliographies

from published works to find more sources. A full list of the websites searched for

reports can be found in Table 1.

Ethics and Safeguards

Permission to use the reports surveyed for this study was not requested because

all reports were accessible online to the general public. No human subjects were used

directly in this study. All names and distinguishing features of refugees mentioned in the

reports surveyed have been omitted in this study to protect their privacy. As this study is

a new representation of previously published data, no further safeguards were necessary.

Sample Characteristics

A list of reports used for this study including demographic information can be

found in Table 2. The list of reports is also available in Appendix B.

Table 1. Websites Used to Gather Reports

Organizations	Acronym	Website
Aide Medicale Internationale	AMI	www.amifrance.org
Care International	CARE	www.care.org
Catholic Relief Services	CRS	www.crs.org
Center for Victims of Torture	CVT	www.cvt.org
Gulf Coast Jewish Family Services, Inc.		www.gcjfs.org
Human Rights Watch	HRW	www.hrw.org
International Committee for the Red Cross	ICRC	www.icrc.org
Medecins Sans Frontieres International	MSF	www.msf.org
Oxfam International	OXFAM	www.oxfam.org
Plan International		www.plan-international.org
Transcultural Psychosocial Organization	TPO	www.tpopom.org
Save the Children International		www.savethechildren.org
United Nations Children's Fund	UNICEF	www.unicef.org
United Nations Development Programme	UNDP	www.undp.org
United Nations High Commissioner for Refugees	UNHCR	www.unhcr.org
UN Office for Cord. of Humanitarian Affairs	OCHA	www.ochaonline.un.org
US Agency for International Development	USAID	www.usaid.gov
Vivo Foundation	VIVO	www.vivofoundation.net
World Health Organization	WHO	www.who.int/en
World Vision		www.worldvision.org
Journals		
American Psychological Association	APA	www.apa.org/journals
International Social Work	ISW	http://isw.sagepub.com
American Academy of Child & Adolescent Psych	JAACAP	journals.lww.com/jaacap
Journal of the American Medical Association	JAMA	http://jama.ama-assn.org
The Lancet		www.thelancet.com
Databases		
EBSCOhost		www.ebscohost.com
Google Scholar		http://scholar.google.com
Refworld		www.unhcr.org/refworld
ReliefWeb		www.reliefweb.int

Table 2. Reports Surveyed

Report Name	Report Location	Report Year	Target Pop.	Organization
Case presentation of a tattoo-mutilated, Bosnian torture survivor	Bosnia	2000	Bosnian Muslim	Gulf Coast Jewish Family Services
A comparison of NET, supportive counseling and psychoeducation for treating PTSD in an African refugee settlement	Uganda	2000	Sudanese	Vivo Foundation
Dance/movement therapy approaches to fostering resilience and recovery among African adolescent torture survivors	Sierra Leone	2006	Sierra Leonean	Center for Victims of Torture
Mental health care for refugees from Kosovo: The experience of Medecins Sans Frontieres	Bosnia	1994-1998	Ethnic Albanian	Medecins Sans Frontieres
Mental status of adolescents exposed to war in Uganda: Finding appropriate methods of rehabilitation	Uganda	2004	Northern Ugandan	Center for Victims of Torture, World Vision
Narrative exposure treatment as intervention in a refugee camp: A case report	Macedonia	2001	Ethnic Albanian	Vivo Foundation
Narrative theatre as an interactive community approach to mobilizing collective action in Northern Uganda	Uganda	2003	Northern Ugandan	World Health Organization
Playing to grow: A primary mental health intervention with Guatemalan refugee children	Mexico	1992	Guatemalan	Centro de Investigationes en Salud de Comitán
Post-traumatic Stress Disorder among Salvadoran women	El Salvador	1992	Salvadoran	Women's Skills and Resource Exchange
Post-tsunami stress: A study of PTSD in children living in three severely affected regions in Sri Lanka	Sri Lanka	2005	Sri Lankan	Vivo Foundation
Psychiatric morbidity among Afghan refugees in Peshawar, Pakistan	Pakistan	2003	Afghan	Ayub Medical College
Psychosocial support for children: Building the capacity of key professionals for dealing with children in a protective and sensitive manner	Ethiopia	2007	Ethiopian	UNICEF
A study of the psychological state of formerly abducted children at Gulu World Vision Trauma Center	Uganda	2004	Northern Ugandan	Center for Victims of Torture, World Vision
Trauma healing in refugee camps in Guinea: a psychosocial program of Liberian and Sierra Leonean survivors of torture and war	Guinea	1999	Sierra Leonean, Liberian	Center for Victims of Torture
Treatment of PTSD by training lay counselors in an African refugee settlement: A randomized controlled trial	Uganda	2003	Rwandan, Somali	Vivo Foundation

The fifteen reports used in this study were published between 1992 and 2007 and documented mental health programs from refugee camps in five major geographic areas: Europe, Africa, Asia, The Middle East and South America. The sample included reports from eleven NGOs working in thirteen different refugee camps in eleven countries. Over half of the reports comprise data collected from refugee camps in Africa because most information on refugee camp mental health programs comes from studies conducted in the mid 1990s and early twenty-first century during refugee crises on that continent. Though more recent statistics place the largest population of refugees in Pakistan and Afghanistan (UNHCR, 2011), there is less current information on refugee camps in that area. Due to this delay in current information, this report provides a snapshot view primarily of refugee camp mental health programs in the late 1990s and early twenty-first century. If this same study were to be conducted in ten years, when more information from Pakistan and Afghanistan becomes available, the results would likely be different.

<h3 style="text-align:center">Data Collection</h3>

Data for this qualitative study were gathered via a structured survey of reports. As there was no published survey on the use of target population cultural knowledge of mental health and healing in refugee camp mental health programs, I used a self-developed survey. I designed the survey to search the reports for evidence of the use of the target population's cultural knowledge of mental health and healing and to describe how this knowledge was being used. The survey was divided into sections pertaining to key phases in a mental health program: assessment, intervention and evaluation, with questions pertaining to use of the target population's cultural knowledge in each phase.

Survey questions were based on an extensive review of literature on refugee mental health and the use of cultural knowledge in refugee camp mental health programs. I also based questions on the guidelines for the use of local knowledge in refugee camp mental health programs as laid out in UNHCR and affiliated NGO operating manuals. In particular I used the United Nations Population Fund 2004 publication, *Guide to working from within: 24 tips for culturally sensitive programming* (United Nations Population Fund, 2004). A reproduced copy of this document in its entirety can be found in Appendix C. I based survey questions on the reports' explicitly expressed uses of target population cultural knowledge of mental health and healing rather than on implicit uses of target population knowledge because I am not an expert on the cultures of the refugee populations studied and as thus cannot identify implicit cultural elements. Instead I surveyed the reports for outright statements regarding cultural integration as the authors sought to define it. I did leave room for notes in the survey so that I could record evidence of what I thought could be implicit use of cultural knowledge, but that information was only used secondarily to explicit data and is described as implicit and unsupported in my findings. I also included an UNCLEAR answer category to each survey question with room for notes. Unclear data were later placed into a separate category for data analysis.

Each survey took approximately five hours. All findings were recorded in handwriting on a survey sheet and attached to the report. Notes were also made on the reports themselves for later referral and analysis. Completed surveys were assigned a number for quick referral. The survey template can be found in Appendix A.

Definition of Terms

Definitions for what constituted cultural knowledge and other terms used in this study were drawn from an extensive review of literature on relevant subjects. In cases where a citation is not assigned to a definition, they are working definitions for this study based on literature on the subject and general knowledge in the field. Definitions for terms used in the survey of documents conducted for this study are represented in Table 3.

Data Analysis

Data collected from the surveys was analyzed for content using the grounded theory model as described in Anastas (1999). Survey results were analyzed for similarities, differences and outliers throughout the data collection phase, and again after all of the surveys were complete. Major themes across surveys were noted and descriptive pieces were highlighted and recorded on for later use in illustrating the findings.

Once all of the surveys were complete I went back over the collected data and compartmentalized it; first by survey section, then by emerging themes across sections and finally by unclear responses and outliers. I arranged the data into simple tables by category and used relevant passages from the reports to exemplify findings.

Table 3. Definition of Terms

Term	Working Definition for this Study
Mental Health	A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 2010).
Healing	A measure of recovery from an affliction, as perceived by the affected individual or group.
Target Population	The group identified to participate in a mental health program.
Culture	A body of learned behaviors common to a given human society which shapes behavior and consciousness from generation to generation. Informs systems of meaning, ways of organizing society and distinctive techniques and products for all aspects of life within the society (Bodley, 1994).
Cultural Knowledge	Knowledge embedded within a culture that informs all parts of life for that culture.
Assessment	Fact finding research conducted during a mental health program prior to the intervention. A needs assessment is conducted in order to gather all information necessary to determine the best course of intervention for the target population. The presence of the incorporation of the target population's cultural knowledge of mental health and healing in the assessment portion of the report would be evidenced by the inclusion of member of the target population in the needs assessment, evidence that the authors did extensive research on the cultural background of the target group with regard to mental health and healing, and/or evidence that the needs assessment was carried out in a manner that was compliant with the target population's approach toward mental health and healing.
Intervention	Intervention refers to the process portion of the mental health program. During the intervention phase some action is taken, based upon the course determined during the needs assessment phase, to improve the mental health status of the target population. The presence of the incorporation of the target population's cultural knowledge of mental health and healing in the intervention phase of the report would be evidenced by the use of mental health and healing terms specific to the target population and/or the inclusion of an intervention determined specifically by the target population based on their expressed understanding of mental health and healing.
Evaluation	Evaluation refers to the assessment of the study, findings, calculated success of the intervention and plans for further studies and interventions. The presence of the incorporation of the target population's cultural knowledge of mental health and healing in this portion of the report would be evidenced by the inclusion of members of the target population in evaluating the efficacy of the intervention and/or by the author's assertion that more cultural knowledge is necessary for proper evaluation and further studies.

CHAPTER IV

FINDINGS AND INTERPRETATIONS

The purpose of this qualitative survey of reports was to examine how mental health workers used target population cultural knowledge of mental health and healing in refugee camp mental health programs. Fifteen reports from completed refugee camp mental health programs were surveyed. A copy of the survey guide can be found in Appendix A of this report.

The first section of survey questions pertained to the involvement of the target refugee population in the authoring and advising of the report, as well as in the facilitation of the mental health program. The second section dealt with the use of target refugee population cultural knowledge of mental health and healing in program assessment, implementation and evaluation. The final section dealt with documented evidence of resistance to the mental health program by the target population. Notes on the program as a whole were also included.

The major finding of this study was that there is evidence of the use of target population cultural knowledge of mental health and healing in refugee camp mental health programs but it is not well organized or documented throughout programs and does not fall into accordance with NGO policy on the subject. No report from the sample contained examples of the use of cultural knowledge in three categories; assessment, intervention and evaluation. Also, the use of cultural knowledge has not increased over time. Survey results and major findings are displayed in Tables 4 and 5.

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Table 4. Survey Results

Report Number	Refugee Author	Refugee Facilitator	Assessment Refugee Knowledge Explicit	Assessment Refugee Knowledge Implicit	Intervention Refugee Knowledge Explicit	Intervention Refugee Knowledge Implicit	Evaluation Refugee Knowledge Explicit	Evaluation Refugee Knowledge Implicit	Resistance to Program	Comments Regarding Cultural Knowledge
1	NO	YES	NO ASSESSMENT		NO	YES	NO	NO	YES	Case manager of same origin key to success.
2	NO	YES	NO	NO	YES	YES	NO EVALUATION		NO	DMT deemed culturally relevant, no evaluation.
3	NO	YES	NO	NO	YES	YES	YES	YES	NO	Studied prior program from area, no assessment.
4	NO	NO	NO	NO	NO	NO	NO	NO	NO	NET used, no integration of local knowledge.
5	NO	YES	NO	YES	YES	YES	YES	YES	YES	Multiple explicit examples of cultural integration.
6	NO	YES	YES	NO	NO	YES	NO	NO	NO	Encouraged rebuilding of social support networks.
7	NO	YES	NO	NO	NO	NO	NO	NO	NO	Used a large local staff.
8	YES	NO	NO	YES	NO	YES	NO	NO	NO	Present in assessment, not explicit in intervention.
9	NO	YES	NO	NO	NO	NO	NO	NO	YES	Locals trained in Western TX, resistance present.
10	NO	YES	NO	NO	NO	NO	NO EVALUATION		NO	Extensive qualitative research, no cultural piece.
11	YES	YES	NO	NO	YES	YES	NO EVALUATION		YES	Multiple explicit examples of cultural integration.
12	NO	YES	NO ASSESSMENT		NO	NO	YES	YES	NO	Present in evaluation, not intervention.
13	NO	YES	NO ASSESSMENT		YES	YES	NO EVALUATION		YES	Friere and Derrida cited, no assessment or eval.
14	NO	YES	NO	YES	YES	YES	YES	YES	NO	Specify need for more cultural knowledge.
15	NO	YES	NO ASSESSMENT		NO	YES	NO	NO	YES	Study cited as successful, no culture in eval.

Table 5. Major Findings and Interpretations

1	Target Population Author	A member of the target population was included in the authoring of just two of the fifteen reports surveyed. The inclusion of a contributor from the target population did not increase the presence of evidence of the use of target population cultural knowledge of mental health and healing in the mental health program described therein.
2	Target Population Facilitator	Thirteen of the fifteen reports surveyed specified the inclusion of the target refugee population in program facilitation. Reports that did not specify the involvement of a refugee facilitator did not contain any explicit evidence of the use of target population cultural knowledge of mental health and healing in the mental health program described therein.
3	Assessment	None of the fifteen reports surveyed contained evidence of a needs assessment, prior to determining the path of intervention, which included a survey of the target population's cultural knowledge of mental health and healing. If these reports encompassed the whole of the studies about which they were written, the authors/facilitators did not, at any point, ask the refugee community that they were serving about their understanding of mental health, trauma and healing. Though one report did contain some evidence of the use of local knowledge of mental health and healing in assessment, it did not point to a full needs assessment that included this component.
4	Intervention	Interventions involving target population knowledge of mental health and healing were present in six reports or forty percent of the sample. Five reports or thirty-three percent of the sample contained no explicit or possible implicit use of cultural knowledge. If these percentages are correct for the larger sample of all refugee camp mental health interventions, only about one third of programs conducted in refugee camps involve target population cultural knowledge in mental health interventions.
5	Evaluation	Four of the reports surveyed contained explicit examples of the use of the target population's cultural knowledge of mental health and healing in the evaluation phase of the project. All examples specified the need for more cultural knowledge for future projects. None of the reports surveyed contained evidence that the mental health project facilitators had involved the refugee population directly in the evaluation of the project.
6	Multiple Categories	Three of the fifteen reports surveyed contained explicit examples of the use of cultural knowledge in two categories; either assessment and intervention or intervention and evaluation. None of the fifteen reports surveyed contained explicit examples of the use of local knowledge of mental health and healing in all three categories; assessment, intervention and evaluation.
7	Zero Categories	Four reports did not contain any evidence of the use of target population cultural knowledge of mental health and healing.
8	Accordance to Regulation	Zero of the fifteen reports surveyed specified the incorporation of target population cultural knowledge in accordance with UNHCR and other affiliated NGO standard operating procedures for mental health programs in refugee camps.
9	Over Time	In the sample, evidence of the use of target population cultural knowledge of mental health and healing in refugee camp mental health programs did not increase over time.
10	Resistance	Six reports included evidence of resistance to the mental health program by the target population. No report connected the use of or lack of cultural knowledge with program resistance.

Target Population Authors

Two of the reports surveyed, or thirteen percent of the sample, identified at least one of the authors as being a member of the target refugee population. A 2003 report from a mental health project in Afghanistan published in the Journal of Ayub Medical College (Naeem et al., 2003), identified one author as being a village leader from the area where the project took place. This report did not contain any explicit examples of the use of target population cultural knowledge. A 2006 report from two Center for Victims of Torture (CVT) mental health projects in Sierra Leone and Liberia (Stepakoff et al., 2006) listed three of the seven authors as being members of the target population. This report contained examples of the use of cultural knowledge in the interventions section. Neither author from the target population was identified as being a specialist in the target population's cultural knowledge of mental health and healing. As one author from the target population contributed to a project that included the use of cultural knowledge and one author contributed to a project that did not include the use of cultural knowledge, the sample shows no connection between the inclusion of a target population author and the use of cultural knowledge in the reported refugee camp mental health program.

The thirteen remaining reports were authored by members of the aid organizations that sponsored the projects. None of the authors were identified as being specialists in the target population's cultural knowledge of mental health and healing. No mention was made of any collaboration with the target population with regard to the authoring of the reports.

Target Population Facilitators

Thirteen of the reports surveyed, or eighty-seven percent of the sample, specified the involvement of the target refugee population in the facilitation of the mental health program. Eight reports specified a process of identifying and training refugee professionals and paraprofessionals who had some previous background in social work. Below are examples from programs in Sierra Leone and El Salvador.

> Twelve clients joined three local psychosocial counselors, or PSCs, and the author for the intervention. (Harris, 2007, p. 142)

> Each interview was conducted by a team consisting of a trained female U.S. interviewer and a Salvadoran lay mental health worker who resided in the camp. (Bowen et al., 1992, p. 269)

Five reports specified the training of members of the target refugee population who had no previous background in social work. In all five reports, members of the target population were trained in Western interviewing and counseling methods. The following is an example from a mental health project in Mexico:

> The workshop introduced to the teachers (agriculturists with limited formal education and training in instructional theory and methods) the idea of play and the expressive arts as legitimate and useful instruments of pedagogy. Camp teachers were provided with extensive training in the Playing to Grow intervention, following which support was provided while they coordinated an actual workshop with a group of 15-20 children. (Miller & Billings, 1994, p. 350)

The authors of four reports cited the involvement of target population collaborators as a key to success for refugee camp mental health programs (Bower et al., 2004; Neuner et al., 2004; Miller & Billings, 1994; Sliep et al., 2004).

Though several programs involved local mental health workers, only one report identified a target population facilitator as being an expert in the target population's cultural knowledge of mental health and healing. A 2004 project by the Center for

Victims of Torture and World Vision in Northern Uganda collaborated with traditional

healers and community elders to facilitate cleansing rituals for former child soldiers.

> The following general rituals were performed to most of those who returned from
> rebel captivity and agreed with the practice: traditional music, dances, and drama.
> Besides these general rituals, this project focused on four major rituals: stepping
> on an egg, burning of clothes, ritual for sexually violated girls, and ritual for those
> who killed deliberately or were forced to kills while in rebel captivity. Traditional
> leaders and elders from the Acholi Council of Elders (Rwodi Moo), under the
> tutelage of the Paramount Chief of the Acholi, conducted these rituals using
> traditional leaders and elders from the communities. (Amone-P'Olak, 2006, p.
> 101)

The report's authors stated that their findings contributed significantly to the growing

hypothesis that traditional methods of rehabilitation and reintegration produced better

outcomes than western therapeutic methods when treating East African former child

soldiers (Amone-P'Olak, 2006).

The Use of Target Population Cultural Knowledge of Mental Health and Healing in

Program Assessment, Implementation and Evaluation

The bulk of the survey contained questions pertaining to the presence of the use of

target population cultural knowledge of mental health and healing during key phases of a

mental health program; assessment, intervention and evaluation/future recommendations.

In all, eight of the fifteen reports surveyed contained explicit evidence of the use of

cultural knowledge in at least one phase. A table of findings for this section of the survey

is located below in Table 6.

Of the fifteen reports surveyed, one report contained an explicit example of the

use of target population cultural knowledge in the assessment phase with three others

containing implicit language that may have suggested the use of cultural knowledge in

assessment.

Table 6. Number of Reports with Examples of the Use of Cultural Knowledge per Section

Number of Reports with Examples of the use of Cultural Knowledge per Section

Number of Reports

12
10
8
6
4
2
0

Assessment: 4, 7, 1, 3
Intervention: 0, 5, 6, 10
Evaluation: 4, 7, 4, 4
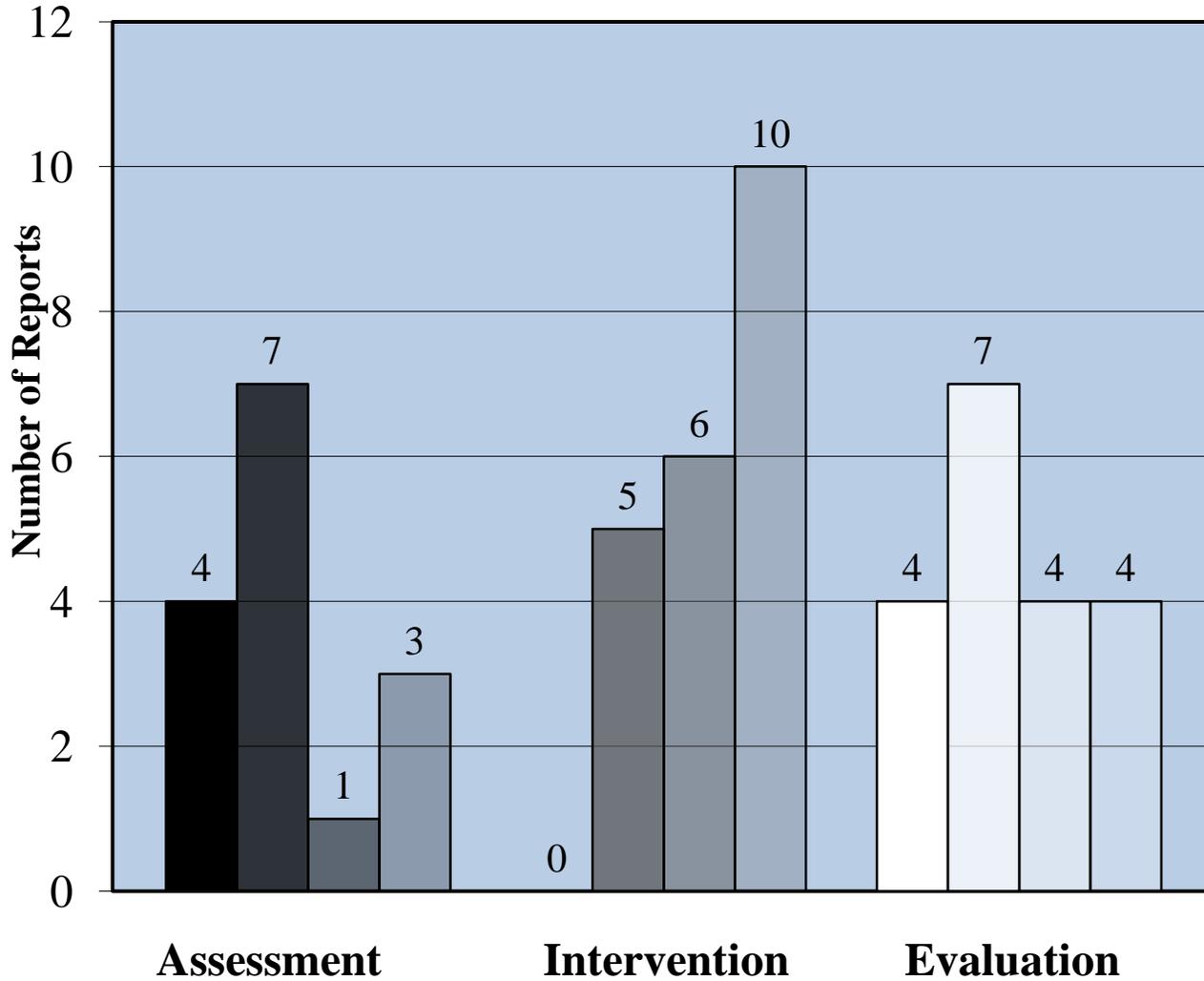
Legend:
- Reports with no assessment section - 4
- Reports with no examples of the use of cultural knowledge in assessment - 7
- Reports with explicit examples of the use of cultural knowledge in assessment - 1
- Reports with possible implicit examples of the use of cultural knowledge in assessment - 3
- Reports with no intervention section - 0 (All reports used for this study contained an intervention section.)
- Reports with no examples of the use of cultural knowledge in intervention - 5
- Reports with explicit examples of the use of cultural knowledge in intervention - 6
- Reports with possible implicit examples of the use of cultural knowledge in intervention - 10
- Reports with no evaluation section - 4
- Reports with no examples of the use of cultural knowledge in evaluation - 7
- Reports with explicit examples of the use of cultural knowledge in evaluation - 4
- Reports with the possible implicit examples of the use of cultural knowledge in evaluation - 4

Six reports contained explicit examples of the use of cultural knowledge in the mental health program interventions with ten reports containing some possible implicit examples. Four reports contained explicit examples of the use of cultural knowledge in the evaluation and recommendation phase and all four contained further possible implicit examples.

In total, eight of the fifteen reports surveyed contained explicit evidence of the use of cultural knowledge in at least one phase of the mental health program. Of these eight, five contained examples in one phase of the project and three contained examples in two phases.

None of the reports surveyed contained examples of the use of cultural knowledge in assessment, intervention and evaluation. Three reports did not contain explicit examples of the use of cultural knowledge in any category but contained some implicit information that suggested the possible use of cultural knowledge in at least one category. Four reports contained no explicit or suggested implicit evidence of the use of cultural knowledge in any phase of the mental health program.

The Use of Cultural Knowledge in Assessment

Only one of the fifteen reports surveyed, seven percent of the sample, contained an explicit reference to the use of the refugee population's cultural knowledge. Three other reports contained information that may have implicitly suggested the use of cultural knowledge. Seven reports contained no examples and the remaining four reports did not contain an assessment section.

The report containing an explicit statement about the use of cultural knowledge in assessment was a 1992 study of Post-Traumatic Stress Disorder amongst Salvadoran

women (Bowen, Carscadden, Beighle & Fleming, 1992). The assessment section of the report stated the following.

> PTSD assessments were conducted in Spanish by Salvadoran lay mental health workers. Data from this study and knowledge of the culture were used to modify some components of the existing program. Ultimately the program was developed by a team of four psychologists, two health care specialists, and several other women familiar with Central American life and culture. (Bowen, et al., 1992, p. 269)

This program did not contain a full needs assessment because the authors had already formed a specific goal: to study and treat PTSD. The authors then used the target population's cultural knowledge to best fit the program to the participants. This report did not contain explicit examples of the use of cultural knowledge in the program intervention. Instead, a Western treatment model for PTSD was used, with some implicit references to cultural considerations.

Three reports contained some possible implicit references to the inclusion of cultural knowledge into program assessment. A report from a program conducted with Guatemalan refugees in Mexico suggested that the facilitators had learned a great deal about mental health concerns and terms specific to the population.

> Indigenous mental health problems, such as *susto* (a complex psychophysiological response to a sudden fright) and *el mal ojo* (the evil eye) are understood within a framework that incorporates psychological and religious dimensions and are not readily translatable into Western diagnostic syndromes. (Miller & Billings, 1994, p. 354)

It was not clear from the report, however, how the authors had gathered this information and whether these mental health problems were viewed as a major concern to the population. Also, the authors reported that they did not have the means to develop an in-depth understanding of psychosocial development from the perspective of the

community. Nevertheless, this report contained the most extensive examples of the use of cultural knowledge out of the fifteen surveyed.

The CVT Uganda report (Amone-P'Olak, 2006) detailing a program to provide cleansing rituals for former child soldiers contained some evidence that the target refugee population had been involved in the program assessment. The treatment team determined which rituals were needed by conducting in-depth interviews with former child soldiers and developing a diagnostic table based on their findings. Interviews were conducted by local staff members using two Western checklists (Amone-P'Olak, 2006). Though it was determined that traditional healing rituals would be the best interventions, what role the target population played in reaching this decision was unclear. This report contained explicit examples of the use of cultural knowledge in intervention and evaluation and was deemed significantly effective by staff and clients.

The Journal of Ayub Medical College report from Afghanistan stated that the trauma scale used in the study had been specifically developed based on qualitative experiences with ten refugees (Naeem et al., 2005). No more information about this process is given and it is unclear how the target population was involved in determining the need for a trauma assessment.

Of the four documents containing either explicit or possible implicit evidence of the use of cultural knowledge in assessment, evidence was present in program design but not initial needs assessment. None of the fifteen reports surveyed contained information about the initial needs assessment that lead to the choice of intervention.

Seven reports did not contain any examples of the use of cultural knowledge in assessment. Of these seven, three went on to contain explicit examples of the use of cultural knowledge in intervention and evaluation.

Four reports did not contain an assessment section. Of these four, two went on to detail explicit use of cultural knowledge in intervention and evaluation.

The absence of the use of cultural knowledge in assessment and then subsequent presence in intervention and evaluation suggests two possible points. It is possible that the published reports were abridged and did not contain information about every stage of the program. In-depth community based assessments could have been conducted but not detailed in the final report. It is also possible that the absence of the use of cultural knowledge in one category and presence in another was due to disorganization in programming. It could be that program administrators involved cultural knowledge when it presented itself but did not include its mandatory presence in every step of operations. This issue will be explored further in the discussion section of this report.

The Use of Cultural Knowledge in Intervention

Six reports, forty percent of the sample, contained explicit examples of the use of target population cultural knowledge in the intervention phase of the mental health program. All six reports contained further implicit examples that could signal the use of cultural knowledge. Four reports contained only possible implicit examples. Five reports did not contain any examples, either explicit or implicit, of the use of cultural knowledge.

The six reports identified as containing explicit examples all contained statements regarding the use of cultural knowledge in the mental health intervention. Examples of statements regarding the use of cultural knowledge include the following:

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Through dance/movement therapy (DMT), group members created a culturally relevant vehicle for ritualizing both the truth of their experience and their need for community reintegration. Appropriately, they embodied their own journey through creative movement performed as communal rite. (Harris, 2007, p. 154)

A hallmark of our work was the combination of Western and African approaches. Elements of traditional West African culture that were incorporated into many of the groups included healing rituals, symbols (e.g., offering kola nuts to welcome newcomers), traditional stories, drumming, chants, rhythmic clapping, and song. (Stepakoff et al., 2006, p. 926)

Narrative Theatre highlights the potential of this form to be participatory and transformative by making use of local knowledge and culture. (Sliep, Weingarten & Gilbert, 2004, p. 317)

Many [adolescents] were psychologically distressed and needed cleansing according to the native Acholi traditional practices of reconciliation and reintegration. Four traditional rituals used in rehabilitation and reintegration were employed. (Amone-P'Olak, 2006, p. 93)

The interventions used in the six reports containing explicit examples of the use of cultural knowledge were dance/movement therapy (Harris, 2007), brief therapy, group therapy and psychoeducation (de Jong, Ford & Kleber, 1999), art therapy (Miller & Billings, 1994), clinical services, case management and psychoeducation (Stepakoff et al., 1999), narrative theatre (Sliep, Weingarten & Gilbert, 2004) and traditional cleansing rituals (Amone-P'Olak, 2006). All reports specified the use of Western therapeutic techniques infused with target population cultural healing methods.

Four of the six reports linked the training of local paraprofessionals to the integration of traditional cultural practices.

The fact that the paraprofessional group facilitators were themselves refugees living in the camps helped to ensure that the treatment methods would be culturally sensitive. (Stepakoff et al., 2006, p. 926)

Training of local staff was of vital importance. Experts in trauma from other countries discussed concepts with Bosnian specialists. This interaction and its implicit message of respect was important for the Bosnian staff: providing support for their own people ensured cultural relevance as well as created a wider sense of

dignity and self-control and a sense of future perspective. (de Jong, Ford & Kleber, 1999, p. 1616)

Three of the six reports specified the use of mental health and healing terms particular to the target population.

According to the Acholi traditional culture, these symptoms of severe emotional and psychological distress in the adolescents are taken to be a sign of contamination, that the gods were unhappy, and of being possessed by "cen" (bad spirits), the spirits of those they have killed or harmed. (Amone-P'Olak, 2006, p. 100)

Most participants identified new-found capacities for coping with their horrific memories and handling their accumulated losses: Gaining "a cool heart" was a common refrain. (Harris, 2007, p. 152)

All six reports contained further implicit details that suggested the integration of target population cultural knowledge.

The report that contained an explicit example of the use of cultural knowledge in assessment did not contain an explicit example in the program intervention but did contain implicit information that could suggest the use of cultural knowledge. Implicit examples from that report included the following:

Data from a previous study and knowledge of the culture were used to modify some of the components of existing approaches or to design new ones as needed. (Bowen, Carscadden, Beighle & Fleming, 1992, p. 273)

The report does not specify what cultural knowledge was incorporated or how. The report also states that a strategy for developing the treatment plan involved identifying existing support networks. It is implied that local health systems and cultural knowledge were incorporated into the mental health program but local involvement was not specified.

Three other reports contained some information that could suggest the use of cultural knowledge in intervention. One program designed a population specific trauma

scale based on interviews with refugees (Naeem et al., 2005) but did not specify how the

scale related to the target population's cultural understanding of trauma and recovery.

Whether refugee input was used for information gathering purposes only or whether the

program was designed around their input was unclear. Another report stated the

importance of involving case managers who were from a similar ethnic background as

the target population and linked the program's success to culturally sensitive assistance

(Bower, Pahl & Bernstein, 2004). The report did not elaborate on the definition of

cultural sensitivity or state how the target population was involved in providing cultural

knowledge.

The other report containing some possible implicit information regarding the use

of cultural knowledge included the following brief statement regarding cultural

considerations.

> The questionnaire was used to assess health-related quality of life in different
> cultures. Several items of the questionnaire had to be adapted to the living
> conditions of an African refugee settlement. (Neuner et al., 2004, p. 582)

The report contained two references to culture but did not specify how the target

population's cultural knowledge was identified or applied.

Five reports did not contain any explicit or implicit references to the use of

cultural knowledge in the mental health program interventions. None of these five

reports contained examples of the use of cultural knowledge in assessment and four of the

five did not contain examples of the use of cultural knowledge in evaluation. One report

recommended culturally appropriate counseling and therapy for future programs

(Amone-P'Olak, 2004) but did not incorporate cultural knowledge into the assessment or

intervention stages of the current program.

The interventions used in the five programs that did not incorporate cultural knowledge were narrative exposure therapy (Neuner et al., 2002), PTSD testing with brief therapy (Neuner et al., 2006), play therapy, family therapy and psychoeducation (UNICEF, 2007), narrative exposure therapy and trauma counseling (Neuner et al., 2008) and art therapy, individual and group counseling (Amone-P'Olak, 2004). The sections of these reports that detailed the interventions used in the mental health programs did not specify the use of target population cultural knowledge of mental health and healing. If target population cultural knowledge was used, it was not documented.

The Use of Cultural Knowledge in Evaluation

Of the fifteen reports surveyed, four contained explicit examples of the use of cultural knowledge during the evaluation phase of the mental health program. The same four reports contained further possible implicit examples of the use of cultural knowledge. Seven reports did not contain any explicit or possible implicit examples of the use of cultural knowledge. Four reports did not contain evaluation sections.

Explicit examples of the use of cultural knowledge in evaluation in the four reports containing some evidence follow:

> In spite of the promising treatment effect found in this trial, this study does not fully prove the usefulness of any psychotherapeutic approach for war-torn populations, as the treatment was carried out by well-trained European psychologists. More information is needed regarding the population's natural course of trauma healing in order to determine the efficacy of imported psychotherapeutic approaches and determine more specialized interventions. (Neuner et al., 2004, p. 586)

> Unfortunately, the implementation of the Playing to Grow project could not, for pragmatic reasons, await the development by the authors of an in-depth understanding of psychosocial development from the perspective of the community. (Miller & Billings, 1994, p. 354)

Miller and Billings (1994) went on to state the following:

> In retrospect, it seems probable that the community's indigenous understanding of mental health and psychological development was not adequately incorporated into the training and that Western conceptualizations of these processes dominated. A greater degree of synthesis is strongly suggested for future workshops. For example, the incorporation of psychological concepts and terms employed by indigenous Guatemalans such as *malcriado* (delinquent or poorly behaved) and *listo* (clever or very bright) could facilitate communication regarding activities to improve children's social skills or stimulate their cognitive development. On a more fundamental level, the cross-cultural implementation of any psychological intervention is certainly likely to benefit from an in-depth familiarity with the target culture's beliefs and practices related to mental health and psychological development. (Miller & Billings, 1994, p. 355)

The report by Amone-P'Olak (2004) on the psychological state of formerly

abducted children in Uganda cited a similar need for future interventions that fit the target

population.

> For any intervention to be meaningful, the following additive factors consequent to experiencing traumatic events should all be adequately addressed in the context of the local culture: low self-esteem and morale, failure to openly discuss what happened, the dehumanizing consequences of the war, restoring the severed bonds between individuals and communities, and strengthening the family systems by improving psychosocial support to parents to man-age their stress effectively and enhancing community resources that the adolescents will be reintegrated back into, improving the material well being.

> The length of psychotherapy should depend on the complexity and severity of the problems of each child and should often be informed by the local culture. Culturally appropriate counseling and therapy (such as cleansing rituals) are recommended in addition to the establishment of community support networks and an education system cognizant of their special needs. (Amone P'Olak, 2004, p.33-34)

Amone P'Olak further cited the need for studies of cultural knowledge of mental health

and healing in refugee mental health programs in a 2006 report, also focusing on

Ugandan adolescents.

> This study is a precursor to longitudinal studies that are required to address the effectiveness of the traditional therapies for rehabilitating adolescents exposed to

> violence and cultural coping mechanisms and how these can inform interventions. Also important to study are other rituals not included in this study. (Amone-P'Olak, 2006, p. 106)

This report contained numerous examples of the use of traditional healing rituals as mental health interventions but did not include target population participation in the assessment of the efficacy of the program. If the target population was included in the assessment, it was not noted in the report.

The four reports containing some evidence of the use of target population cultural knowledge in evaluation only contained suggestions that more knowledge of target population culture be included in future studies. The reports did not give evidence of the inclusion of the target population in the actual evaluation of the mental health program described in the report.

Seven reports contained an evaluation section but did not mention any use of target population cultural knowledge in the evaluation phase. Of these seven, one contained evidence of the use of cultural knowledge in one report category and six did not contain explicit evidence of the use of cultural knowledge in any category.

Four reports did not contain an evaluation section. Of these four reports, three contained evidence of the use of cultural knowledge in one report category and one did not contain explicit evidence in any category.

The Use of Cultural Knowledge in Multiple Categories

Three of the fifteen reports surveyed contained explicit examples of the use of cultural knowledge in two categories, intervention and evaluation. None of the reports surveyed contained explicit examples in assessment and intervention or assessment and evaluation.

Reports containing explicit examples of the use of cultural knowledge in both intervention and evaluation phases of the refugee camp mental health program were a comparative report on trauma therapies in a Sudanese refugee camp (Neuner et al., 2004), a report on play therapy with Guatemalan refugee children (Miller & Billings, 1994) and a report on methods of rehabilitation for former child soldiers in Northern Uganda (Amone P'Olak, 2006). All three reports contained evidence of the use of the target population's cultural knowledge of mental health and healing during the mental health intervention followed by suggestions for further incorporation of cultural knowledge in future studies. The three reports did not contain evidence of the use of cultural knowledge in assessment and did not involve the target population in the project evaluation.

None of the fifteen reports surveyed contained evidence of the incorporation of the target population's cultural knowledge of mental health and healing in all three categories: assessment, intervention and evaluation phases of the refugee camp mental health program. The report that contained the most prevalent examples of the use of cultural knowledge (Miller & Billings, 1994), contained some possible implicit examples of the use of cultural knowledge in assessment followed by explicit examples in intervention and suggestions for further cultural consideration in future projects. The report did not collaborate with an author from the target population but did use members from the target population as counselors in the program intervention. The target population was not directly involved in the project assessment or evaluation.

The Use of Cultural Knowledge in Zero Categories

Four reports did not contain explicit or possible implicit evidence of the use of cultural knowledge in assessment, intervention or evaluation. The subjects of these reports were a study of the efficacy of narrative exposure therapy for treating PTSD in Kosovar refugees in Macedonia (Neuner et al., 2002), a study by Médecins Sans Frontières on mental health care for refugees in Kosovo (de Jong et al., 1999), a study of the efficacy of training lay counselors to treat Post-Traumatic Stress Disorder (PTSD) in Rwandan and Somali refugees in Uganda (Neuner et al., 2008) and a study of PTSD in children living in tsunami affected regions of Sri Lanka (Neuner et al., 2006).

The report on Kosovar refugees in Macedonia (Neuner et al., 2002) did not involve a target population author or facilitator and did not contain any evidence of the use of cultural knowledge in assessment, intervention or evaluation. The mode of intervention described in this report was narrative exposure therapy (NET), which the authors found to be a promising treatment for refugees experiencing significant levels of PTSD (Neuner et al., 2002). There was no mention of target population cultural integration at any point in the report.

The Médecins Sans Frontières report (de Jong et al., 1999), also on Kosovar refugees, involved target population facilitators in the mental health program but did not contain any evidence of the use of target population cultural knowledge. The interventions described were limited sessions of individual and group counseling to treat depression and PTSD and psychoeducation to increase public knowledge of mental health and trauma. The report concluded that mental health needed to be a greater focus

for agencies working with Kosovar refugees. The report contained the following brief

suggestion of the need for cultural knowledge.

> MSF believes it is important to initiate mental health programmes during the emergency phase of are refugee crisis: local staff must be identified and trained, time is required to understand the local cultural context, and people need to become aware that such help exists. (de Jong et al., 1999, p. 1617)

The report did not include any further evidence of the use of cultural knowledge in any

phase of the mental health program.

In the Neuner et al. (2008) article on treating PTSD in Rwandan and Somali

refugees in Uganda, members of the target population were trained in traditional Western

therapy methods. Neuner et al. concluded that training lay counselors was a relatively

effective way to treat PTSD in refugee populations. The following statement contained

the only mention of the integration of cultural knowledge in the report.

> This implies the necessity of developing community-based treatment approaches that are suitable for the requirements of the field conditions in war-affected societies. The procedures have to be culturally appropriate, short, and pragmatic enough so that they an be easily disseminated to professionals with little or no training in mental health or counseling. (Neuner et al., 2008, 687)

The report did not contain any further evidence of the use of target population cultural

knowledge in assessment, intervention or evaluation.

The study on Post-Tsunami Stress (Neuner et al., 2006) involved a needs

assessment and basic counseling conducted by local counselors trained in trauma therapy.

The counselors measured PTSD using the University of California at Los Angeles

(UCLA) PTSD Reaction Index (PTSD-RI) for children which had been proven effective

for testing PTSD in a wide variety of cultural settings (Neuner et al., 2006). This was the

only mention of cultural consideration in the report. There was no recorded use of

cultural knowledge in assessment or intervention and the report did not contain an evaluation section.

The Use of Cultural Knowledge in Accordance with NGO Standards

Zero of the fifteen reports surveyed specified the incorporation of target population cultural knowledge in order to meet the standards of NGOs affiliated with the projects. Though all reports were conducted in camps affiliated with the UNHCR, no report mentioned the necessity to follow UNHCR operating procedures regarding the use of cultural knowledge. The report authored and published by UNICEF (UNICEF, 2007) did not specify any UNICEF operating procedures with regard to the use of cultural knowledge and did not contain any explicit evidence of the use of cultural knowledge in any category. This finding will be discussed at length in the next chapter.

The Use of Cultural Knowledge over Time

The reports surveyed did not show an increase of the use of the target population's cultural knowledge of mental health and healing in refugee camp mental health programs over time. The two reports surveyed that contained the most significant evidence of cultural knowledge were published in 1994 and 2004. The most recent report surveyed, from 2007, did not contain any explicit evidence of the use of target population cultural knowledge. A graphical representation of this finding is located in Table 7 below. This finding will also be discussed further in the next chapter.

Table 7: Change in the Use of Cultural Knowledge over Time

Change in the use of Cultural Knowledge over Time
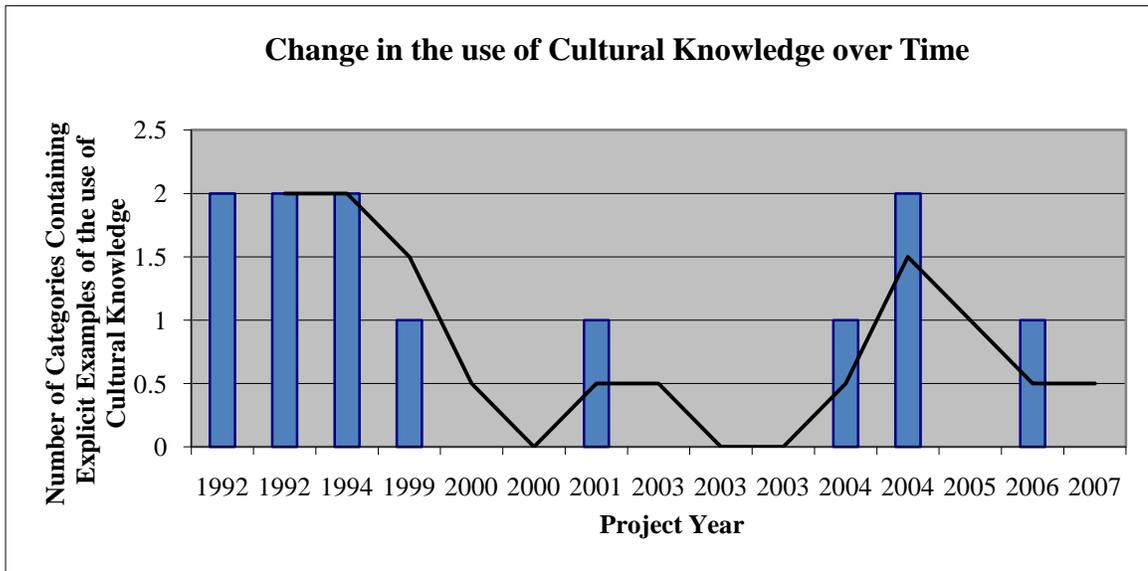
Resistance to the Mental Health Program

Six reports surveyed contained some documented evidence of resistance by the target population to the mental health program. Documented resistance could suggest that the program facilitators were not conducting a program that fit with the target population's needs or cultural understanding of mental health and healing. However documented resistance could also suggest that the program facilitators were attuned enough to the needs of the target population to identify resistance and change the program in accordance with the population's needs. The following examples seem to suggest both scenarios.

Bower, Pahl and Bernstein (2004) wrote the following about a client who had a particularly difficult time in reducing PTSD symptoms following the severe trauma that she suffered during the war in Bosnia.

Fatima continued to report PTSD symptoms even after receiving antidepressant medications, attending traditional talk therapy, completing further tattoo removal

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procedures and cognitive-behavioral therapy. (Bower, Pahl, Bernstein, 2004, p. 22)

The report went on to recount how the client's therapeutic process did not appear to be particularly successful in reducing trauma symptoms until she became more directive and changed the course of treatment to include practical wellbeing considerations such as job placement and education. In this report, the facilitators identified the client's resistance to traditional therapeutic approaches and allowed the treatment to be more directive in nature, which may or may not have fit more closely with her cultural understanding of healing. The report did not specify how the client's cultural understanding of mental health and healing informed her treatment.

Miller and Billings (1994) wrote about the following difficulties they had in coordinating with target population facilitators.

The conceptual and linguistic differences between ourselves and the teachers with whom we were working regarding childhood mental health and psychosocial development complicated communication about these topics during the training sessions. In retrospect, it seems probable that the community's indigenous understanding of mental health and psychological development was not adequately incorporated into the training and that Western conceptualizations of these processes dominated. (Miller & Billings, 1994, p. 354)

This report contained evidence of the use of cultural knowledge in intervention and evaluation though the facilitators did not involve the target population directly in the assessment for or evaluation of the project. The authors clearly specify the need for more cultural consideration in future projects.

The report by Neuner et al. (2008) on training lay counselors to treat PTSD identified somewhat high dropout rates amongst the study's participants.

In the NET group, 4 participants (3.6%) refused or dropped out of treatment, whereas in the TC group 22 participants (19.8%) did not complete therapy. (Neuner et al., 2008, p. 690)

High dropout rates could suggest resistance to the mental health program. Neuner et al. (2008) found that participants were dropping out because they needed more time to plant crops before the rainy season. No amendment was made to the program in order to decrease the dropout rate.

In the Stepakoff et al. (2006) article regarding trauma healing in Guinea, the following was reported regarding the target population's resistance to participating in the therapeutic process specified by the facilitators:

Many clients, when asked about feelings of anger in regard to the atrocities perpetrated against them, would reply that they did not feel any anger toward the perpetrators and that they had forgiven them. Although these words sounded admirable in some ways, several clinicians sensed that these statements did not convey these clients' affective experiences fully or honestly. There are people who have undergone a process, often arduous, of experiencing genuine forgiveness toward their perpetrators, yet for many of our clients, facile pronouncements such as "He killed my whole family but I forgive him" seemed to lack the ring of truth. (Stepakoff, Hubbard, Katoh, et. al., 2006, p. 929)

The report went on to detail the facilitators' decision to push the clients further in order to elicit a more "true" anger response. How the clients' anger response might have tied to their cultural knowledge of mental health and healing was not specified.

Lastly, the report by Sliep, Weingraten and Gilbert (2004) on a narrative theatre approach to trauma healing in Northern Uganda, detailed resistance by the target population which suggested that they did not understand the purpose or goal of the mental health program in which they were participating.

At the start of the workshop, it turned out that participants had thought that the workshop would deal with HIV/AIDS only and that the outcome of the workshop

would be that they had learned how to use drama as an educational tool. (Sliep, Weingraten, Gilbert, 2004, p. 313)

This program appeared to have been designed with an intention that was not at all evident to the target population. When faced with opposition from the target population the authors changed the topic of the intervention from HIV/AIDS to domestic violence to more closely meet the needs presented by the participants.

The incidence of target population resistance to refugee camp mental health programs will also be discussed further in the next chapter. Suggestions for better practice will be explored.

Summary of Findings

A summary of major findings is located above in Table 5. In brief, seven reports surveyed contained some explicit evidence of the use of target population cultural knowledge of mental health and healing at some point during the mental health program but none of the fifteen reports contained evidence of the use of cultural knowledge in program assessment, intervention and evaluation. None of the reports surveyed specified compliance with standards set by affiliate NGOs regarding the use of cultural knowledge and the use of cultural knowledge has not increased over time. Six reports included evidence of resistance by the target population to the mental health program. Implications of these findings on the provision of mental health services to refugees will be discussed in the next chapter along with suggestions for future practice.

CHAPTER V

DISCUSSION

The purpose of this qualitative survey of documents was to determine how mental

health workers in refugee camps used the target population's cultural knowledge of

mental health and healing in refugee camp mental health programs. This study revealed

that while evidence of the use of cultural knowledge was present in eight of the fifteen

reports surveyed, fifty-three percent of the sample, none of the reports surveyed

contained evidence of the use of cultural knowledge in the assessment, intervention and

evaluation phases of the refugee mental health program. The study also showed that,

based on the reports surveyed, the use of target population cultural knowledge has not

changed over time and reports did not show that refugee camp mental health workers are

following guidelines for the use of cultural knowledge established by the NGOs with

which they are affiliated.

This chapter will explore the findings with regard to literature on the subjects of

refugee camp mental health programs and the use of cultural knowledge. I provide

suggestions for better practices in refugee camp mental health programming. Limitations

of this study and recommendations for future research will also be discussed.

Linking Literature to Practice

I found in my survey of reports that the use of target population cultural

knowledge in refugee camp mental health programs was existent but sparse, disordered

and not well documented in program reports. Some reports surveyed contained evidence of the use of cultural knowledge but this theme did not carry through the whole mental health program and did not connect to guidelines for the use of cultural knowledge or literature on the subject. The reports did not point to any pattern or policy toward the use of cultural knowledge and instead pointed to a piecemeal inclusion of cultural knowledge that was not based on previously compiled knowledge and did not contribute to a greater wealth of literature on the subject. Each report remained separate in space; the inclusion of cultural knowledge seeming to have grown and died in that circumstance only without having been properly assessed prior to the project implementation or reported on post-completion.

My primary finding reflected literature on the topic of the use of cultural knowledge in refugee mental health, which is also fragmented and largely nonexistent. The impetus for this study was based partially on my initial discovery that little to no literature on the use of target population cultural knowledge in refugee camp mental health programs existed. Much has been written about cultural considerations in mental health (Aponte & Wohl, 2000; Fong, 2004; Pérez Foster et al., 2004; Siegel et al., 2000; Westermeyer, 1987) and researchers have contributed to a growing amount of writing on the subject of refugee mental health (Drumm et al., 2003; Gong-Guy at al., 1991; Kinzie, 2001; Miller & Rasco, 2004; Watters, 2001). Much of the writing on refugee mental health, however, focused on mental health issues that arose in refugee populations post-resettlement or repatriation rather than in refugee camps. The existing literature on refugee camp mental health programs did not focus on the inclusion of target population cultural knowledge and the literature on cultural consideration in refugee mental health

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did not connect to mental health programs in refugee camps. I found a dearth of

literature on the topic of cultural considerations in refugee camp mental health programs

and no literature that connected that topic to practice. I could not find any literature that

connected cultural practice theory to NGO policy documents which established

guidelines for the use of cultural practices in refugee camp programs. In concluding my

review of literature I had found no document that showed how mental health workers

were actually using the target population's understanding of mental health and healing in

refugee camp mental health programs or following NGO guidelines regarding the use of

cultural knowledge.

While a review of literature showed a movement over time toward more

incorporation of cultural knowledge in mental health, the reports surveyed for this study

did not follow this pattern. The report containing the most explicit examples of the use of

cultural knowledge (Miller & Billings, 1994) was published six years prior to the

publication of the DSM-IV-TR (*DSM-IV-TR*, 2000) which detailed "culture-bound

syndromes" that the authors of the report had described. The twelve reports published

after the release of the DSM-IV-TR jumped around from containing no evidence of the

use of cultural knowledge to containing some evidence in some categories. None of the

reports cited the use of the DSM-IV-TR for definitions of culture-bound syndromes and

none of the authors stated that they had built their model for including cultural knowledge

upon previous studies or literature regarding the issue. The most recent report surveyed

(UNICEF, 2007) did not contain any evidence of the use of cultural knowledge and did

not report any connection to previous studies or documents related to the use of cultural

knowledge. The movement over time toward more cultural consideration in refugee

mental health was not evident in this sample at all.

The reports surveyed for this study were neither connected to the increase, over

time, of literature on the topic of the use of cultural knowledge nor to policy documents

on the use of cultural knowledge. While every report detailed a mental health program

conducted in a refugee camp under the authority of the UNHCR, none of the reports

made any mention of following UNHCR guidelines regarding the use of target population

cultural knowledge. For instance, none of the reports contained evidence that the mental

health program administrators had used the UNHCR Tool for Participatory Assessment

in Operations (UNHCR, 2006) which gives specific requirements for the inclusion of the

target population and cultural factors during the assessment phase of a mental health

program. Reports for UNICEF and Vivo did not contain any evidence that the mental

health programs described had followed the guidelines established by those agencies

either. The reports conducted in conjunction with the World Health Organization did not

mention inclusion of any WHO standards (WHO, 1996; WHO, 1997; WHO, 2001;

WHO, 2003; WHO, 2004) for the use of target population cultural knowledge. The four

studies conducted through the Center for Victims of Torture did not reference the CVT

manual Healing the Hurt (Center for Victims of Torture, 2005) which gives very specific

directions on how to involve the target population in a mental health program and

incorporate cultural knowledge.

Some reports used for this study were written before their affiliated NGO guides

were produced so clearly there would be no connection between the two published works.

However the incidence that this sample does not include a single connection between a

report from a refugee camp mental health program and an NGO operating document on the correct method for carrying out a refugee camp mental health program, particularly with regard to the use of cultural knowledge, is significant. It suggests again, as with the disconnect between the reports and the increase in cultural consideration over time, that each refugee camp mental health program is carried out in a veritable vacuum; neither referencing past projects and literature nor contributing much to the growing discourse on the inclusion of cultural knowledge in refugee mental health.

Implications for Better Practices in Refugee Camp Mental Health Programs

Reports for this study contained some very good examples of the use of cultural knowledge that should be studied and built upon in future refugee camp mental health programs. Reports detailed the efficacy of empowering target population counselors (Bower et al., 2004; Neuner et al., 2008), the importance of learning and using local mental health and healing terms (Miller & Billings,2004) and the positive outcomes reached by combining traditional therapy methods with target population rituals (Amone-P'Olak, 2006). These examples all point back to the literature on the impetus for using target population cultural knowledge in mental health programs, though the reports contain no obvious connection between literature and practice. Thus the objective now is to connect literature on the use of cultural knowledge to practice in order to ensure the inclusion of good practices in the use of cultural knowledge in all future refugee camp mental health programs.

The reports that I surveyed had not yet built upon literature on the topic of the use of cultural knowledge. Focus groups were not established, target population cultural leaders were not consulted and the target population was not involved in the program

design. The conducting of a comprehensive needs assessment which includes input by

the target population did not occur in any of the reports surveyed and did not seem to be

deemed necessary by facilitators for the success of a refugee camp mental health

program. In the absence of a needs assessment, interventions seem to have been created

off the back of the desire to conduct some sort of mental health research rather than to

meet the explicit needs of the community. And in turn, achievements in refugee camp

mental health programs seem to be measured within the scope of those programs only, or

possibly a series of programs by the same group without involving an evaluation by the

target population or a connection back to a greater scope of literature. The use of target

population cultural knowledge in refugee camp mental health programs is segmented

between programs because there is no connection to the literature or policy documents

that would create commonalities and is disordered within programs because they do not

seem to start with a comprehensive needs assessment that would direct the program

toward cultural integration throughout each phase.

All parts considered, recommendations for better practice with regard to the use

of cultural knowledge in refugee camp mental health programs are threefold; follow

established guidelines for the inclusion of cultural knowledge, begin the program with a

comprehensive needs assessment as dictated by the target population and report on the

uses of cultural knowledge throughout a program so that the report will contribute

adequately to a greater store of knowledge on the topic of target population cultural

knowledge in refugee camp mental health programs.

Following Guidelines to Cultural Integration; Policy Meets Procedure

If NGO policy documents are not required operating manuals for all employees and affiliates, they should at least be required reading. Policy documents comprise an extensive amount of literature already in place to support the incorporation of target population cultural knowledge into refugee camp mental health programs. The documents are not culture specific which would put them into a category of writing that defines a particular culture rather than drawing definitions through case by case observations. Instead the documents give broad suggestions for incorporating cultural knowledge from any population such as creating an initial target population focus group to assist in conducting an accurate needs assessment (UNHCR, 2006), surveying all different demographics within the target population (WHO, 2003), identifying traditional healers who are well recognized within the target population (UNHCR, 2008) and encouraging the reestablishment of normal cultural practices (The Sphere Project, 2004). The use of target population cultural knowledge is emphasized for every step of a mental health process from assessment to intervention to evaluation in ways that can be easily incorporated into a short-term or long-term refugee camp mental health program. Of any literature on the topic of cultural integration, NGO policy documents seem to be the most applicable for use in refugee camp mental health programs because they are the bulk of current texts written for that specific setting.

The next step in matching policy to procedure within refugee camp mental health programs is to create more formal requirements for the adherence to NGO operating procedures. If a mental health program is operating under the umbrella of the UNHCR, the program administrators should be required to follow basic operating procedures as

established in UNHCR manuals with regard to mental health programs. They should also be required to include adherence to guidelines into their final reports as a way to connect process back to policy and strengthen that connection. This is a simple scenario; the mental health facilitators follow basic guidelines and then produce reports that show adherence to those guidelines. As the guidelines already exist and the programs do as well, this connection could easily be made with more regulation and formalization across the field of refugee camp mental health programs.

Comprehensive Needs Assessments

All successful mental health programs must start with a comprehensive needs assessment (Kaplan, 1964). This should be particularly true in a refugee camp mental health program because the primary facilitators come from outside the target population and have only been in the area for a short time. Mental health facilitators may enter a refugee camp with a treatment plan already established but will not be able to meet the true needs of the population until a comprehensive needs assessment involving the population has been completed.

I interpreted from the reports surveyed that the authors had conducted refugee camp mental health programs from a top down standpoint in which they had gone in with a plan and implemented it in such a way that it fulfilled the conditions of their study. Interventions may have produced some markedly positive results from the perspective of the authors but this success does not signal the efficacy of the program with the target population because they were not involved in forming the program nor in evaluating it.

Refugee camp mental health workers must instead take a Frieren approach to populous dialogue (Friere, 1970) to create programs that suit the needs of the community

and promote the greatest measure of positive change for the target population. The

Active Learning Network for Accountability and Performance in Humanitarian Action

(ALNAP, 2006), of which most UN organizations are members, provides a set of specific

guidelines for conducting a needs assessment focused on target population involvement.

The United Nations Population Fund's booklet *Guide to working from within* (UNFPA,

2004), which has been included as an appendix to this report, also acts as a good guide

for culturally sensitive programming. Texts exist to promote this method of assessment;

they must now be disseminated and adhered to. The evolutionary process of a mental

health program can then grow from a comprehensive needs assessment that involves the

target population to interventions that incorporate the target population's cultural

knowledge of mental health and healing to evaluations that reflect the efficacy of the

program as deemed so by the target population.

Better Reporting to Strengthen the Field

A major limitation of this study was that information was only gathered from

what was recorded in reports; which did not seem to encompass a full synopsis of the

mental health programs described therein. Reports that did not contain an assessment or

evaluation section may not have fully described each step of the mental health program. I

found it impossible to determine what was not there. Thus not only are published reports

on refugee camp mental health programs rare, the ones that do exist seem to leave large

gaps between what actually happened throughout the entire duration of the mental health

program and what is reported on. Just as I found a gap between the literature on policy

and practice in refugee camp mental health programs, I discovered the same gap between

practice back to policy. If a report is to effectively contribute to a larger store of

knowledge on refugee camp mental health programs, every phase of a project must be

well documented. Better reporting will lead toward better practices in refugee camp

mental health in that future projects can build off an established model which will, if

other recommendations are followed, include target population cultural knowledge at

every phase of the project.

A Better Program Design

With all literature and findings from this study considered, I have compiled a list

of suggestions for better refugee camp mental health programming.

- Review Literature: Begin with a full review of literature on NGO policies regarding mental health and the incorporation of cultural knowledge and on other mental health programs conducted in the area. Learn as much as possible about the target population and their culture.

- Focus Groups: Before program design or implementation, hold focus groups comprised of the target population to determine strengths and needs.

- Involve Women: Be sure that women are target in focus groups, either in mixed groups or in specific women's groups.

- Needs Assessment: Conduct a comprehensive needs assessment incorporating findings from the focus groups and involving partners from the focus groups.

- Program Design: Design a program based on the findings from the needs assessment and with the full involvement of members of the target population.

- Focus on Community Building: As social creatures, humans must have faith in a community in which they can rely on the predictable responses of those around them. Rebuilding faith in a strong community must be at the center of every mental health program.

- Maintain Focus Groups: Conduct focus group check-ins during the mental health program and once it is completed to be sure that there is perceived progress from the target population.

- Conduct a Full Evaluation: Upon completion of the program, involve the target population in a full evaluation of the program including measures of the program's efficacy and suggestions for future programming

- Report in Full: Publish a full report that involves information about each step of the program from initial research through to evaluation. Report on how the program met with NGO operating standards.

- Compile Reports: Compile published reports in an easily accessible database for use by future practitioners.

Limitations of the Study

The greatest limitation to this study is that the sample size is very small and only encompasses a very limited view of the current state of refugee camp mental health programs. Several of the reports used in this study were written by the same authors, which further narrowed the scope of the sample. Information on two of the authors who contributed to more than one report used in this study can be found in Appendix C.

Published reports on refugee camp mental health programs are rare and not organized into any online database. Refworld (www.unhcr.org/refworld, 2011), the UNHCR research database, recently created an online bank of articles related to mental health. Of the 158 articles listed, none are reports from completed refugee camp mental health programs. It could be inferred that refugee camp mental health programs are occurring but the reports are not being published or released. While this study is based on a sample size that comprises a significant portion of published reports, it does not comprise a significant portion of programs. A better sample size cannot be achieved until more reports are published.

This study is limited to a specific point in time and would produce different results if conducted in the future once more reports have been published and a stronger

connection is possibly established between policy and practice within refugee camp mental health programs. The most recent report used for this study was published in 2007; now four years back in the evolution of refugee mental health. However a more recent search for articles, conducted in 2011, did not produce a larger sample. As thus, this small sample can still be considered a good current review of published literature on refugee camp mental health programs.

This study was also based on what was printed in reports and not on direct information from the authors. Interviews with report authors may have produced much more specific information about the planning behind a refugee camp mental health program and the incorporation of cultural knowledge. Research on this topic gathered directly from the refugee camp setting would also be far more accurate.

Future Research

The aim of this study was to determine how refugee camp mental health workers were using the target population's cultural knowledge of mental health and healing in refugee camp mental health programs. The most evident finding was that cultural knowledge is being used sporadically; without continuity throughout a program and without connection to relevant literature or policy documents. Limitations to this study were the size of the sample and the absence of firsthand information from the authors regarding the specific topic of the use of target population cultural knowledge.

This report provided a narrow snapshot view of the current state of refugee camp mental health programs and a jumping off point for future research. The next step would be to interview the authors directly in order to get a clearer picture of the whole scope of the refugee camp mental health program. An even more indepth look would come from

traveling to refugee camps and making direct observations on the process of assessing,

implementing and evaluating a mental health program. A report created from direct

observation would include the perspectives of the target population who could be

interviewed regarding their involvement in the program and its perceived efficacy. Once

a large sample of direct reports had been created they could be compiled into an easily

accessible database so that future programs would be built off of successes documented

in previous reports and would lead to uniform better practices across the field. In

conjunction, more research should be done on the efficacy of culture based mental health

practice with reference specifically to refugee populations.

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World Health Organization. (2003). *Mental health in emergencies: Mental and social aspects of health of populations exposed to extreme stressors.* Geneva: Author. Retrieved June 12, 2008, from www.who.int/publications

World Health Organization. (2004). *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons.* Geneva: Author. Retrieved June 12, 2008, from www.who.int/publications

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Appendix A

Report Survey Guide

Report Name:
_____

Target Population:
_____

Project Location:
_____

Project Date:
_____

Implementing Organizations:
_____

1. Was one or more of the authors of the report identified as being a member of the target population?

   YES   NO   UNCLEAR

   Comment:
   _____

2. Was one or more of the authors of the report identified as being an expert on the target population's cultural knowledge of mental health and healing?

   YES   NO   UNCLEAR

   Comment:
   _____

3. Did the report identify one of the facilitators of the mental health program as being a member of the target population?

   YES   NO   UNCLEAR

   Comment:
   _____

4. Did the report identify one of the facilitators of the mental health program as being an expert on the target population's cultural knowledge of mental health and healing?

   YES   NO   UNCLEAR

   Comment:
   _____

5. Did the report contain an assessment section?

   YES   NO   UNCLEAR

   Comment:
   _____

6. If YES to Question 5; did the assessment section of the report contain explicit evidence that the program facilitators did background research on the target population's cultural knowledge of mental health and healing?

   YES   NO   UNCLEAR

   Comment:
   _____

7. If YES to Question 5; did the assessment section of the report contain explicit evidence that the program facilitators interviewed the target population about their cultural knowledge of mental health and healing?

   YES   NO   UNCLEAR

   Comment:
   _____

8. If YES to Question 5; did the assessment section of the report contain any explicit evidence that the program facilitators involved the target population in the assessment phase of the mental health program?

   YES   NO   UNCLEAR

   Comment:
   _____

9. If YES to Question 5; did the assessment section of the report contain possible implicit evidence that the program facilitators involved the target population in the assessment phase of the mental health program or used the target population's cultural knowledge of mental health and healing in the program design?

YES   NO   UNCLEAR

Comment:
_____

10. Did the report contain an intervention section?

YES   NO (NO Response = Rule Out)   UNCLEAR

Comment:
_____

11. If YES to Question 10; did the intervention section of the report contain explicit evidence that the program facilitators used the target population's cultural knowledge of mental health and healing in the mental health intervention? Was there a sentence or section that explicitly stated, "The facilitators used the target population's cultural knowledge of mental health and healing in the mental health intervention."?
YES   NO   UNCLEAR
Comment:
_____

12. If YES to Question 10; did the intervention section of the report contain explicit evidence that the program facilitators used the target population's cultural knowledge of mental health and healing in the mental health intervention by using mental health and healing <u>terms</u> and <u>practices</u> specific to the target population?

YES   NO   UNCLEAR

Comment:
_____

13. If YES to Question 10; did the intervention section of the report contain possible implicit evidence that the program facilitators used the target population's cultural knowledge of mental health and healing in the mental health intervention?

YES   NO   UNCLEAR

Comment:
_____

14. Did the report contain an evaluation section?

    YES   NO   UNCLEAR

    Comment:
    _____

15. If YES to Question 14; did the evaluation section of the report contain explicit
    evidence that the program facilitators involved the target population in the
    evaluation of the mental health program?

    YES   NO   UNCLEAR

    Comment:
    _____

16. If YES to Question 14; did the evaluation section of the report contain explicit
    evidence that the program facilitators used the target population's cultural
    knowledge of mental health and healing in the program evaluation?

    YES   NO   UNCLEAR

    Comment:
    _____

17. If YES to Question 14; did the evaluation section of the report contain
    recommendations from the authors and/or program facilitators that the target
    population's cultural knowledge of mental health and healing be used in future
    mental health programs?
    YES   NO   UNCLEAR

    Comment:
    _____

18. If YES to Question 14; did the evaluation section of the report contain possible
    implicit evidence that the program facilitators used the target population's cultural
    knowledge of mental health and healing in the evaluation of the mental health
    program?

    YES   NO   UNCLEAR

    Comment:
    _____

19. Was there any explicit or possible implicit evidence that the target population was <u>resistant</u> to the mental health program?

YES   NO   UNCLEAR

Comment:
_____

20. Was there any other section of the report that contained evidence of the study of, use of or suggestion for future use of the target population's cultural knowledge of mental health and healing in the mental health program?

YES   NO   UNCLEAR

Comment:
_____

Final Comments:
_____
_____
_____
_____
_____
_____
_____
_____

Appendix B

List of Reports Surveyed

Amone-P'Olak, K. (2004). A study of the psychological state of former abducted
    children at Gulu World Vision Trauma Center. *Torture: Journal on Rehabilitation
    of Torture Victims and Prevention of Torture, 14*(1), 24-34. Retrieved January 17,
    2008, from www.irct.org

Amone-P'Olak, K. (2006). Mental states of adolescents exposed to war in Uganda:
    finding appropriate methods of rehabilitation. *Torture: Journal on Rehabilitation
    of Torture Victims and Prevention of Torture, 16*(2), 93-107. Retrieved January
    17, 2008, from www.irct.org

Bowen, D., Carscadden, L., Beighle, K., & Fleming, I. (1992). Post-traumatic stress
    disorder among Salvadoran women. *Women & Therapy, 13*(3), 267-280.
    Retrieved January 25, 2008, from www.informaworld.com

Bower, R., Pahl, L., & Bernstein, M. (2004). Case presentation of a tattoo-mutilated,
    Bosnian torture survivor. *Torture: Journal on Rehabilitation of Torture Victims
    and Prevention of Torture, 14*(1), 16-24. Retrieved January 25, 2008, from
    www.irct.org

de Jong, K., Ford, N., & Kleber, R. (1999). Mental health care for refugees from Kosovo:
    the experience of Medecins Sans Frontieres. *The Lancet, 353*(9164), 1616-1619.
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Harris, D. (2007). Dance/movement therapy approaches to fostering resilience and
    recovery among African adolescent torture survivors. *Torture: Journal on
    Rehabilitation of Torture Victims and Prevention of Torture, 17*(2), 134-155.
    Retrieved February 20, 2008, from irct.org

Miller, K., & Billings, D. (1994). Playing to grow: A primary mental health intervention
    with Guatemalan refugee children. *The American Journal of Orthopsychiatry,
    64*(3), 346-356. Retrieved January 27, 2008, from http://onlinelibrary.wiley.com

Naeem, F., Mufti, K., Ayub, M., Haroon, A., Saifi, F., Qureshi, S., Ihsan, A., Chaudry,
    H., Dagarwal, S., & Kindgon, D. (2005). Psychiatric morbidity among Afghan
    refugees in Peshawar, Pakistan. *Journal of Ayub Medical College (JAMC), 17*(2).
    Retrieved February 2, 2008, from www.ayubmed.edu.pk/jamc.html

Neuner, F., Onyut, P., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008).
    Treatment of posttraumatic stress disorder by trained lay counselors in an African
    refugee settlement: A randomized controlled trial. *Journal of Consulting and
    Clinical Psychology, 76*(4), 686-694. Retrieved January 27, 2008, from
    www.apa.org/pubs/journals/ccp

Neuner, F., Schauer, M., Catani, C., Ruf, M., & Elbert, T. (2006). Post-tsunami stress: A study of posttraumatic stress disorder in children living in three severely affected regions in Sri Lanka. *Journal of Traumatic Stress, 19*(3), 339-347. Retrieved January 28, 2008, from http://web.ebscohost.com

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling and psycho education for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579-587. Retrieved January 17, 2008, from www.apa.org/pubs/journals/ccp

Neuner, F., Schauer, M., Roth, W., & Elbert, T. (2002). A narrative exposure treatment as intervention in a refugee camp: a case report. *Behavioral and Cognitive Psychotherapy, 30*(1), 211-215. Retrieved January 27, 2008, from http://journals.cambridge.org

Sliep, Y., Weingarten, K., & Gilbert, A. (2004). Narrative theatre as an interactive community approach to mobilizing collective action in Northern Uganda. *Families, Systems & Health, 22*(3), 306-320. Retrieved January 28, 2008, from http://find.galegroup.com

Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J., Nkhoma, P., & Omagwa, Y. (2006). Trauma healing in refugee camps in Guinea: psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *American Psychologist, 61*(8), 921-932. Retrieved January 20, 2008, from www.ncbi.nlm.nih.gov

United Nations International Children's Fund. (2007). *Psychosocial support for children: Building the capacity of key professionals for dealing with children in a protective and sensitive manner.* Ethiopia Project Report. Geneva: Author. Retrieved January 25, 2008, from www.unicef.org/publications

Appendix C

The Use of Cultural Knowledge by Author

Two authors, Frank Neuner and Kennedy Amone P'Olak, coauthored more than

one report used in this study. A brief note on their background and connection to refugee

mental health and the use of cultural knowledge follows.

Doctor Frank Neuner, who coauthored four of the reports used in this study, is a

professor of clinical psychology and psychotherapy at Bielefeld University in Bielefeld,

Germany. His research has included neuroscientific studies on the effects of violence on

the brain and epidemiological studies and experimental therapy studies with traumatized

survivors of war, torture, and natural disasters in current and former war zones. He

partnered with the Italian aid agency Vivo in a two year study to improve healthcare for

refugees and has coauthored numerous reports on refugee mental health, focused mainly

on comparisons between modes of intervention for refugees suffering from high levels of

PTSD (Bielefend University). Dr. Neuner has made significant contributions to the field

of refugee mental health and is considered one of the few experts in the specific field of

refugee camp mental health programs.

Dr. Neuner coauthored four reports used in this study, of which three contained

no evidence of the use of target population cultural knowledge. His report on trauma

therapies in a Sudanese refugee camp (Neuner et al., 2004) contained the use of cultural

knowledge in two categories.

Doctor Kennedy Amone P'Olak authored two reports used in this study. A native

Ugandan, Amone P'Olak received his master's degree in education from Makerere

University in Kampala, Uganda and his doctorate from the University of Groningen in

the Netherlands. He is currently a lecturer at the Departments of Psychology and Mental

Health at Gulu University in Northern Uganda where he focuses primarily on studying

the impacts of war, violence and traumatic events on children and adolescents (Gulu

University). He has published reports on this topic for publications such as *Intervention*

and *The Oxford Journal* and has been a long-time collaborator with Gulu World Vision; a

Christian aid agency which provides aid to Northern Uganda's formerly abducted

children and their families (World Vision).

Dr. Amone P'Olak authored two reports used in this study, both based on studies

of the mental health impacts of war and violence on adolescents in Northern Uganda. His

report for World Vision on the psychological state of formerly abducted children (Amone

P'Olak, 2004) contained evidence of the use of cultural knowledge in evaluation. A

report two years later on rehabilitation methods for adolescents exposed to war in

Northern Uganda (Amone P'Olak, 2006) contained evidence of the use of cultural

knowledge in intervention and assessment.

Appendix D

Guide to Working from Within:
24 Tips for Culturally Sensitive Programming

1. **Invest time in knowing the culture in which you are operating.** Understanding how values, practices and beliefs affect human behaviour is fundamental to the design of effective programmes. Nowhere is this understanding more important than in the area of power relations between men and women and its impact on reproductive health and rights.

2. **Hear what the community has to say.** Before designing a project, find out from community members what they hope to achieve. Soliciting their views on different aspects of a project, from the overall strategy to specific advocacy messages, can foster local acceptance and instill a sense of ownership.

3. **Demonstrate respect.** Make an effort to show that you understand and respect the roles and functions of community leaders and groups, avoiding attitudes or language that may be perceived as patronizing.

4. **Show patience.** A great deal of dialogue and awareness-raising may be needed to persuade others to accept new ways of thinking, especially ones that challenge beliefs closely tied to individual and social identity. Invest as much time as necessary to clarify issues and address any doubts. If questions are not resolved, they may resurface later and derail progress.

5. **Gain the support of local power structures.** Winning over those who wield power in a community whether they be NGOs, women's groups, religious leaders or tribal elders, can be a crucial first step in gaining acceptance at the grass roots level. Make sure your first encounter sends a positive message.

6. **Be inclusive.** The best way to dispel mistrust is through a transparent process of consultation and negotiation involving all parties.

7. **Provide solid evidence.** Using evidence-based data, show what programme interventions can achieve, such as saving women's lives. In addition to advocacy, such information can be used to clarify misconceptions and obtain support from policy makers and local power structures, including religious leaders. Credible evidence is especially important when the issues under discussion are controversial.

8. **Rely on the objectivity of science.** Addressing culturally sensitive issues in the context of reproductive health can help disuse the strong emotions that may be

associated with them. A technical or scientific perspective can make discussion and acceptance of such issues easier.

9. **Avoid value judgments.** Don't cast judgment about people's behaviour or beliefs. Rather, put your own values aside as you explore other people's thoughts and dreams, and how they think they can best achieve them.

10. **Use language sensitively.** Be cautious in using words or concepts that may offend. The term 'family planning', for example, may have negative connotations in some societies. Instead, frame issues in the broader context of reproductive health and healthier families.

11. **Work through local allies.** Rely on local partners that have the legitimacy and capacity to influence and mobilize a community. Such partners have the added advantage of knowing what local people are likely to accept. The importance of women's groups should not be underestimated.

12. **Assume the role of facilitator.** Don't presume to have all the answers. Give up control and listen to others express their views, share their experiences and form their own ideas and plans. In an environment charged with ethnic or religious differences, assuming the role of facilitator sends a message of neutrality.

13. **Honour commitments.** Doing what you say you will do is a powerful way to build confidence and trust.

14. **Know your adversaries.** Understanding the thinking of those who oppose your views can be key to successful negotiations. Analyze the rationale on which they base their arguments and be ready to engage in an ongoing and constructive dialogue.

15. **Find common ground.** Even within seemingly monolithic institutions there are different schools of thought. Look for areas of common interest – reducing maternal and infant deaths, for example – that can provide entry points for working with nontraditional partners.

16. **Accentuate the positive.** When addressing harmful traditional practices, emphasize that both harmful and positive practices are found in all societies. This can help to diffuse tensions around especially challenging issues, such as female genital cutting.

17. **Use advocacy to effect change.** Legal action by itself is usually not enough to bring about change. Though essential, legislation should be buttressed by a broad advocacy campaign, involving opinion makers and local power structures. Well-planned advocacy campaigns are particularly important when project goals are likely to provoke religious or cultural controversy.

18. **Create opportunities for women.** Give women the opportunity to demonstrate their capabilities through various development programmes. This can help diminish false, culture-based beliefs about stereotypical gender roles.

19. **Build community capacity.** Reinforce a sense of ownership and ensure sustainability by strengthening the skills of community members, including health-care providers and peer educators.

20. **Reach out through popular culture.** In many parts of the world, music and dance are popular cultural expressions. Use them to communicate new ideas, and be sure to involve young people in the creative process.

21. **Let people do what they do best.** Often, an appropriate role for traditional or religious leaders is mobilizing communities or helping to reshape public opinion. Seek their engagement in these areas, while letting health workers manage the technical aspects of reproductive health programmes.

22. **Nurture partnerships.** Cultivating relationships requires an investment of energy, patience and time. Don't allow them to disappear just because a project has ended. Sustaining partnerships beyond a single programming cycle allows trust to develop and relationships to mature, increasing the chances for positive results over the long term.

23. **Celebrate achievements.** Bringing accomplishments to the attention of others and publicizing success can create a sense of pride and reinforce community involvement.

24. **Never give up.** Changing attitudes and behaviors can be an excruciatingly slow process, especially in closed societies. Don't expect to accomplish everything at once. Even small changes are significant, and may be more enduring over the long term.

This booklet was based on research carried out by UNFPA on integrating cultural perspectives into its programming. For more information, see the following publications, *Culture Matters* **and** *Working from Within* **on the UNFPA website: www.unfpa.org.**

United Nations Population Fund. (2004). *Guide to working from within: 24 Tips for culturally sensitive programming.* **Geneva: Author. Retrieved January 25, 2008, from http://www.unfpa.org/public/cache/offonce/home/publications/pid/1410**