Theses, Dissertations, and Projects

2009

The necessity of "conflict transformation" in approaches to psychosocial interventions

Kay Naito
Smith College

Kay Naito
The Necessity of 'Conflict
Transformation' in
Approaches to Psychosocial
Interventions

ABSTRACT

This theoretical study examines the psychosocial discourse in humanitarian aid. International humanitarian assistance through psychosocial interventions is now common in complex emergencies – the context that emerges from war and violent conflict that is unique to the contemporary era of globalization. Humanitarian assistance aims to meet the needs of war-affected communities, alleviate suffering, remove barriers to health and development, quell cycles of violence, work towards long-term benefits, and maintain the core principle of 'do no harm' at the center of its moral intentions. Lively ethical, medical and cultural debates have contributed to the development of a wide range of different approaches in psychosocial interventions while achieving the goals of humanitarian aid and maintaining its commitment to human health and development. Despite a lack of evidence to support its effectiveness, interventions based on the notion of logical positivism prevail in international psychosocial discourse and program implementation. Conflict transformation, a radical perspective with familiar practices, is introduced and discussed as an essential inclusion when considering or implementing psychosocial interventions. Key contributions of Conflict Transformation are: the perspective that conflicts are opportunities for change rather than examples of social regression; and the understanding that processes toward peaceful relationships are relational and person-centered. The thesis concludes with possible contributions to conflict transformation by social work, and the implications for international social work theory and practice.

THE NECESSITY OF 'CONFLICT TRANSFORMATION'

IN APPROACHES TO PSYCHOSOCIAL INTERVENTIONS

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

Kay Naito

Smith College School for Social Work
Northampton, Massachusetts 01063

2009

ACKNOWLEDGMENTS

This thesis could not have been possible without the support of my parents, Ema, Lisa, my relatives, teachers, my friends, brothers and sisters around the world who keep me grounded in the beautiful stories of life. I could not have completed this without the nourishment and tabletops of so many coffee shops in Chiang Mai (Thailand), Tokyo (Japan), Vancouver (Canada) and Northampton (USA). I am so grateful.

I extend special thanks to the professors and advisors who have enriched my understanding of social change and whose integrity and commitment to humanity is something I will always admire and strive for. Thank you Josh Miller, Andrew Jilani, Basanti Majumdar, and Jean Wilson. Thank you, Yoosun Park for your consistent guidance from the beginning until the very end of the end.

Thank you to everyone in the A09 graduating class. I could not have finished without you laughing, standing, and running next to me. In particular I am thankful to Amy Kwan, Kristin Pinto-Wilson, Michelle Marlowe, Nada Michael, Prairie Chiu and the ad-hoc thesis study groups in helping me get this completed. Thank you, my ever reliable friends for being with me from the start: Alika, David, Tania, Beatrice, Janet, Sarah BN, Marko, Joe Park, Nelson, Hilary, Pawel, and Becky. Thank you, Joey for holding me through the process – the long journey across oceans and rice fields (you are here, finally!)

I dedicate my thesis to Shoji ojisan, my great-uncle whose stories of war and of rebuilding life in Tokyo will forever be a source of inspiration.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Humanitarian assistance in times of great communal distress in the aftermath of large-scale disasters, such as war and violent conflict, has always been an important part of recovering a community's security and enabling its healing and development (Ager et al., 2005; Duffield, 2002; Fox, 2001). An important principle of humanitarian assistance is its non-political and impartial stance. Humanitarian ideals puts forth that assistance should be given based on need, treating every individual and community as equal entities (Chandler, 2001; Seybolt, 1996). Over time, however, this practice has become unsustainable; the nature of human needs is now perceived to be more complex; and conflict has become more infused with violence in all forms. Today, the need for peace-building is intertwined with the need for humanitarian assistance in war-affected communities. How might interventions for peace work with humanitarian assistance following contemporary violent conflict?

Traditionally, humanitarian aid interventions consisted of basic provisions of water, food, shelter, sanitation, and health care. These needs were considered to be the basic necessities of life by aid providers from the West (Schloms, 2003). Since the end of the Cold War, violent conflict has weighed more heavily on civilian populations and has more significantly disrupted its psychological and social well-being. In response to the changing nature of violence, humanitarian aid has taken up psychosocial interventions as a major part of its work in the field. Psychosocial intervention itself has developed over the last few decades in response to strong criticisms about meeting the needs of the

populations it serves to benefit. While the urgency and complexity of needs in affected communities continue to demand international attention, issues of peace and conflict, culture and identity, and the significance of the global context are still inadequately addressed (Pederson, 2002; Summerfield, 1999; Wessells, 1999). The study presented in this thesis argues that *conflict transformation*, a perspective and practice that works toward building peace, is an essential element of addressing current demands for psychosocial interventions in communities affected by violent conflict.

Psychosocial interventions have also been influenced by aspects of globalization including the universal application of development standards defined by the West, and the increased flow of information, goods and services across state borders (Pupavac, 2004b). In the context of globalization and its accompanying era of postmodernity and social constructivist thought, the emotional and empathetic relationship between aid workers and aid recipients, such as altruism and ethical behavior, are subject to critical analysis. Humanitarian organizations and workers can no longer assume that the fundamental components of their work are ethical or beneficial to their aid recipients (Pupavac, 2004b). Some authors propose that contemporary interventions that aim only to address perceived needs around psychosocial well-being is a reflection of how social and emotional distress is defined for health in the West (Almedom, 2004; Pupavac, 2001; 2004a; Summerfield, 2002). Although the intersections of mental health and humanitarian aid following war have been much written about in the literature, only a few have discussed the unique context of globalization and its implications for the health of millions of war-affected individuals worldwide (Almedom & Summerfield, 2004; Piachaud, 2008; Pupavac, 2004b).

The psychosocial approach first emerged out of the idea of medical aid and provision of basic human needs. Its emphasis is on psychological assistance justified by trauma research which had mostly been based on work with war veterans within a Western cultural context. This incited ongoing critique from a relativistic and anthropological position that emphasized the social factors of healing and underscored the cultural relativism of psychology. This has since developed into a fierce debate, said to have resulted in the "demoralization" and "paralysis" in the psychosocial and humanitarian discourse (Abramowitz, 2009; Kienzler, 2008; Pupavac, 2004b). Although they have become more culturally sensitive, self-reflective, and localized, psychosocial interventions are still fundamentally guided by a politicized humanitarian aid regime that frames contemporary violent conflict as an instance of social regression and an "irrational" problem of communities who have failed the modern liberal agenda (Duffield, 2002).

In contrast, the ideas of conflict transformation, a theory, perspective and practice in the field of peace studies, helps us, as external agents, to understand conflict not as regression, but a normal part of human relationships that are opportunities for change from destructive and unhealthy relational patterns (Botes, 2003; Duffield, 2002; Michels, 2003; Wright, 2004). This perspective also allows us to understand how aspects of globalization may favor a negative outcome from naturally occurring conflict for those who are directly affected, and tends to benefit external communities – mainly those of the West. Transforming conflict in order to alleviate the protracted violence which characterizes contemporary war has now become an integral part of the language used in peace studies (Botes, 2003; Francis, 2002; Lederach, 2003). At the heart of conflict

transformation is an attempt to bring something new and healthy to human thought and relationships within local and global communities (Francis, 2002; Lederach, 2003). It has as its goal, real revolution in ways of relating and fundamental change in ways of thinking (Lederach, 2003).

I have chosen to address the conditions of war-affected communities in this thesis, where *war-affected communities* is defined very generally. Populations that have been, and in some cases, continue to be affected by contemporary violent conflict include civilians who are currently in regions where direct violence plays out erratically and unpredictably. They include asylum seekers and refugees who have fled areas where staying is not a safe or viable option. Under this term, war-affected communities, I also include communities in which direct violence from conflict and imminent challenges to safety have passed but structural violence and oppression continue to hinder healing and development.

In the following chapter, I define the context of *complex emergency* and describe the unique features of contemporary violence that contribute to creating this social, political and cultural climate. More specifically, I describe the psychological and social suffering associated with complex emergencies. I consider the contexts where there is individual suffering; even more pertinently, I am concerned with contexts in which there is social suffering. This is defined as

> the notion of suffering (that) evokes an assemblage of human problems that have their origins and consequences in the devastating injuries that the existing social order of the world inflicts, in variable degrees according to local situations, on the experience of individuals up to entire communities and nations. (Pederson, 2002, p.187).

In the third chapter, I define *psychosocial intervention* by detailing the development of this umbrella term and its discourse in the area of humanitarianism and humanitarian assistance. The term, psychosocial intervention, has been used to describe a wide variety of aid programs. As it is outside the scope of this thesis to discuss all the different permutations of interventions, I have chosen to describe only the polar ends of the spectrum of existing interventions. On one end of the spectrum are interventions that focus its attention on providing psychological and mental health assistance. The interventions coming out of this perspective are fundamentally based in the medical model. They are undergirded by empirical studies and the logical positivism of modernism, a perspective that continues to dominate psychosocial interventions (Bracken, Giller & Summerfield, 1997; Kleinman & Cohen, 1997; Miller, Kulkarni & Kushner, 2006). At the other end of the spectrum are interventions that focus on sustainable development and long-term community benefits through community mobilization efforts based in local knowledge and methods. I also describe the most recent and emerging understanding of the term in the remainder of the chapter which emphasizes the significance of both ends of the spectrum and the importance of coordination of all interventions in a certain community or region.

In the fourth chapter, I further develop and define conflict transformation and describe the ways in which this perspective enhances the psychosocial agenda in contemporary context and its necessity in confronting the moral and practical dilemmas faced by humanitarian aid today. I describe the peace practitioner's emphasis on navigating the issues of war-affected communities through the relational and person-centered processes of recovery with conflict transformation theory and practice. Such a

framework in the approach to psychosocial interventions may be a constructive step toward systemic change and transforming the persistent culture of violence in much of the world.

Finally, the fifth chapter summarizes the information introduced in the previous chapters: contemporary conflicts and complex emergencies, psychosocial interventions, and conflict transformation. I include recommendations for research that may consolidate conflict transformation as an appropriate and necessary inclusion in psychosocial interventions in war-affected communities in this context of globalization. I also include implications for the field of international social work as well as the potential contributions of social work theory and practice in the discourse of psychosocial interventions.

CHAPTER II

COMPLEX EMERGENCIES

Whether it is waged in state warfare or between ethnic groups, violent conflict is one of the most pressing problems in the world today (Desjarlais & Kleinman,1997; Piachaud, 2007; Wessells, 1999). The nature of armed or violent conflict since the end of the Cold War has changed substantially with the influence of globalization, into a phenomenon that can no longer be placed in the same category as the wars prior to the 1970s (Pederson, 2002). Even more so in the past couple of decades, conflicts have called for humanitarian assistance with greater urgency and need; the size and complexity of conflicts have become inestimable; and the responses to them, ever more challenging.

Mollica, Lopes Cardozo, Osofsky, Raphael, Ager, and Salama (2004) define complex emergency as "a social catastrophe marked by the destruction of the affected population's political, economic, sociocultural, and health care infrastructures" (p.2058). The definition used by OCHA (United Nations Office of Humanitarian Affairs) is provided by the IASC (Inter-Agency Standing Committee): "a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict which requires an international response that goes beyond the mandate or capacity of any single agency, and/or the ongoing United Nations country program" (Inter-Agency Standing Committee [IASC], 1994). I use complex emergency to designate the context of communities affected by contemporary war and violent conflict.

The international responses to complex emergencies have come mostly from the West whose understanding and conceptualization of the motives, targets and methods of

7

contemporary wars are themselves based in its particular ideas and culture. In the literature, for example, academics using a social psychological frame, view war and violent conflict as a psychological dysfunction that lead affected communities into cycles of violence and revenge (Pupavac, 2001, 2004a; Summerfield, 2002; Yoder, 2005). The emotional state of war-affected populations has become a significant focus of interest and concern for international policy-makers including those who employ international humanitarian, economic and political interventions (Pupavac, 2004a).

War-affected civilian communities, including displaced populations, often elicit public health responses from primary health care providers, traditional healers, and relief workers from external and local resources. However, as its definition states, the effects of a "social catastrophe" have multiple dimensions. At a community level, the effects of violent conflict on populations might include economic and cultural devastation, fragmentation of families, and disruption of social, economic and political institutions. At an individual level the effects may include, alongside the loss of life, feelings of pain, grief, guilt, anxiety, hatred, sadness and fear in survivors. (Desjarlais & Kleinman, 1997; Mollica et al., 2004; Summerfield 2000). A summary of the social and psychological effects of contemporary violence in complex emergencies, as they are described throughout the literature from multiple dimensions, is in the second part of this chapter.

Contemporary War and Violent Conflict

Since the Second World War, there have been more than 160 ethnic conflicts and wars and 24 million war-related deaths worldwide; some have estimated double this number (Pederson, 2002). More than a hundred armed conflicts have occurred within states since the end of the Cold War (Wessells, 1999). At any one time, the predicted

number of wars or conflicts occurring around the world range between 25 and 90 (Piachaud, 2007; Wessells, 1999). The length of conflict situations have also increased, affecting several generations of a community as a result. Violence in war-affected communities is no longer a temporary, unusual or extraordinary experience, or one that is outside of social functioning in normal times (Almedom & Summerfield, 2004; Pederson, 2002; Somasundaram, 2006; Yoder, 2005). The effects of violence, social tension and war have become chronic and are incorporated into the economic and social life of communities through a series of ordinary reactions and adaptations (Almedom & Summerfield, 2004; Pupavac, 2004b; Somasundaram, 2006; Summerfield, 1995).

In the 1990s, regional wars developed into humanitarian emergencies in popular Western consciousness and in the language of international relations (Greenaway, 1999). Whether or not there is an intrinsic quality of contemporary conflicts that make them significantly different from wars of the past is contentious (Greenaway, 1999) but the unique impact of conflicts today and the qualities ascribed to affected communities are proof that complex emergencies are a real and pressing phenomenon. Today's conflicts are described as chronic, while fluctuating between states of violence and nonviolence. They entail continuous violations of cease-fires and disruption of health services and relief operations which were once trusted to be politically neutral (Pederson, 2002; Piachaud, 2008). They are new in size, speed and complexity (Summerfield, 1995). They present determinants of peace that are different from before and reveal complicated moral choices before us (Piachaud, 2008). Most of all, their impact on present populations, and the issues they present are different.

9

Contemporary violent conflicts are *internal wars*; they occur more often within nation states than between them (Almedom & Summerfield, 2004; Farwell & Cole, 2002). But contemporary conflicts are characterized by several other attributes. These prevailing forms of armed conflict are also called "wars of a third kind" which are "wars of resistance and a campaign to politicize the masses whose loyalty and enthusiasm must sustain a post-war regime" (Pederson, 2002, p.176). They are often conflicts with an asymmetrical balance of power; conflicts which are population based, diffuse and difficult to monitor (Piachaud, 2008). They produce issues around which agents are to be held accountable and responsible for war (Almedom & Summerfield, 2004) as well as those that blur the line between times of war and times of peace. Examples of these issues include land mines, displaced people, shifts from political to criminal violence, and violence that remains long after a ceasefire (Wessells, 1999).

The effects of violence in today's internal wars are often destructive to the physical, social, and cultural infrastructures of a population. Pervasive violence and destruction, and the humanitarian crisis they create make modern conflict, complex emergencies by definition. Many people face complex emergencies that are rooted in context – in their histories of colonialism, oppression, poverty and environmental degradation (Wessells, 1999). Several authors write about the breakdown of a community's social fabric and the extreme suffering through family loss, disruption of daily activities, and destruction of local infrastructure; all of which produce the intended environment in which large numbers of people must manage their distress and cope with the damage (Pederson, 2002; Summerfield, 1995; Wessells, 1999; Wickramage, 2007). Cultural elements such as a sense of group identity, a people's history and value systems,

components that are often essential for survival in times of suffering are threatened to disappear in complex emergencies (Pederson, 2002). As much as society and culture are affected by conflicts, they are also what influence the responses to and engagement with conflict (Almedom & Summerfield, 2004). Conflict involves a web of violent political, economic, military, social and cultural forces and the relations between them.

The causes and engagements of modern conflict are as multi-dimensional and multi-layered as its effects. Violent conflict has played a central role in the emergence of globalization (Piachaud, 2008). Conflict helped to forge new technologies and socio-political processes, especially around governance that transcend state boundaries. Likewise, globalization and the imposition of global culture are important influences on violent conflict; the two phenomena are inextricably interlinked (Pederson, 2002; Piachaud, 2008). Although conflicts themselves are waged between groups and communities within nation-states, complex emergencies transcend national boundaries and their scale of needs is global (Wessells, 1999). Rising tensions between global processes with local or regional methods inform the ways in which identity continues to be shaped, constructed, imagined and reconstructed for political ends (Pederson, 2002).

In addition to internal wars, transnational economic trade, global communication, and transnational social movements challenge notions of nationalism and the existence of nation-state borders. Contemporary violent conflicts are also called 'resource wars' because of the idea that internal wars come out of ethnic tension over meager resources. According to Pederson (2002), in the 1970s, the slow economic growth of countries reversed as governments turned to Western-oriented production. National economies tried to increase production of raw materials but intensification failed only to accelerate

11

environmental decline and deplete assets which have led to rivalry, ethnic conflict, political violence and internal wars.

Conflicts are a critical impediment to sustainable development (Schloms, 2003; Silove, Steel & Bauman, 2007; Wickramage, 2007). Economic collapse and situations of economic crisis have led to further impoverishment and food insecurity (Pederson, 2002) but in many parts of the world, deep-seated structural violence, that is, a pervasive normative denial of one's capacity is both a barrier to development and a cause of direct or visible violence. There is a complexity of causes and consequences to all forms of violence including impacts on health, human well-being, destruction of civilization and humanity. In contemporary conflicts, war, civil war, genocide, violent repression and torture merge with structural violence such as poverty and lack of health care. The state, religion and corporate interest appear to be key institutions of war but the institutional structures that would support clinical or community interventions may be destroyed or absent (Pederson, 2002; Piachaud, 2008). Violence, in acts of war and in institutional or political structures and processes are not only the cause of suffering to a community's members, but also barriers to its development.

Conflicts since the Second World War are fought increasingly along lines of ethnic and group identity, often with the aim of ending what is considered to be illegitimate rule over a defined community or nation (Wessells, 1999). Losers and winners of a conflict may be an entire social sector or ethnic group (Almedom & Summerfield, 2004). While some see the roots of violence in the desire for power, others see the human process of group formation and identity as the roots of contemporary conflict (Piachaud, 2008). Nevertheless, the group motivations for conflict are

12

encapsulated in one or more of the following: persistent inequalities over access to critical resources; fundamental differences about ideology or nature of collective identity, nationalism, processes of state-building; legacies of colonialism and the Cold War; unresolved religious, cultural or ethnic conflict; and the enduring presence of illegitimate or repressive regimes (Pederson, 2002).

Violence in contemporary conflict is overwhelmingly targeted at civilians, their livelihood systems, social networks, where people live and work (Wickramage, 2007). In the Second World War, roughly 50% of casualties from war were non-military civilians (Farwell & Cole, 2002). Civilian casualties have since increased significantly and now make up approximately 80-95% of all war-related deaths (Farwell & Cole, 2002; Pederson, 2002; Summerfield, 1995). Large numbers of civilians are rendered near destitute and most internal migrations or forced displacements have resulted from violent conflicts that cause unstable conditions for survival (Pederson, 2002; Summerfield, 1995). Using systematic rape, ethnic cleansing, torture and mutilation as tactics in war, violence is especially targeted at the poor, women, children and other vulnerable populations, as well as community leaders like priests, health workers and teachers (Farwell & Cole, 2002; Pederson, 2002; Summerfield, 1995; Summerfield, 2000; Wickramage, 2007). Just as there may be little distinction between combatants and others, there is a blurring distinction between civilian and military targets (Farwell, 2004; Summerfield, 1995). Violence is also targeted at collectivity, specific community structures and resources and other elements that keep communities together, disconnecting individuals from supportive relationships and disrupting daily life (Farwell & Cole, 2002).

Psychological warfare tactics to induce terror, such as mass execution, torture, disappearances and rape, are devastatingly effective central features if not the horrific "norm" in contemporary conflicts (Pederson, 2002; Somasundaram, 2006; Wessells, 1999). Sexual violation is standard and often under-reported (Eyber, 2003; Summerfield, 1995). Children have been forced to take on active roles bearing arms. Contemporary war is waged in the homes, hearts and minds of people and is a strategic attempt to systematically control populations, dehumanize individuals and rupture families. Because their communities are targeted, individuals are separated from their known context, thus sociopolitical context is a key element in both trauma and recovery (Farwell & Cole, 2002). Psychological tactics create memories of victimization that could motivate future conflict; shatter social trust; immobilize one with anxiety and despair; disrupt people's sense of safety; destroy their means of livelihood and prevent social organizing (Farwell & Cole, 2002; Wessells, 1999).

New wars have been characterized by some scholars as irrational conflicts since the 1990s. The deep motivations that drive such conflicts are often conceptualized by the West as symptoms of dysfunctionality that can ultimately be traced back to the psychological and social functionalism of individuals (Almedon & Summerfield, 2004; Pupavac, 2004). This inability to dissipate emotions that is thought to cause psychosocial dysfunction is further encouraged by a loss of ideological conviction, which had formerly made the idea of fighting and dying for a cause, appear noble, become one informed by righteous anger (Pupavac 2004). As outsiders, it is difficult to fathom that for those who benefit, war is far from irrational and might be the only possibility to achieve desired ends. Individuals and communities affected by war include perpetrators and victims, but

all are survivors. In contemporary wars and violent conflict, complexity is certain but the psychological and social suffering in these contexts of urgent need is as yet to be fully understood.

Psychological and Social Suffering

People all around the world have known for a long time that war and violence have negative consequences for their emotional, mental, spiritual and social well-being, in addition to people's physical well-being (Eyber, 2003). With the various changes in the ways of war today and the rise of globalization, what has changed about psychological and social suffering in contemporary violent conflicts and complex emergencies? The consequences of contemporary conflict expressed and understood through the models and language of Western experts in psychosocial well-being have influenced who the victims of violence are and the kind of impact contemporary conflict might have on them. For example, special attention has been paid to mental health effects of conflict on soldiers and displaced civilian populations above all other casualties and psychosocial issues of complex emergencies (Piachaud, 2008). Researchers in other fields have recognized that large populations around the world and across time are affected by violent conflict and they have assessed that these impacts are extensive. At its worst, economies are devastated, cultures are destroyed and the lives and families of communities are shattered. There is a breakdown in economic, social and political systems. Weakening of a society's moral fabric coexists with domestic and civil conflicts (Desjarlais & Kleinman, 1997).

In communities around the world, it has been recognized that participation in warfare can cause difficulties and problems for the combatant and his or her family. It has

been accepted in the West that the duty and responsibility for ameliorating these negative impacts is held by medical specialists, psychological practitioners and mental health workers (Farwell, 2004). But in many communities, these difficulties are unlike those recognized or helped by psychology and psychiatry. For example, they may include having to appease vengeful spirits of civilians that were killed in warfare (Eyber, 2003).

There is variety in the conceptualizations of the social, personal and health-related consequences of participating in warfare (Eyber, 2003). Depending on the perspective taken by intervening agencies, and their understanding of the psychological effects of violent conflict in complex emergencies, the kinds of support and the methods they use will differ. These differences and emphases will be further discussed in the subsequent chapter. In the remainder of this chapter, I present a summary of the psychological and social suffering, as described by various researchers; however, readers should be aware that the reviewed literature, no matter how culturally sensitive, comes out of the research conducted by and validated in the West.

Differences in psychosocial consequences for individual trauma and collective trauma, though believed to exist, are not extensively researched (Elcheroth, 2006). The Psychosocial Working Group's (PWG) helpful framework conceptualizes and organizes individual and collective effects and the interventions that aim to relieve them, into three domains: *human capacity*, *social ecology* and *culture and values*.

Human Capacity

Complex emergencies reduce human capacity by their impact on individual psychologies. These forms of suffering include physical disability, loss of skilled labor, social withdrawal, depression, and a reduced sense of control over events and

16

circumstances (Ager, Strang & Abebe, 2005; Psychosocial Working Group [PWG], 2003a). Somatic presentations of the impact, such as headaches, non-specific pains, discomfort in the torso and limbs, dizziness, weakness, and fatigue are common ways of communicating the distresses caused by experience of war, worldwide (Summerfield, 2000). Whether or not they lead to a Post-Traumatic Stress Disorder (PTSD) diagnosis, there is growing evidence in diverse cultural contexts that particular symptoms entailing intrusive re-experiencing of negative incidents such as nightmares and flashbacks, and those of hyper-arousal such as a heightened startle response and sleep disturbances, are present (Miller et al., 2006; Wessells, 1999).

The conclusion that all signs of distress are evidence of traumatization or PTSD in individuals is problematic. However, the literature about the long-term effects of war and atrocities include predominantly discussions on the linkages between original experience of trauma and persistent symptoms such as anxiety, depression, alcohol and drug abuse, and chronic PTSD. That violent conflict causes distress or suffering in populations is understandable. But some signs of distress and suffering may fall within the range of 'normal' responses to the context, and illustrate aspects of normal cognitive functioning (Pederson, 2002; Summerfield 2000). Emotional states are not necessarily psycho-pathological however they may present as risk factors for PTSD, anxiety and depression.

The experience of contemporary violent conflict and complex emergencies are more likely than wars of the past to produce graphic and disturbing sensory impressions, chaos, lack of security, broken social rules, loss of meaning, immense sadness and loss, and other psychological symptoms (Farwell & Cole, 2002). People who have been

17

directly or indirectly affected by such contexts may find difficulty in generating a sensible interpretation of what has happened causing feelings of helplessness, shame, anger, loss of self-coherence, uncertainty, disorientation, nostalgia, alienation, depression and confusion (Almedom, 2004; Perren-Klingler, 2000; Summerfield, 1995). These impacts to human capacity, believed to affect processes mental health, are expected in complex emergencies and may also lead to physical ailments, epidemics, poor health outcomes, mental illness and behavior-related conditions (Pederson, 2002).

The effects of complex emergencies in the domain of human capacity are also likely to affect a population's ability to care for itself – an effect that cannot be described by accepted psychopathological diseases like PTSD (Mollica et al., 2004). The collective effects of complex emergencies occur in the domains of social ecology and culture and values. Disruptions of social ecology involve social relationships within families, peer groups, religious and cultural institutions, links with civic and political authorities. They may also include changes in power relations between ethnic groups and shifts in gender relations (Ager et al., 2005). Unique effects of contemporary violent conflict in the domain of culture and values include challenges to human rights, infringements on social norms and customs, and threats to cultural traditions of meanings that have served to unite and give identity to a community. Unfortunately, these factors also reinforce hardened images of other political or ethnic groups and the escalation of violence and hatred (Ager et al., 2005).

Social Ecology

Extreme forms of suffering in many societies come from the breakdown of social fabric and daily life within one's family, community and supportive social institutions

(Pederson, 2002). Suffering is felt in the experience of the loss of safety and security typically provided by family (and social equivalent), shelter, food, basic public services and local infrastructure (Pederson, 2002). Impaired psychosocial functioning, family conflict, and domestic abuse are often more urgent concerns in communities than the trauma that may result from a single event (Miller et al., 2006). It is the ongoing context of violence in complex emergencies that destruct the social patterns that would, in contexts of peace create the basis for a sense of community and allow community institutions to function effectively. Violence takes its toll on every level of society and a focus on individual psychopathology cannot effectively take into consideration, the experience of suffering beyond the individual as a unit of analysis (Miller et al., 2006).

Studies have shown that the relationship of individuals' psychological suffering to family breakdown and violence in war-affected communities have caused transgenerational suffering and people's desire for revenge (Piachaud, 2008). Because the family's ability to protect its children from negative effects of violence is often impaired by other effects of violence, the likelihood of future violence and cycles of violence within a community is increased (Farwell & Cole, 2002; Piachaud, 2008). Distress and family conflict within the community can be related to individuals' feelings of loss or separation from social networks, their experience of poverty, lack of opportunity to engage in culturally important rituals, and for some, a feeling of disempowerment resulting from the inability to provide for one's family (Miller et al., 2006). Family breakdown often leads to further social breakdown.

Complex emergencies particularly affect children, youth and women. They produce large numbers of widows, orphans, and people with disabilities who depend on

scarce community resources for survival (Miller et al., 2006). Experiencing events that affect family and community such as profound loss, disrupted development by terror and social change, may destroy a young person's inner sense of home and community, identity and personhood (Farwell, 2004; Farwell & Cole, 2002). These contexts, which often entail premature assumption of adult roles and responsibility by young people (Miller et al., 2006), increase their vulnerability in stressful situations because young people are deprived of intrafamilial coping resources during their development (Farwell, 2004).

Contemporary violent conflict is also characterized by violations of rights (Mollica et al., 2004). Sex-based and gender-based violence including rape and exploitation are carried out by armed forces, military groups or civilians in all phases of conflict. Women often suffer abuse and rupture in their social relationships as well as serious mental health effects after rape (Eyber, 2003; Mollica et al., 2004, Pederson, 2002). In situations of general poverty, disempowerment and frustrations after displacement, domestic violence also increases (Eyber, 2003)

Displacement and relocation of communities affected by violent conflict is a prevailing element of contemporary wars. Conditions of new environmental contexts are often no better than the ones left behind. Lack of sanitation, food and water shortages, loss of family and social support networks, crowding and overall deprivation impose even more health risks such as dysentery, viral diseases, tuberculosis, and sexually-transmitted diseases. Even though displaced families and individuals are removed from the original context of violence, the resulting deprivation of social, material and emotional support systems, poverty and high unemployment, inadequate shelter and

separated families are thought to create greater vulnerabilities to environmental

adversities and the community members' social distress (Farwell, 2004; Pederson, 2002).

The effects of conflict are highly visible to outsiders in the forms of poverty,

hunger, harassment, alcohol and drug abuse, disease, suicide, domestic and street

violence, and politically-motivated tensions. There is a general externalization of

violence in the relationships of individuals and groups within war-affected communities

that is likely to turn into multiple sources of adversity with physical and psychosocial

consequences (Farwell, 2004; Kleinman & Cohen, 1997). Contemporary violent conflict

damages one's trust in others and oneself (Farwell & Cole, 2002; Miller et al., 2006).

Individuals' ability to respond to others' suffering and to be hopeful is severely affected.

Community members may develop ill feeling and wariness toward social institutions

because their services have already failed to protect the social well-being of their

constituents (Miller et al., 2006). Communication, which enables a sharing of the

experience and mutual understanding for the development of identity and culture, is

disrupted in a number of ways (Almedom & Summerfield, 2004; Farwell & Cole, 2002).

Culture and Values

Since contemporary conflict often occur along lines of ethnic and group identity,

those involved in the conflict are likely to face existential crises and dilemmas of self-

identity (Farwell & Cole, 2002). With the threat of great harm, people are often unable to

live in accordance with their beliefs. Help-seeking behavior is determined by

background, culture and social norms. There is never one standard reaction to events

(Summerfield, 1995). However, it is assumed that violent conflict contributes to a shift in

the norms of culture, personal beliefs and moral values.

Individuals may hold feelings of revenge and anger about what has happened to them (Almedom, 2004; Summerfield, 2002). Faith in existing moral or legal norms may be lost, which in turn may facilitate justifying the violation of rights of other individuals or groups. Some scholars (Elcheroth, 2006; Miller et al., 2006) argue that the experience of conflict negatively affects the way a group reacts to subsequent threats to its security or status because elements of collective identity are rooted in past violence, which have set off the cycle of violence between groups. Exposure to violence or injustice may enhance support of violent means to cope with rival groups. They may become legitimized as an approach to solving social conflicts.

In contrast, in a study that specifically looks at changes in collective norms, Elcheroth (2006) found that traumatic experiences from war affect an individual person's trust in the strength or relevance of legal institutions or conventions, but not their adherence to moral principles. At the community level however, legal conceptions tend to replace ideological positions that legitimate the violation of norms within the communities who have experienced massive war trauma. The more war produces tragic human consequences, the less violation of international humanitarian principles is tolerated by those who are affected. And the more a community is confronted with its collective vulnerability, the more its members adopt a legal perspective on basic norms regulating human behavior. In contrast to the assumptions of humanitarian aid agencies and workers, this study shows that communities neither feel humiliated nor seek revenge as individuals might. Instead, they are more likely to mobilize and transform through sharing and meaning-generating interactions that refer to collective experiences.

The psychological effects of violent conflict are best understood with the comprehension of the concepts of collective trauma and social suffering (Farwell & Cole, 2002; Pederson, 2002). The notion of social suffering, like structural violence, refers to a set of human problems that have their roots and consequences in injuries from an existing social order. In complex emergencies, suffering continues long after a crisis has ended because of this pervasive presence of violence in contemporary conflicts (Mollica et al., 2004). It results in negative effects in health, welfare, legal, moral and religious issues from the enactment of political, economic and institutional power, in addition to how these forms of power have responded to those very social problems (Pederson, 2002). Social suffering carries the "idea that it is necessary to address both individual and collective levels of analysis; personal experience and politico-economic context; local problems and their relation to global issues; community grounded solutions and professional responses; health problems and social problems" (Pederson, 2002, p. 187). Psychological and collective wounds of a community, which may be recognized as poverty, chronic oppression, discrimination, and extreme physical need, cannot be addressed individually in contexts where they have been caused by deficits to human capacity; disruption of a community's social ecology; and violation of culture and values (Wessells, 1999). The interrelationships between all domains and agencies in a complex emergency cannot be underestimated and they need to be better understood.

CHAPTER III

PSYCHOSOCIAL INTERVENTIONS

There are as many ways to help a community in the aftermath of violent conflict as there are ways of framing and understanding it. The foundation of humanitarian aid and assistance in complex emergencies had for many years focused on the provision of physical medical care, food, shelter and sanitation support for short-term relief. In the last few decades, as the nature of violence and understanding of it continues to evolve, it has become necessary for the humanitarian field to also respond to the long-term consequences of war. Psychological impacts of war were slow to be recognized but long-term effects and efforts to contextualize the experience of human suffering spurred the provision of mental health assistance and much more activity in this sphere (Dybdahl, 2001). In the first chapter, I described how the psychological effects of violence have become more intentional in contemporary wars, thus making psychological and social areas of health more of a concern for international humanitarian aid workers and organizations. This has brought about an increase in the number and scale of psychosocial interventions and research in the field of external aid as well as the debates and perspectives within it (Strang & Ager, 2002).

Humanitarian aid agencies that typically provided support to refugees, the displaced, and other war-affected populations have attempted to meet new perceived needs by paying more attention to the provision of psychological assistance (Ager, 2005). The aftermath of the war in Bosnia coincided with the beginning of new attention toward psychological suffering in traumatic circumstances. In response to expansive claims by the World Health Organization (WHO) and United Nations High Commissioner for

Refugees (UNHCR) that 700,000 people had suffered from severe psychic trauma and statements by United Nations Children's Fund (UNICEF) that *psycho-social trauma programs* must be the foundation for the rehabilitation of millions of children affected by the war, more psychosocial interventions were implemented in former Yugoslavia than any war previous to it (Bracken et al., 1997; de Jong, Kleber & Puratic, 2000; Dybdahl, 2001). The interventions proposed and implemented were variable in methods and the humanitarian agencies that went to provide aid had equally varied perspectives and philosophies on what the needs were and what would be most helpful to meet those needs. This variability raised the dilemma of knowing what psychosocial intervention is really comprised of.

Psychosocial interventions have emerged out of the still-evolving notion of *humanitarianism* (Pupavac, 2004a). The concept of humanitarian relief in war was conceived in the latter 1800s when Jean Henri Dunant, who later founded the International Committee of the Red Cross (ICRC), provided medical aid to suffering soldiers of the Battle of Solferino. *Humanitarian aid* or assistance is defined as "the provision of basic requirements which meet people's needs for adequate water, sanitation, nutrition, food, shelter and health care" (Schloms, 2003, p.43). The ICRC established the values of humanitarianism: impartiality, neutrality and universality – principles that were based on separating humanitarian ideals from political ones (Chandler, 2001). The main priority is to alleviate human suffering; provide unconditional aid to meet basic human needs and save lives. The ethical motivation behind aid efforts from its *modernist* perspective is the responsibility to act in ways which are justifiable and be practically effective (Bracken et al., 1997). This ethic might

be considered modernist because it is attached to rational analysis and is considered universally valid.

In the late 1980s, "do no harm" became an important consideration as relief organizations came under critique suggesting that not only were the aims of relief – that of alleviating suffering – insufficient as a response to political crisis (Fox, 2001), but that such organizations played a role in the prolonging and exacerbating of conflict in regions where they were operating. Structural violence was one major cause of human suffering in complex emergencies, and it was possible that outside humanitarian aid, among the myriad internal and external factors, was part of this structure by functioning as a re-traumatizing factor or imposing models of aid that disempowered the targeted groups. Ways that humanitarian aid may be construed as being a part of local structural violence is by mirroring power structures or the chaos that initiated the original complex emergency.

In response to such critiques, humanitarian efforts became more goal-oriented, aiming for peace and overall alleviation of suffering as an outcome of relief delivery in the long-term. Agencies began to think of ways to go beyond minimalist, straightforward relief of human suffering and strengthen capacities for peace and development (Fox, 2001; Schloms, 2003). They began to address questions such as: how does an external organization help a community attain long-term benefits? How can the principle of 'do no harm' in humanitarian aid be upheld?

Broadening their spectrum of relief work, current humanitarian aid projects are "at one end, preventative, community-based, partner-oriented, faith-based, developmental, food delivery agencies, and at the other, emergency, objective/scientific,

operational, curative, secular, 'health' agencies" (Schloms, 2003, p.45). Psychosocial

interventions can be similarly located on a broad, idealized spectrum.

The Umbrella of Psychosocial Intervention

The term psychosocial refers to the close association between "psychological

aspects of experience (our thoughts, emotions and behaviors) and the wider social

experience (our relationships, traditions and culture)" (PWG, 2003a, p.1) and describes

the underlying "dynamic relationship between psychological and social effects" (Eyber,

2003, p.6). UNICEF describes the term psychosocial as one that

> underscores the close relationship between the psychological and social effects of
> armed conflict, the one type of effect continually influencing the other.
> 'Psychological effects' are defined as those experiences which affect emotions,
> behaviour, thoughts, memory and learning ability and the perception and
> understanding of a given situation. 'Social effects' are defined as the effects that
> various experiences of war (including death, separation, estrangement and other
> losses) have on people, in that these effects change them and alter their
> relationships with others. 'Social effects' may also include economic factors.
> (UNICEF, 1997, p.10).

Although this definition is popular and referenced by many aid groups, in depth

contemporary understandings of social effects and suffering at a collective level is not

captured in this definition (Galappatti, 2003). It does not effectively describe the

integration of psychological and social effects. It also lacks programmatic parameters that

may help guide humanitarian agencies and aid workers in their interventions.

WHO defines health as "a state of complete physical, mental and social well-

being" and mental health as "a state of well-being in which the individual realizes his or

her own abilities, can cope with the normal stresses of life can work productively and

fruitfully, and is able to make a contribution to his or her community," where "normal" is

context dependent (Herman, Saxena & Moodie**,** 2005, p.XIII). In this definition, the
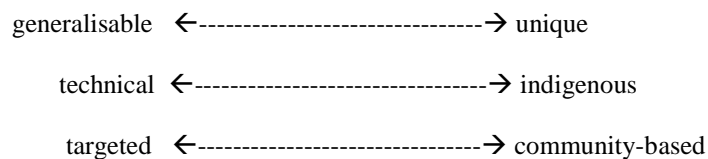
concept of psychosocial well-being is linked to general health, acknowledging that a combination of psychological and social factors is necessarily and jointly responsible for a person's well-being (Eyber, 2003).

The inclusion of mental health considerations in aid programs and the critique of the trauma model in *mental health aid* have led to the development of the current notion of psychosocial interventions, a much debated and still ambiguous term. Psychosocial intervention has been used as a popular buzzword in humanitarian discourse. It is used by actors from all perspectives and it lacks a set of definitive and consistent components. In general, psychosocial interventions are those that address both psychological and social effects as well as the influential and dynamic relationship between them (Eyber, 2003). However, every agency, depending on its approach, answers questions about psychosocial assistance differently. There is little agreement in the field; not only do different organizations emphasize different aspects of psychosocial assistance, they also hold differently, the conceptions of what is *psychological* and *social* (Eyber, 2003).

Ager (1997) identifies three continua that characterize the ways in which psychosocial interventions may vary conceptually (see Figure 1). The first continuum illustrates the range in complexity of problems that faces agencies planning interventions. Most interventions aim to be culturally sensitive but they vary in approaches and perspectives on whether the suffering in affected communities is universal and generalisable, or unique to its specific context. The second describes the knowledge that is used in an intervention as ranging between technical and indigenous. Technical knowledge is used by experts or professionals who are qualified to diagnose and treat patients clinically, usually according to standards set by the West. Indigenous knowledge

28

refers to local understandings of suffering. Ager (1997) uses this continuum to describe

"which forms of understandings exerts the dominant influence on program goals,

structure and reporting" (p.403). Ager identifies the last continuum as a tension between

the focus on serving a specific client group such as women or children within a

community versus having a community-wide focus that serves all groups.

These three continua are often interlinked. For example, interventions with a

community-wide focus are likely to use local understandings of the circumstance to

inform the intervention and will assume its context is unique. Psychosocial interventions

that utilize a medical model are likely to use generalisable, universal approaches that

have been used in other contexts, employ technical knowledge while working with a

specific group like orphaned children.

generalisable ←-------------------------------→ unique

technical ←-------------------------------→ indigenous

targeted ←-------------------------------→ community-based

Figure 1. Tensions in the psychosocial discourse[1]

With limited resources and competing agendas, actors in the field can find

themselves in disagreement about what principles are at the core of psychosocial

interventions. There is a growing concern about the legitimacy and effectiveness of

---

1 From "Tensions in the psychosocial discourse: implications for the planning of interventions with war-affected populations," by A.

Ager, Development in Practice 7(4), p. 403.

activities carried out to address important needs in complex emergencies (Galapatti, 2003). What is an appropriate humanitarian aid response to suffering in complex emergencies and how should it be determined? Why should community development be considered together with mental health effects of violent conflict? How can they work together in coordination instead of in competition for aid funds?

Mental Health Aid

A search in journal databases for "mental health and war" now reveals thousands of citations representative of a shift in awareness toward psychological and social considerations in humanitarian aid (Pichaud, 2007). This literature consists largely of post-conflict reconstruction of mental health services and the impact of war on mental health. It is also largely comprised of the debates around how these should be realized together such as arguments about the cultural relevance of treatments, what constitutes psychosocial support, complications of structural vulnerability, and the ubiquity and uniformity of traumatic experience, to name a few (Abramowitz & Kleinman, 2008).

The increased attention toward mental health effects in humanitarian aid discourses has been attributed to a few different factors. Popularization of psychology and the notion of trauma in the West have contributed to understanding human suffering in these terms (Ager, 2005; Bracken et al., 1997; Pupavac, 2004b) and have been applied to suffering in the aftermath disaster situations and other potentially traumatizing events (Bracken et al., 1997). Medicine and psychology became the source of explanations for suffering and provided the vocabulary of distress (Miller et al., 2006; Summerfield, 1999). Like many other aspects of Western culture, these trends have been globalizing (Bracken et al, 1997) particularly as humanitarian aid from the West continues to operate

in affected nations. Conversely, observations by medical service providers of refugees coming to the West may also contribute to mental health perspectives on suffering.

Previously, cross-cultural psychiatrists and medical anthropologists working with groups in the resettled areas were primarily interested in issues of acculturation and assimilation (Silove et al., 2007). With the introduction of PTSD in the DSM-III in 1980, the trauma paradigm could be applied to war-affected populations whose symptoms were characterized by affective instability and sensitivity to stress. PTSD originally described the suffering experienced by many Vietnam War veterans when they returned to the United States. Refugees and other displaced populations in a new culture were thought to have long-term illnesses in their readjustment experience (rather than physical injury) which were primarily rooted in emotional pain, trauma and cultural bereavement (Eyber, 2003). The experiences of suffering from war within this paradigm are recognized as symptoms of universal illness, namely war-trauma, PTSD and generalized anxiety disorder (GAD).

Conceptualization of the effect of violent conflict and complex emergencies in this way expresses need for treatments that are primarily psychological in nature. They have subsequently brought to fore, arguments about the cultural relevance of provided treatments and the cultural construction of war-trauma and PTSD. There have been strong arguments in favor of a more interdisciplinary approach and psychosocial interventions that put their emphasis on the "social" effects of war (Wessells, 1999). However, using diagnostic labels is functional to service providers in contemporary violent conflicts to communicate the severity of needs to funding agencies (Silove et al., 2007). It is argued that there are practical consequences to the controversy over cultural

relevance in an era when health expenditure is tied to evidence that PTSD may be contributing to a global burden of disease (Silove et al., 2007).

In accordance with what I described earlier as the modernist ethic of humanitarian aid, the key question in psychosocial interventions for complex emergencies from the mental health aid perspective is one of content: how can we attend to psychological effects of war in addition to the medical and physical effects of war on civilian populations? Are resources and knowledge being used effectively to help alleviate global human suffering and work towards health for all people? Critically thinking about these kinds of interventions, one might also wonder what mental health aid might miss and the assumptions and implications of holding this perspective.

Perspective and Approach

The so-called "first generation" of psychosocial interventions (Galappatti, 2003) is what I have identified as mental health aid. They consist of psychological treatments administered indiscriminately and universally to suffering members of war-affected communities in accordance with traditional humanitarian ideals. They are supported by a medical foundation consisting of scientific evidence from trauma research that has involved people of a specific (usually Western) cultural context, and a conviction that post-traumatic stress worsens over time unless treated by Western-style approaches (Kienzler, 2008; Mollica et al., 2004; Perren-Klingler, 2000; Somasundaram, 2006; Yule, 2006). It is generally accepted by humanitarian aid agencies and workers that some percentage of a conflict-affected population will have severe reactions to the traumatic event and will require mental health aid (Eisenbruch, de Jong & van de Put, 2004; Yoder, 2005). The application of Western psychotherapeutic approaches and counseling is

suggested as an important intervention for providing help to individuals affected by violent conflict (Kienzler, 2008).

Post-war symptoms entailing intrusive, re-experiencing of traumatic events such as nightmares and flashbacks, avoidance or numbing, self-blame or survivor guilt, and symptoms of hyper arousal are found in a diversity of cultural contexts (Farwell, 2004; Miller et al., 2006). Trauma as a psychological fall-out of war became a popular concept among Western mental health professionals in the 1980s, and the notion of trauma became more common in the literature on refugee health (Almedom & Summerfield, 2004). Although researchers readily recognize that PTSD does not occur in everyone who has experienced traumatic events, certain populations including those affected by violent conflict are considered to be at great risk for PTSD and other trauma-related disorders (Kienzler, 2008). From this perspective, clinical treatment for PTSD is helpful to any person who has experienced traumatic events because they may experience recognizable reactions to violence such as flashbacks, sleep disturbances, or substance abuse. The treatments have been proven to alleviate these symptoms of psychological suffering (Eisenbruch, et al., 2004; Perren-Klingler, 2000). Suffering is objectified as a treatable ailment within the individual.

War is itself identified by international health agencies and their informants as a mental health emergency and PTSD is seen as a "hidden epidemic" (Almedom & Summerfield, 2004; Bracken et al., 1997). According to a number of dissenting researchers in the field it is thus considered a legitimate cause for mental health interventions, but not without many political and socio-cultural implications. Although some have argued that no convincing evidence of the effectiveness of advocated practices

in mental health aid in war-affected communities exist, criteria on trauma treatment find consensus in western-style approaches (Kienzler, 2008; Wessells, 1999). This is particularly true in acute emergency contexts. Yule (2006) expresses the modernist humanitarian ethic in his assertion that there is a medical imperative to use known methods in crisis and disaster situations because culturally specific treatments have not yet been identified. A cautionary approach is misplaced in complex emergencies. If critiques about the use of PTSD in intervention are mistaken, vulnerable groups may be further disadvantaged by a lack of appropriate care for their mental health needs (Silove et al., 2007; Vazquez & Perez-Sales, 2007; Yule, 2006).

There are a number of guidelines for service providers and humanitarian agencies in the literature to assist the development of helpful intervention for mental health aid. A major collaborative paper by Hobfoll, Watson, Bell, Bryant, Brymer, Friedman et al. (2007) recommends five essential elements for interventions. They include the promotion of safety, security and calming. These are similar to elements in a typical counseling treatment that would alleviate symptoms of PTSD. Guidelines of this nature assume that all humans react in a similar way to violence and benefit from similar treatments – just like they might handle physical injury. Although "there are many ways to operationalize these principles, and they should be applied in a design that fit the ecology of the culture, place and type of trauma" (Hobfoll et al., 2007, p.301), these interventions are structurally similar in every context. Content varies according to society's interpretation of events, but mental health aid can be repeatedly used with similar procedures (Perren-Klingler, 2000). The formulated plans are generalised and aim to simplify the intervention process. It is successful in doing so by decontextualizing the suffering.

Mental health aid, including psychological first aid in acute emergency phases, also claims to address long-term effects. Treatments are supported by the premise of traumatology that 'unhealed trauma' in affected communities can lead to the reiteration of violence (Yoder, 2005); that abused people can turn into abusers (Pichaud, 2008; Summerfield, 1999). The therapeutic model constructs war-affected populations as traumatized, hopeless and brutalized – vengeful enough to start a new cycle of violence (Kienzler, 2008). In mental health aid, PTSD is a framework for understanding unhealed trauma (Yoder, 2005) and by treating the trauma, these feelings may be dissipated and further violence may be prevented.

Critique

Mental health aid was, and still is widely criticized for universally applying knowledge and intervention techniques that were generated solely in the West, thereby neglecting the cultural context of their target population, indigenous knowledge, collective and local resources (Silove et al., 2007). From this perspective of interventions in response to complex emergencies, symptoms of war-induced disorders are very often assumed a priori to comprise the trauma response (Summerfield, 1999). PTSD exists independently of the ways in which experts might diagnose and treat it (Kienzler, 2008). Evidence describing the usefulness of diagnostic labels in non-Western contexts is inconclusive. Studies that have been carried out among refugees in Asia and Africa confirm that a significant proportion of the populations have psychological problems such as psychosis, PTSD or depression (Eisenbruch et al., 2004). However, Vazquez and Perez-Sales' (2007) study analyzed the applicability of PTSD after an incident of

collective trauma. Their results show a dramatic surge in emotional symptoms following a collective disaster, but a low prevalence for PTSD.

Cultural relevance is assumed in areas of assessment as well as in treatment. In medical treatment, the diagnosis of PTSD is not simply a label; it also dictates the kind of intervention which may be culturally foreign and/or inappropriate for the population or the kind of traumatic event they have experienced (Miller et al., 2006; Summerfield, 1999). There is a lack of evidence that shows mental health is an issue to be addressed by war-affected people separately from other concerns, or that it is a priority to be tackled by projects conceived and led by outsiders (Bracken et al., 1997). Kleinman's (1987) term *category fallacy* is relevant here: the mistaken assumption that a diagnostic category in one cultural context is meaningful in another because the symptoms can be identified in both settings.

Trauma discourse influences international humanitarian responses to suffering caused by violent conflict (Almedom & Summerfield, 2004; Pupavac, 2001; Pupavac, 2004b). Trauma-based projects that frame suffering into a technical problem to which technical solutions like counseling, pharmacological and cognitive-behavioral interventions are applied may risk discounting indigenous knowledge, capacities and priorities (Bracken et al.,1997; Kienzler, 2008; Miller et al., 2006; Summerfield, 1999), as well as overlooking the severity of the traumatic event which produce these reactions (PWG, 2003a). Instead of describing their suffering by the terms of those living through them, humanitarian aid workers in mental health aid use the language of psychological effects to capture and understand their pain and needs. Mental health aid has shaped the

known experiences of violence in complex emergencies that take place in non-Western communities (Miller et al., 2006).

Although the prevalence of symptoms of PTSD have been documented (with marked variability) in numerous studies of war-affected populations (Miller et al., 2006), the mental health effects of violence in war and conflict have not actually been well-documented (Almedom & Summerfield, 2004; Hobfoll et al., 2007), and impact assessments on populations affected by contemporary wars are scarce (Hobfoll et al., 2007; Mollica et al., 2004; Pederson, 2002). As a result, evidence-based, culturally competent mental health practices in emergency situations are not yet well developed (Almedom & Summerfield, 2004; de Jong et al., 2000; IASC, 2007; Mollica et al., 2004; Pederson, 2002; Summerfield, 1999; Yule, 2006). One source puts forth that "there is little or no evidence that survivors of war, even in Western cultural contexts, do better if they undergo individual counseling" (Almedom & Summerfield, 2004, p.384).

There is a general acceptance that psychosocial interventions offer relevant and needed alleviation to people's suffering during and after war. Contemporary research on the effects of conflict remain focused on the prevalence of psychiatric symptomatology, primarily that of PTSD (Miller et al., 2006). Contextualized studies are mostly absent in trauma literature but the few that exist have become the justification and basis for mental health aid programs in all contexts (Pederson, 2002). The evidence base from the field continues to be developed through new intervention projects; however they elude rigorous evaluation because the need for action is deemed to outweigh the importance of research (Dybdahl, 2001; Yule, 2006). There appears to be a problematic gap between research and practice.

Whatever the culture, in the context of complex emergencies there are real ethical dilemmas in humanitarian aid about how to address acute reactions to violence while implementing interventions that do no harm and work toward long-term, sustainable changes. Ager (1997) puts forth that a "one-size-fits-all" tendency in the universal prescriptions of mental health aid "lead to clear problems in programme-sustainability" (p.403) because they are inevitably externally imposed, externally dependent, incongruent with local culture and ultimately fail to fulfill the new humanitarian imperatives (Miller et al., 2006). The trauma model is supported by globalizing trends and the power of Western culture. But in humanitarian aid, questions of who benefits and whose agenda drives the intervention are critical. Wessells (1999) is firm about the importance of placing culture at the center of psychosocial assistance and promotes community-based approaches to this end. In the next section I discuss *psychosocial programs* – an approach that represents the opposite of mental health aid in terms of Ager's three continua on the spectrum of psychosocial interventions.

Psychosocial Programs

The question that mental health aid is primarily concerned with has to do with the content of interventions. Aid providers from the mental health aid perspective ask: how can psychological effects of war be addressed? The "second generation" of psychosocial interventions which I identify as psychosocial programs, came out of the critique of psychological and psychiatric approaches to aid in complex emergencies in the 1990s (Galappatti, 2003). Although knowledge of the effects of war and violence now acknowledge psychological stresses in addition to material and physical needs, contemporary understanding of the human consequences of disaster draws heavily on

psychology and psychiatry and clinical frameworks that often neglect social, cultural and moral dimensions of the affected community's experience (Ager, 2005). Critics of mental health aid frame psychosocial issues more holistically (Farwell & Cole, 2002). The outcome consists of psychosocial interventions that emphasize social roots of healing so as not to risk neglect of the cultural and moral dimensions in the experiences of war-affected communities within a discourse that is dominated by the biomedical paradigm (Ager, 2005; PWG, 2003a; Summerfield, 2000; Wessells, 1999).

The use of the term *psychosocial* causes further confusion in the discourse. In the health sector, agencies have historically used the terms *psychosocial rehabilitation* or *psychosocial treatment* to describe non-biological interventions for people with a mental disorder (IASC, 2007). In this paper, psychosocial program refers to the interventions of agencies that primarily operate outside of the clinical or medical health sector, using interventions that support *psychosocial well-being* and thereby at thwarting the impacts of violence on international human rights, peace and development (IASC, 2007; PWG, 2003a; Strang & Ager, 2002). Whereas mental health aid providers may have consisted of psychiatrists and psychologists, psychosocial programs may be implemented, for example, by members in the field of international development with contributions from anthropologists.

Interventions may not be able to distinguish mental health needs with suffering from problems of underdevelopment without better knowledge of local experiences in low-income countries which have been exposed to traumatic violence (Silove et al., 2007). Development literature and theories since the end of the Second World War have focused on goals similar to psychosocial interventions. Goals of development have

typically focused on ideas of modernity and economic progress, such as industrialization, urbanization and technology. But more recently, human development in relation to human well-being and health have factored in as important indicators of development (Willis, 2005). Similar processes are used by development organizations and humanitarian agencies to best meet long-term sustainable needs. Community development models, public health responses, and peace and reconciliation research are sources for evidence-based practices for psychosocial program implementation. Furthermore, if collective trauma is "systemic shock in ecological context" (Farwell & Cole, 2002, p.25), development theories can help to understand how psychosocial interventions themselves are part of that context – the totality of experience of the affected community.

Psychosocial programs developed when the humanitarian aid agencies were considering how to proceed with psychosocial interventions without inflicting harm and without contributing to the very suffering they wished to alleviate. In other words, the perspective behind psychosocial programs typifies the framework of postmodernism in which these agencies reject the notion of an objective reality that espouses ultimate truths and universal principles (Bracken et al., 1997). Rather, the agencies reflected on the world and their subjective place and reality in it. The theory of knowledge that justifies this notion, social constructivism, conceptualizes reality as a creation of the subject's perspective and its present context. A social constructivist stance helps refocus psychosocial interventions in ways that are attuned to the needs of war-affected communities (Miller et al., 2006).

A postmodernist ethic, in contrast to the modernist responsibility to act, urges a "responsibility to otherness" (Miller et al., 2006). Psychosocial programs are primarily attentive to the process and method of intervention because if the responsibility to otherness is to be fulfilled, that "other" must have an avenue to be heard and understood. Local or traditional methods and definitions pertaining to health, culture, context and human agency in creating meaning are central elements of this approach (Eyber, 2003, Wessells, 1999). The key question for psychosocial programs is one in which the interventions must reflect on itself: how do we ensure that we do no harm or undermine the long-term development of war-affected communities? The culture and context of the complex emergency is of primary importance. Therein is invitation for the emergence of other voices and ideas, even if it increases complexity and ambivalence about what aid is good and what is valid (Almedom & Summerfied, 2004; Bracken et al., 1997; Farwell & Cole, 2002).

From this perspective, humanitarianism, formerly motivated by understandings of universal health and human rights, acknowledges aid is rarely non-political or neutral (Greenaway, 1999; Seybolt, 1996). This approach that focuses on 'do no harm' is necessarily incompatible with principles of neutrality that characterizes traditional humanitarianism (Schloms, 2003; Seybolt, 1996). The possibility of being neutral and impartial is rejected and the perspective that all humanitarian ideals can do no harm is dependent on context in this social paradigm. New humanitarians argue for politically-conscious aid that is mindful of its power within the resource-poor context of their work (Fox, 2001; Summerfield, 1999; Wessells, 1999). Conceptual tensions in the discourse of psychosocial interventions continue to be the foci of debate that shapes this field in

41

humanitarian aid (Ager, 1997). These interdisciplinary dialogues converse around what is appropriate, needed and ethical when implementing psychosocial interventions for war-affected populations. Adopting the approach of psychosocial programs is one way of accepting these tensions.

Perspective and Approach

One of the main characteristics of psychosocial programs is its emphasis on community and development. The health and well-being implications of complex emergencies, while they may include individual and personal suffering, are equally devastating to the social and cultural fabric of their community (Summerfield, 2000). The psychological effects of contemporary conflict result from violence targeted at communities and its structures that are consequently unable to fulfill their customary role as a source of support and adaptation for community members (Farwell & Cole, 2002; Summerfield, 2000). Accordingly, some researchers claim that humanitarian responses to complex emergency must also be community-based for healing to occur (Farwell & Cole, 2002; Tolfree, 1997; Wessells, 1999). They advocate that the affected community must be an integrated part of the psychosocial programs in their recovery process, often utilizing participatory and collaborative methods in their intervention (Wessells, 1999). Psychosocial programs recognize that the joint experience in the aid process is necessarily part of the sum of experiences in the affected community (Summerfield, 1999).

The experience of long-term trauma and identity loss has serious implications for health, the success of development schemes and the hope of future generations (Yoder, 2005). Resilience in a community, the process of adaptation after adversity, emerges

from economic development, social capital, information and communication, and community competence – the processes which may build resources within a community (Norris & Stevens, 2007). On the other hand, failure of development, which is indicated by the community's economy, political stability and population health, is thought to increase the likelihood of violence (Piachaud, 2008; Pupavac, 2004a). A high level of poverty in particular has been associated with increasing incidence of local violence. Psychosocial programs tend to integrate the intervention with economic development and political reconstruction, and sometimes address issues of structural peace and justice indirectly. This appears particularly salient in the humanitarian responses to widespread and continuous violence that is embedded in the political and economic structures of a community and its functioning (Farwell & Cole, 2002).

Critics of mental health aid are aware of the cycles of violence in communities which may not only be caused by complex emergency, but also the way in which external aid is conducted in affected communities (Pupavac, 2004a). In the context of a complex emergency, affected communities may show effects of trauma and victimization but it is also likely that they will display resilience and capacity to use internal resources. If external aid emphasizes the community's deficiencies and pathological responses by only responding to mental health needs from a technical and expert perspective, it is possible to induce continuation of the cycle of violence and victimhood rather than moving into a narrative of healing and change. Community-based interventions are concerned with not causing further harm in humanitarian actions that continue the social cycle of violence, which sustains rather than quell the enduring conflict (Chandler, 2001; Gilbert, 1999).

Mental health aid individualizes issues and tends to discount the traumatic impact of violence on families and communities (Summerfield, 1999; Wessells, 1999). PTSD is conceptualized as an individual dysfunction and cannot adequately describe collective trauma, which is the experience of a traumatic event or series of events affecting large numbers of people (Yoder, 2005). The cultural and socio-political context, community resilience, post-traumatic growth and transformation are lost in the depiction of a community affected by war if such effects are only understood as an "epidemic" of PTSD (Silove et al., 2007; Vazquez & Perez-Sales, 2007). The experience of trauma in complex emergencies is not merely private or personal. It can set off widespread fear, horror, helplessness, or anger (Yoder, 2005).

In the war-affected contexts where chronic oppression, discrimination, and social disruption are present, psychological wounds cannot be separated from collective wounds (Pederson, 2002; Wessells, 1999). The experience of complex emergency can be traumatic, but dilemmas of identity and ruptures in ability to make meaning of traumatic experiences are also at issue when a person is unable to live in accordance with his or her beliefs (Farwell & Cole, 2002). An essential component of culture and maintenance of cultural and ethnic identity is communication – mediums for sharing experiences and understanding (Farwell & Cole, 2001). Contemporary violent conflict mostly plays out within non-Western countries and often among collectivist societies in which individualistic approaches to healing may not suit the local culture (Farwell & Cole, 2001; Wessells, 1999). In these collective societies, care for others is based on a sense of shared and personal responsibility toward one another, on mutuality, reciprocity, and

44

shared past experience with an expectation of a continued relationship in the future

(Farwell & Cole, 2001).

The framework for interventions created by the PWG (see Chapter II) identifies

three domains in which violent conflict affect a community: human capacity, social

ecology, culture and values. Each domain contains resources for psychosocial recovery in

a community (PWG, 2003a; Wessells, 1999). Principles of good practice in psychosocial

interventions within this framework are: thorough assessment and appraisal of needs;

negotiation and communication with the affected community and other agencies; and

approaches that provide a supporting, rather than a leading or expert role in the affected

community. These principles assume that communities are resilient and they have social

and healing resources to respond to the violence that affects them (PWG, 2003a).

The goal of the intervention is to help actualize and empower the potential that is

assumed to be present in the community as a whole (Strang & Ager, 2002). These

interventions seek to support resources that exist within the community, rather than

imposing the knowledge and resources of the interventionists which may lead to

mismanaged distribution, problems in long-term recovery, and continued violence. "The

goal of any …external support should be seeking to enhance the ability to deploy

resources…" (Strang & Ager, 2002, p.6). Through social development processes of

community building, capacity building, community mobilization and empowerment,

external agencies may provide physical and social resources in an intervention.

Psychosocial programs may include implementation of education and job-skills training

in collaboration with the affected communities (Jones, 2000; Wessells, 1999). Some of

the most supportive sources of help in complex emergencies may have to do with food,

safety and security, the building of these resources in the community, and basic survival (Pederson, 2002; Wessells, 1999).

Critique

The role of humanitarianism in development and political reconstruction is questionable at times. Critics of psychosocial programs and new humanitarianism wonder whether humanitarian aid agencies and workers are in a position to make politically relevant decisions (Fox, 2001; Schloms, 2003). Wickramage (2007) makes a distinction between relief aid – the provision of aid during an emergency that is meant to attend to immediate requirements for survival, and development aid – the provision of emergency aid that attends to immediate requirements for survival while reducing societal vulnerabilities and increasing capacities. Psychosocial interventions are increasingly expected to achieve the objectives of development aid. While mental health aid concentrates on reducing societal vulnerabilities, it can be said that psychosocial programs are focused on increasing capacities.

The approach of psychosocial programs acknowledges cultural differences in the humanitarian relationship and takes them into account by re-situating culture within the interpretation and intervention of the affected community. With so much that depends on the context in this framework, some authors criticize that the level of complexity that is taken into account limits the ability to provide aid when it is needed (Schloms, 2003; Yule, 2006). According to some community-based intervention guidelines and critiques of the mental health aid approach, aid agencies may be expected to abandon their own cultures in the interaction with targeted communities but this is as implausible as being neutral in this postmodern paradigm (Gilbert, 1999; Wessells, 1999). Elements of a local

culture may be helpful or harmful (IASC, 2007). The culture and institution of

humanitarian aid and the power of cultural, political and historical forces in the

interaction of external and affected communities must be equally taken into account. The

psychosocial program approach assumes that culture is a distinct, static entity within each

community instead of a fluid process between them (Abramowitz & Kleinman, 2008).

In what ways can external communities integrate their culturally-embedded

responses to the needs of vulnerable populations who are affected by real psychological

distress and live in broken social environments following violent outbreak? Recent

papers by experts in their field have attempted to bring the importance of both needs into

their recommendations for psychosocial interventions.

A group of mental health and trauma researchers who produced the "Five

Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical

Evidence" consider psychosocial intervention in its broad sense, "ranging from provision

of wide-ranging community support and public health messaging to clinical assessment

and intensive intervention" (Hobfoll et al., 2007, p.285) and view psychosocial support as

the provision of psychosocial and economic resources to ease a transition to normalcy.

Likewise, the IASC Task Force on Mental Health and Psychosocial Support in

Emergency Settings accepts both mental health and psychosocial well-being as equally

necessary and complementary parts of a response to a complex emergency. This

consortium of both United Nations (UN) and non-UN humanitarian agencies recognizes

the need to protect and improve mental health and psychosocial well-being in the acute,

as well as long-term consequences of violent conflict. To identify a wide range of

programs that considers psychological effects of violence, they have coined the

composite term *mental health and psychosocial support* (MHPSS) for "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC, 2007, p.1).

<center>*Mental Health and Psychosocial Support (MHPSS)*</center>

The consequences of violence and its systemic impact on health for individuals and the social fabric of whole populations are rooted in a complexity of causes (Pichaud, 2008; Summerfield, 2000). Globalization of the Western biomedical approach and focus on individual pathology continues to dominate psychosocial interventions. This is despite considerable literature that deconstructs the assumption of universal applicability of Western psychological concepts; and recognition that any consideration of mental health requires a multi-disciplinary approach (Bracken et al., 1997; Miller et al., 2006; Pichaud, 2008; Pupavac 2004a; Pupavac 2004b).

More recently, there have been major collaborations and research in the field to define certain principles or methods that could guide implementation of psychosocial interventions in a way that answers to questions of content and process while meeting the needs of everyone. The process of healing after traumatic stress is long and nonlinear. Different levels of need must be addressed. Different forms of intervention are needed for all kinds of suffering after violent conflict. Using the wide range of experiences and knowledge in psychosocial interventions, researches have attempted to expand its definition while still achieving precision and common understanding; to simplify without losing the complexity of issues in complex emergencies.

MHPSS also addresses the need for coordinated psychosocial intervention from the external community and a way of understanding how mental health aid and

<center>48</center>

psychosocial programs fit together to meet the needs of the affected community. Needs

must be understood as ranging between those of individual and collective stress at a given

time, and over a period of time ranging between those of local to spiraling stress.

MHPSS maintains a holistic view of psychosocial needs and resources of psychosocial

interventions. Proponents of this view outline methods, principles and guidelines to

manage the meeting of the two.

Perspective and Approach

The IASC's "Guidelines on Mental Health and Psychosocial Support in

Emergency Settings" (2007) responds to the medical, moral and cultural issues that are at

the heart of humanitarian engagement in psychosocial interventions. It frames the

problems and issues of need in complex emergencies as multilayered and thus requiring

interventions on several levels and through several aspects. The IASC interprets needs in

complex emergencies as issues that are predominantly social in nature, as well as

problems that are predominantly psychological – each type has issues that are rooted in

pre-existing conditions, are emergency-induced, and those induced by humanitarian aid.

The IASC guidelines emphasize the range of risk factors that put particular populations in

unique positions of need, and the availability of resources within communities that can be

helpful or harmful to the recovery of communities affected by violence.

The guidelines focus on implementing "minimum responses, which are essential,

high priority responses" (IASC, 2007, p.5) but they also list concrete strategies for

support that would rely on the foundation of comprehensive efforts set by these

guidelines. The guidelines acknowledge the impacts of emergencies may be acute in the

short term but may also undermine long-term mental health and psychosocial well-being

of a community. They define their own core principles that are the basis of their intervention strategies: human rights and equity, participation, do no harm, building on available resources and capacities, integrated support systems and multi-layered supports. The guidelines are thus, comprehensive, multi-sectoral and are directed toward a wide audience of helping agencies that complement each other in supporting affected communities. It stresses importance of coordination between agencies in order to respond in a comprehensive manner to meet all needs which has been a source of problems that has not yet been adequately addressed (Abramowitz & Kleinman, 2008; PWG, 2003a).

Critique

The approach in psychosocial interventions continues to change in definition, evolving with the understanding of long-term and developmental effects of violent conflict. Despite these recent developments, the acceptance and legitimacy of mental health aid and the foundations that justifies this approach in humanitarianism continues to be an important influence on the assessment of and interventions for populations affected by violent conflict. Even in MHPSS, what is recommended in the immediate response to complex emergency for the protection and improvement of people's mental health and psychosocial well-being are a) psychological first aid for people in acute distress by community workers, and b) care for people with severe mental disorder by trained and supervised health staff (IASC, 2007; Kienzler, 2008). Consensus criteria in the field continue to largely ignore the criticism brought to the table by researchers who argue that no convincing evidence of the efficacy of advocated practices exist (Kienzler, 2008). Despite the expansion of the field toward an interdisciplinary discourse, concepts like

'social suffering' that are introduced to the field barely enter the psychiatric discourse on the effects of contemporary violent conflict (Kienzler, 2008).

Critics of the IASC guidelines have also pointed to its lack of understanding in the conceptualization of culture and the institutional culture of humanitarian organizations under which psychosocial interventions continue to operate. Culture is represented as a fixed and immutable entity rather than a fluid process of iterative formation between affected communities and humanitarian agencies (Abramowitz & Kleinman, 2008). The guidelines suggest that local cultures and contexts may be learned by humanitarian workers, and then managed and integrated into interventions (IASC, 2007). However, for local participants, culture may not be articulated but experienced as a process with unknown and uncertain outcomes. These outcomes are still constrained by the structural hierarchies of institutional power and authority of external forces and their limited resources (Abramowitz & Kleinman, 2008). In the practice of psychosocial intervention, the structural and cultural hierarchies that exist must be taken into account and their roles in perpetuating suffering or violence may be considered. Though inclusive and interdisciplinary, the perspective of MHPSS may not be sufficient to achieve transformational shifts toward healing and peace.

Activities under psychosocial intervention already vary enormously but without much consensus. Programs using a fundamentally medical model (i.e. mental health aid and psychological interventions) define the problem as illness or dysfunction that needs application of treatment. Development models frame the problem more in terms of disruption and looks to facilitation and empowerment to achieve restoration and development. Human rights approaches are focused on issues of justice and violation. In

the past, these have been competing camps within humanitarian aid where the medical model has, and continues to attain the most credibility and funding (Strang & Ager, 2002).

Peace studies, an area of praxis and research that explores the ways in which transnational, cross-cultural relationships may be most beneficial to the targeted communities but also fulfill the intent of humanitarian aid workers and agencies. These areas of study have important contributions to MHPSS and can be helpful to developing our understanding and implementing psychosocial interventions in complex emergencies in our contemporary socio-political and historical context. In the next chapter, I will propose that the inclusion of conflict transformation is essential to meeting the current demands for humanitarian aid in complex emergencies. Conflict transformation from the field of Peace Studies gives a helpful perspective on intervention relationships in a complex emergency which benefit both donor and affected parties.

CHAPTER IV

CONFLICT TRANSFORMATION

Conflict transformation is a theory and practice used by practitioners of peace and development who have worked in war-affected communities often as mediators and educators. It is also used by leaders in the field who have guided community-based peace activities and workshops cultivating peaceful relationships among participants. Conflict transformation is conceptualized and articulated in peace and conflict studies as distinct from conflict resolution because it rejects the idea of a resolved and fair end as a goal. It describes a process that accepts conflicts as an inevitable and unavoidable part of human relationships and that violence can arise from destructive patterns in them. Conflict transformation asks: how do we end something destructive *and* create something constructive (Lederach, 2003)?

Whether it manifests in active, passive, direct or indirect forms, violence is defined as the denial of another's essential capacity. Galtung, a leader in the field of peace studies, describes violence as any "avoidable insult to basic human needs" (Francis, 2002, p.70). Nonviolence is an essential and important part of conflict transformation that primarily responds to structural violence, which is the manifestation of violence in societal structures. Its assumption is that fundamental change in ways of relating is a constant and desired outcome of intervention. Nonviolence embraces conflict as a means of change and a way of honoring the humanity of all (Francis, 2002). Matters surrounding identity, human rights and human-to-human relationships are therefore central to the work of conflict transformation. In current notions of interventions for

contemporary conflict however, these issues are usually only implicitly addressed (Lederach, 2003).

In the first chapter, I addressed the factors that make contemporary violent conflict a unique phenomenon in the history of wars. Today's wars embody a 'culture of violence' in which societies engage in and perpetuate structures and acts that deny the human capacity of others. Violence centers on communities' social fabric, laying the foundation for years, sometimes decades of hatred and mistrust. Assertions of nationalism, sovereignty, discrimination and exclusion are strong elements of conflict (Duffield, 2002). Contemporary violence and conflict take place in unexpected spaces and in the daily life of ordinary people (Summerfield, 1995). Societies are transformed by conflict and a return to the way things were before the onset of violence, may not be possible or desirable in the communities that have been affected (Botes, 2003). These changes in the nature of conflict, and its intractable violence and suffering suggest a need for a set of concepts and approaches that go beyond traditional statist diplomacy, with which to respond to contemporary violent conflict (Wright, 2004).

There has been a radical change in the notion of aid in response to the effects of conflict and globalization. In the second chapter, I described how the practice of aid has changed in important ways. The development of psychosocial interventions and the conceptualization of conflict that involves people's psychologies is a major part of this change. Aid work is no longer a practice of providing short-term relief; it moves toward permanence and comprehensiveness. They reflect a perspective on new wars as a form of social regression (Duffield, 2002). Humanitarian agencies are seen as central components of the international strategy to bring "order" to areas of "disorder" using programs to

mitigate psychological motivations for violence. Recently, the notion that unhealed violence can lead to more violence; that the contexts created by war are complex emergencies; that funding is limited and needs are more dire; and that humanitarianism itself is a tool of polity that may harm and/or help communities, has increased the need to incorporate various disciplines in the discourse of aid interventions. It has become necessary to discuss the ethics of compassionate action within the humanitarian agenda.

The changes in violent conflict and corresponding humanitarian response are as much about structural challenges as they are about the profound psychological and social suffering we are witnessing today. While there is no consensus on the new agenda of humanitarianism and the appropriate relationship between humanitarianism and politics, there is no doubt that the relationship between them has changed (Duffield, Macrae & Curtis, 2001; Macrae & Leader, 2000). Political and humanitarian actors are now expected to be consistent, sharing a vision of peace and security. Objectives of aid, diplomacy, military and trade policies are assumed to be compatible and humanitarian action is expected to serve a foreign policy function.

New humanitarianism characterizes the international response to many recent conflicts (Duffield et al., 2001; Fox, 2001). The new humanitarian responses are networked and non-territorial, thus defying former notions of state sovereignty (Duffield, 2002). Humanitarian action is increasingly an important part of the governments' strategy in the West to set the stage for development according to the liberal agenda (Duffield et al., 2001). With the politicization of humanitarianism, the provision of assistance has become conditional not on need, but on the installment and implementation of conflict management principles that underlie liberal visions of peace and stability (Duffield et al.,

2001). Aid is no longer given if it is perceived to encourage wrong behavior and attitudes such as dependency (Duffield, 2002). New humanitarianism acknowledges that complex emergencies surely need "complex response" (Greenaway, 1999).

On the other hand, humanitarian agencies may find it difficult to remain operational while simultaneously conducting activities perceived as political by host governments and warring parties. In fact, there is no consensus on the new agenda for a "liberal peace" comprised of democracy, respect for human rights and support for deregulated global economy (Duffield et al., 2001; Macrae & Leader, 2000). Humanitarian aid aligned with political intention is an approach that has been neither ethical nor effective. It has been redefined as a strategic tool of conflict resolution and social reconstruction, but it has not especially nor necessarily demonstrated effectiveness (Duffield, 2002; Fox, 2001). While the liberal radicalization of traditional aid has achieved a fair degree of consistency at the level of policy and institution, its ability to actually transform whole societies has achieved ambiguous results (Duffield, 2002).

Health and mental health care in the present-day context of globalization has put emphasis on the natural tensions between an international will to govern and resistant self-government, calling for a critical analysis of the dialectic (Duffield, 2002). Today, nation-states are increasingly unable to contain human suffering and social problems within their borders; correspondingly, there is an increase in the need to look beyond the local and consider how such problems might be solved on a global scale (Alphonse, George & Moffat, 2008). Mental health aid in psychosocial interventions dominated by international organizations like the WHO leads to too much central planning and insufficient participation of local actors, while psychosocial programs often results in

fragmentation of care (Piachaud, 2008). MHPSS, conceptualized by the IASC, appears to provide a solution to the problem of getting local participation while maintaining coordination of resources based on internationally deployed needs assessments. However, the imbalance of power in the dialectic in favor of globalization needs to be acknowledged.

The conflict of global and local forces has frequently swept away the benefits of development in "a tide of death, destruction and hatred" (Mitchels, 2003, p.404). The ill effects of globalization on the well-being of local communities have been accused of playing out as old oppressions with globalizing forces (Alphonse et al., 2008) and the encounter of global liberal governance with resistance can consequently be seen as shaping the unification of aid and politics since the end of the Cold War (Duffield, 2002). For example, there continues to be a pressing need to manage conflicts and direct societies in a liberal direction toward modernity through this unification.

Underdevelopment is also considered a threat to international security since, as the majority view supports, it fuels the spread of terrorism, increased displacement and refugee flow, poverty and drug-trafficking (Duffield et al., 2001, Julia & Kondrat, 2005). Using this security argument for development concerns means that enhancing security and reducing the risk of conflict involves changing the behavior of populations, which some have argued has been encouraged using psychosocial interventions (Pupavac, 2001, 2004b, Somasundaram, 2006). Rather than building structures or redistributing material resources, development now means getting inside the head to govern action (Duffield 2002). The concerns about interventions for conflict-affected populations may be understood as part of a wider project of hegemonic governance and political control.

The values of the traditional humanitarian regime is captured in the principled desire to "prevent and alleviate human suffering wherever it may be found" which has always been based in universalism (Greenaway, 1999). But the assessment of needs and psychosocial interventions developed from this perspective has yet to show its effectiveness in many parts of the world. In this chapter, I present an alternative view of conflict – one which has implications for psychosocial interventions in complex emergencies. A conflict transformational perspective is essential to creating change toward lasting peace.

Conflict transformation perspective

Much of the literature that I reviewed on new wars regards them as a failure of modernization and development in the psychosocial program model, as a symptom of social regression in mental health aid, something in between, or both in the MHPSS model of intervention. The predominant view sees conflict as, or leading to a kind of systemic pathology (Duffield, 2002). The medical literature describing war-affected communities, mostly about trauma and PTSD, contains sweeping statements that are questionable, pathologizing and stigmatizing (Almedom & Summerfield, 2004). This literature depicts emotional reactions of war-affected individuals and communities also as harmful and potentially dangerous to others. When conflict is framed in these ways, the view implicitly communicates that "their" irrational, internal violence – wars of today – are flawed and wholly unlike "our" restrained, state or ideological wars. Duffield (2002) comments that rather than seeing for example, our shared capacity for genocide, the ways in which we are different or apart are highlighted, hiding our responsibilities for the existing violence.

Framing modern conflicts as destroying a nation's social fabric, and perpetuating generations of hatred and civilian involvement benefits external, international or Western humanitarianism by giving them a powerful justification for providing aid (Duffield, 2002; Pupavac, 2004a). The result is an established and legitimated will to govern the places where human suffering continues. External assistance takes on the importance of having the capability and capacity to promote co-operative integration, provide training and strengthen capacities to rebuild the confidence and trust in communities that war has destroyed (Duffield, 2002). While such goals are usually agreeable to war-affected communities, the way in which external aid is carried out particularly when they are in congruence with political action may not work toward their best interests and may in fact inhibit recovery (Pupavac, 2004b). External aid could lead to their further disempowerment if it is not carried out with reflexive questions about who benefits and whose agenda takes priority. Denying the affected community's inherent capacity by imposing external models of healing is another way that violence might be perpetuated (Pupavac, 2004b).

Alternatively, a small number of authors interpret conflict in terms of social transformation (Duffield, 2002; Mitchels, 2003; Summerfield, 2000; Wessells, 1999). Transformation means changing the relationships between parties within the context of their joint relational continuum. It tries to minimize destructive effects of social conflict and maximize its potential for growth at physical, emotional and spiritual levels; it envisions disruption as an opportunity for response and engagement of the political, social and cultural systems within which relationships are embedded. The transformational approach interprets conflict as a motor of and opportunity for change in

relationships between agents (Lederach, 2003). From her own research, K. Pinto-Wilson (personal communication, June 18, 2009) says that once conflict is experienced as an opportunity for personal and collective growth or transformation, individuals and communities are likely to experience hope and excitement in the face of conflict.

This view helps to frame conflict as a normal response to contemporary context and a normal part of human relationships. Conflict transformation views conflict as a natural occurrence in human relationships rather than a social dysfunction. Direct violence and war is one way in which conflicts are managed and eliminated by explicitly forcing a change in circumstances (Francis, 2002). Practitioners of conflict transformation develop capacities and competencies in relationships that allow conflicts to be expressed and dealt with as opportunities for change with respect and without the infliction of violence.

Conflict transformation helps make sense of war from the perspective of those involved. From this view, war is not a unique, irrational or unusual occurrence. Similarly, humanitarian aid is not the inevitable outcome but a selective response toemergency of the agencies' choosing (Almedom & Summerfield, 2004). External agencies that carry with them the modern ideas of "awareness raising", "rights" and "empowerment" may privilege certain visions at the expense of others. *Good governance* and *democratization* are not necessarily the value-free goals they are espoused to be. Agencies, in this alternative paradigm, are prompted to consider their mandate for intervention (Ager et al., 2005).

Duffield (2002) suggests that contemporary wars are not a form of social regression but modernization in which the opportunities of liberal globalization were

transformed into non-liberal forms of autonomy, security and social structure. The economic, political and cultural systems on which new wars depend represent capacities for adaptation of survival despite their basis in resistance to globalized ideological recommendations of the West (Duffield, 2002). If so, this radical view suggests that instead of war-affected communities being confined to tradition and irrationality, they may be framed in the context of globalization that has produced multiple modernities (Duffield, 2002). Conflict transformation supports this view but also asserts a position of nonviolence in the eminent struggle that has characterized globalization.

Constructive and active nonviolence is a necessary part of the change process in conflict transformation. Given the amount of human suffering, displacement, famine and destruction violent conflict has caused, nonviolence is an important part of conflict transformation (Francis, 2002; Lederach, 2003). Active nonviolence may be conceptualized as an engagement with struggle, protest and action for change toward justice in structural and cultural elements that connects people with other people and their contexts. From this perspective, conflict is seen largely in terms of the lack of justice – the lack of an agreeable social structure wherein relationships between agents do not allow the rights and capacity of human development (Francis, 2002). Importance is placed on understanding the other and the conflict; commitment to growth and increased understanding of ourselves; and the goal of viewing possibility for change in circumstances and suffering through the structure of relationships where conflicts are a shared problem and humanity is honored by all (Francis, 2002).

A relational and people-centered process

Peace building is an inherently relational process that involves a wide range of activities both preceding and following formal peace agreements between groups. These may include a number of different stages needed to transform conflict toward more sustainable and peaceful relationships. Psychosocial interventions have conceptualized conflict as an erratic effect of internal disagreement or deficit of resources. In contrast, the conflict transformation perspective frames conflict as a dynamic relational process between individuals, communities and groups that moves along a continuum between unpeaceful and peaceful relationships. Peace may be defined by the continuously evolving and developing quality of relationships. Peace is characterized by the intentional attention to the natural flow of human relationships by addressing issues of difference and contradiction, thereby increasing understanding through respect (Lederach, 2003). Peace building is a process made of interdependent roles, functions, and activities that accompany the relational continuum toward social change for sustainable peace (Wright, 2004).

The goals in psychosocial interventions focus on recovering from interpersonal experiences. But no part of the literature on mental health aid or psychosocial programs to my knowledge discusses what targeted war-affected communities might need from external communities or what victims of war need relationally from perpetrators in their healing process. The literature in large part assumes that conflicts will be resolved with an agreeable formula for redistributing contested resources and that any psychological wounds must be taken care of internally within individuals or communities. In contrast, conflict transformation works toward reconciliation in human relationships.

62

Reconciliation focuses on relational needs and changed psychological orientation between conflicting parties (Shnabel & Nadler, 2008). Relationships in the reconciliation process, as Lederach describes, are built on balancing truth, mercy, justice, and peace. Truth represents acknowledgement and validation of suffering; mercy articulates the need for a new beginning; justice seeks social restructuring; and peace underscores the need for interdependence and well-being (Wright, 2004). Reconciliation focuses on re-establishing lost trust between groups and maintaining a collective and inclusive memory (Farwell & Cole, 2002).

Social psychologists Shnabel and Nadler (2008) conducted a study to examine the feelings of people experiencing a pattern of interpersonal violation. Victims exhibited an increase in power-seeking behavior and a need for a restored sense of status or relative power. They desired perpetrators to acknowledge and take responsibility for the injustice they caused. Perpetrators demanded empathy and relatedness; they showed enhanced need to restore their sense of belonging, social acceptance and public moral image. The researchers report that "emotional resources can be subsumed under the human need for power and the human need for love and belonging – two needs that constitute the core of interpersonal experience" (Shnabel & Nadler, 2008, p.117).

Conflict transformation aims for an end to cycles of violence, not unlike the goals of psychosocial interventions. In a process of healing that will help develop peaceful relationships, agreements satisfactory to all sides (and therefore durable and sustainable) cannot be found unless the fundamental needs of the affected parties are identified and met: needs such as security, a sense of personal and collective identity, recognition of beliefs and participation in their local culture (Francis, 2002). Unsatisfied emotional and

interpersonal needs serve as barriers to reconciliation (Shnabel & Nadler, 2008). Peace practitioner, Adam Curle argues that "separation", "alienation" and "soul wounds" contribute to the regeneration or perpetuation of conflict that may arise following war. Alienation – a feeling of separateness from a common humanity – may contribute to individuals' justification to act on negative emotions and to carry out violent acts without empathy for those hurt in the process (Mitchels, 2003).

The findings in the study by Shnabel and Nadler (2008) show not only that victims and perpetrators are deprived of unique and distinct psychological needs, but that their needs are best met by each other. The study further shows that people's judgments of justice in a situation are emotionally, rather than cognitively based. There is a gap between victims' and perpetrators' perception of the latter's responsibility for the emotional needs of the situation. This appears to be a significant barrier to achieving lasting peaceful relationships between them. It calls for fundamental change in the ways agents that are in unpeaceful relationships relate to each other.

It has been agreed in peace studies that the fundamental way to promote constructive change in a relationship between conflicting agents is through dialogue or direct interaction with one another. This interaction is rooted in the agents' communicative abilities of listening and telling (Lederach, 2003). Lederach (2003) calls for honesty, iterative learning and appropriate exchange in the process of working with issues of identity between conflicting groups. To promote dialogue, interventions could prioritize cultivating spaces, where safe and deep reflection about the nature of the situation, responsibility, hopes, and fears can be pursued.

Practices of conflict transformation creates spaces for exchange within and between conflicting agents through which all experiences of a specific context may find validation, rather than pursuing an immediate negotiated solution in processes of conflict resolution (Lederach, 2003). Particularly in complex emergencies, where power asymmetry is central to conflicts, a desire for conflict resolution may deny the knowledge and experience, the values and the passion of the less powerful agents (Shnabel & Nadler, 2008). The new awareness that comes out of such spaces is the beginning of an empowerment process, which is the next step toward action and change (Francis, 2002).

Conflict transformation frames culture and identity as relational, incomplete social constructions that are dynamic and evolving. They are concepts that are under constant definition, especially in times of conflict, and constructive change may arise through interaction with other cultures (Lederach, 2003; Wessells, 1999). From the transformative perspective, conflict affects and changes the cultural patterns of a group. These accumulated and shared patterns in turn, affect the way individuals understand and respond to conflict. Society and culture are impacted by war, but they are also elements that engage with it at many levels; the relationship is built both ways. Changes are possible in the worldview and identity of particular populations, and in the social, political, or religious institutions that represent those (Almedom & Summerfield, 2004). The transformative framework highlights and makes meaning of the cultural patterns that contribute to conflict, identifies, promotes and builds on the resources and mechanisms of that culture to constructively respond to and handle conflict (Lederach, 2003)

Patterns of communication and interaction are affected by conflict. In conflict transformation, external agencies may intervene to minimize poorly functioning

communication and to maximize mutual understanding (Lederach, 2003) Maximizing

mutual understanding requires intentional attention toward the less visible dimensions of

relationships (Lederach, 2003). Whereas psychosocial intervention has tended to see

change occurring within individuals or their communities, the conflict transformation

perspective emphasizes their dynamic, adapting and changing relationships.

The relationship between external humanitarian agencies and war-affected

communities must be treated in the same way. Are efforts to share and enrich, through

cross-cultural work, the insights and experiences which are being accumulated for

constructive approaches to conflict, the skills and ideas that are being developed, are

misguided (Francis, 2002)? The critique that trainers from the West may engage in a

"residue of imperialism" when they use their models in other cultures as "the right way"

to resolve conflict, is credible (Rupesinghe, 1995; Wright, 2004). An already existing

vertical power dynamic between parties has implications in humanitarian aid. The

integrative, transformative process promotes the role of outside consultants as assistants

in building local capacity and empowering people to secure democratic space necessary

to transform conflict by developing core conditions of empathy, acceptance and

congruence (Mitchels, 2003; Rupesinghe, 1995; Wessells, 1999).

Complex situations require developing individual and collective capacities of

participants in conflict. Capacity building in intervention work is a people-centered,

participatory and sustainable process whose purpose, design and content is determined by

those receiving the training. Its purpose is to enhance the abilities of people to address the

well-being of a population in accordance with their specific context (Corbin & Miller,

2009). In conflict transformation, there is also a need to build personal capacities that

enhances one's ability to address conflict with relational awareness and nonviolence. These capacities include the ability to live with apparent contradiction choices and experiences and to understand them as interdependent goals; to understand and respond to issues in the context of relationships and its ongoing changes; to envision conflict positively with potential for constructive growth; to envision and engage in change processes at all levels of relationships; and to see the immediate situation without being overwhelmed, or ignore the demands of presenting issues (Lederach, 2003).

The ability to lower reactivity and urgency for a quick solution even as conflict escalates, it increases one's capacity to express a clear sense of self and place and therefore move toward and not away from appeals to identity – an issue central to contemporary complex emergencies (Lederach, 2003). Clinicians of Western psychotherapy might recognize this ability and capacity as part of mindfulness practice which develops the skill of stepping away from a situation where emotions might be running high and observing simply what is happening in the present. Conflict transformation centers its attention on the present and historical context of relationship patterns. It allows individuals and communities to look through the immediate issue to bring into focus what lies beyond it and to differentiate between the content of a conflict and its context (Lederach, 2003). Curle proposes that revolutionary change may occur when a critical mass of people share the same ideas and beliefs, and the capacity to be aware of self and of others' needs may successfully challenge and change the global culture of violence and promote one of peace (Mitchels, 2003).

The recovery process

The process of recovery and conflict transformation spans from acute care to peace and reconciliation. Psychosocial interventions have been helpful at all stages of recovery, from crisis intervention to designing and planning a desired future and social change (Wright, 2004). Similarly, conflict transformation denotes a collection of processes while bringing complex emergency into the context of relationships (Lederach, 2003). The acute phase of conflict resulting in a complex emergency, for example may only be one of many instances of violation of a community's relationship with other communities and groups. These processes are designed to facilitate and maximize choice by eliciting awareness of violence in relational patterns and the possibility of making desired change (Francis, 2002). They are processes in which parties to a conflict are enabled to see that adversaries, like the self, are deeply motivated by shared, human concerns and that, violence will be perpetuated unless these are fulfilled (Francis, 2002).

Workshops are one of the most-used tools in peace building interventions. These are gatherings of people for a time and space of active thinking and discussion. They share inputs from a facilitator and utilize a variety of activities to stimulate thinking and encourage participation. Its purpose is to share knowledge, develop skills, learn approaches, and encounter "the other" (Francis, 2002). They may use a prescriptive approach, which focuses on the transfer of information from the expert trainer and empowerment of participants by providing content for facing conflict, or they may employ an elicitive approach to training, which values discovery and creation (Wright, 2004). The facilitator is a catalyst in the process by using metaphors to describe conflict

68

situations (Wright, 2004). The way in which these spaces are initiated will make a difference in the outcome toward relational change.

For the most part, conflict transformation does not bring any guideline or underlying principle to practice in psychosocial interventions that is new or different. Many guidelines in the literature on psychosocial interventions with war-affected communities and individuals already highlight specific principles and methods that are also recommended for work in conflict transformation. Program implementation protocols and guidelines for practitioners include general principles about the importance of enhancing safety, calming, respect, openness and acceptance, and validating skills and strengths (Ager et al., 2005; Hobfoll et al., 2007; IASC, 2007; PWG, 2003a). Interventions are important for individual and social healing. Almedom (2004) identifies emotional support – behavior that fosters feelings of comfort, respect and care – cognitive support – information and knowledge that enables understanding of crisis – and material support for mitigating effects of crisis. Understanding complexities and issues of a situation within its context, reflecting on your own assumptions about the impact of war and the impact of aid, highlighting survivors' skills, priorities and resilience; and providing a space for inter-communal communication are some of the other principles suggested by Summerfield (1995). These may all be found to enhance the capacity for peaceful relationships as advocated by peace studies.

The transformative perspective provides additional insight for implementation of these principles toward healing by changing the way they might be enacted in practice, and highlighting their necessity in the relationships between external aid providers, and war-affected communities. In this people-centered process, personal capacity-building is

important for every individual involved, not least of all for the aid provider who plays the key part in setting the tone of calmness and faith, and sharing the transformative perspective. The role of aid is to provide the intentional space for community members to share experiences and receive the validation and support needed to further engage in the transformative and relational process. The strength of the process is in the listening and significance given to every shared voice even when they may contradict each other. It is important that for every principle suggested in the literature as essential components for a psychosocial intervention, that local meanings of them are empowered. For example, safety is determined by the values agreed upon by the targeted group and not an imposed idea from any external culture. By sharing meanings, a new and local culture of acceptance and respect may be borne.

Conflict transformation is a practice in the ways of looking and seeing, the use of multiple lenses to observe a complex reality. Practitioners and participants are compelled to take in the immediate issues of a conflict and the system of relational patterns that they stem from. It is crisis responsive, rather than crisis-driven. It involves engaging in the conflict, allowing escalation if necessary in pursuit of constructive, long term change in relational patterns (Lederach, 2003). Each lens is in relationship with the others; various dimensions of reality are to be held together as a whole (Lederach, 2003). In this way, conflict transformation ensures the connection of short-term "issue" concerns with long term "systemic" concerns.

Systemic change is as much a goal of conflict transformation as peaceful relationships. Conflict transformation is a method of inducing change in relationships through mutual understanding and bringing about change in the characteristics of conflict

(Botes, 2003). Those that choose to engage in contemporary conflict are also looking for change in power relationships. Power, however, is not simply a matter of amassing wealth. Leaders must establish legitimacy, provide protection and rights, provide social regulation for their followers. Contemporary violence shows how social and political groups will go to extremes to secure the conditions for their existence. Assessing the social conditions that give rise to conflict and the way they affect change in social structures and patterns of power use is part of conflict transformation. This step in the process is a deliberate intervention to gain insight of underlying causes and social conditions that create and foster violent expressions for social change (Lederach, 2003).

Transformation calls for short-term empowerment of communities, but it also means enacting democracy at all levels of public life (Francis, 2002). In the medical model under 'mental health aid,' the psychological and emotional needs of individuals might be addressed by naming it, and treating it in the individual person. In contrast, the development model in 'psychosocial programs' often uses methods of empowerment to tend to the victims' economic and social needs. The source of healing comes from within the communities themselves. Transformation also ensures that those who have been the subjects of dominant structures discover and develop the power to participate in what affects them. Adopting a conflict transformation perspective helps to understand the assertion of MHPSS in the importance of interventions that meets basic human needs while also maximizing the involvement of people in the decisions that affect them (Lederach, 2003) but it does so while being aware of the interplay of global and local forces. It highlights the complexity of complex emergencies by involving multiple actors, pursuing multiple and interdependent actions and initiatives, simultaneously.

Recovery from complex emergency is not an isolated process. It happens in people's lives rather than their psychologies – the familial, sociocultural, religious and economic activities that make the world intelligible. It is practical and unspectacular, grounded in the ordinary rhythms of daily life where the disruption of conflict is often the most destructive. War may be enduring but this is not necessarily "trauma" as Western psychologists, psychiatrists, lawyers and other proponents of humanitarian projects would have it (Almedom & Summerfield, 2004). Psychosocial interventionists may always work toward peace by using methods such as mediation, negotiation and reconciliation, and trauma healing but they must also learn to transform within themselves and their own societies, recognizing the attitudes and activities out of which the culture of violence develops (Mitchels, 2003). The recovery process is based on the transformative assumption that human beings, of whatever culture and in whatever circumstances retain capacity for choice and change (Francis, 2002).

Peacebuilding is a long-term and multi-faceted process. Complex emergencies bring about change, affecting all dimensions of communities. This makes dynamic models of needs assessment and intervention absolutely necessary. Conflict transformation, with its alternative perspective on the causes of complex emergencies, and its suggested methods of understanding individual and community needs, is a people-centered and relationship-centered process that meets the urgent desire for change in contemporary violence. Conflict transformation embraces the reality in knowing that settings of simple emergency are non-existent (Almedom & Summerield, 2004). Transformation aspires to create constructive change processes through conflict and

72

frame them as opportunities to learn about and address relationships while providing

concrete solutions (Lederach, 2003).

CHAPTER V

DISCUSSION

The purpose of this study was to consider the links and relationship between the

need for peace-building and the need for humanitarian assistance in war-affected

communities in the present context of globalization. In this study, I propose that current

models of psychosocial interventions in complex emergencies are insufficient to address

the need for relational change that may continue to perpetuate violence, and the kinds of

suffering experienced by communities affected by contemporary violent conflict. The

study argues that conflict transformation, a perspective and practice from peace studies, is

an essential element to psychosocial recovery in complex emergencies. This chapter will

summarize the information introduced in the previous chapters; discuss limitations of this

study and recommendations for research; and consider the implications of this study for

international social work.

Summary

In Chapter II, I outlined the context of contemporary violent conflicts and

complex emergencies. Complex emergencies are defined as humanitarian crises that

affect a community's political and economic structures, as well as social, cultural and

healthcare infrastructures (Seybolt, 1996; Summerfield, 1999). Complex emergencies are

typical of communities and regions where violent conflict has endured within the last few

decades. The extent of suffering and damage in complex emergencies demand

humanitarian assistance from beyond community and state boundaries and are thus

uniquely associated with elements of globalization (Chandler, 2001; Seybolt, 1996).

The second half of this chapter summarizes the psychological and social suffering of war-affected communities found in the literature. Physical and emotional suffering is compounded in complex emergencies by the fact that contemporary war targets the very social fabric of a community and its resources that traditionally provide groups and individuals with psychological and social support during times of distress (Bracken et al., 1997; Summerfield, 1995). The PWG (2003a) separates the kinds of effects that an individual and collective of a community may experience into three overlapping categories. Effects of human capacity may include individual symptoms of distress such as physical disability, fatigue, anxiety, loss of a sense of control and the populations sense of loss in ability to care for itself. Social ecology refers to disruptions and changes in relationships within a community's social groups and families, as well as their links to civic authorities. Lastly, the culture and values domain of a war-affected community include challenges to human rights, threats to traditions of meanings, norms and customs that unite a community. Issues and crises in individual and collective identity also fall in this domain. Using these domains is also a way of conceptualizing how psychosocial interventions may address issues in specific arenas and their interrelatedness in a complex emergency (PWG, 2003a).

Chapter III defines psychosocial and provides an extensive overview of the psychosocial interventions discourse and its debates. Psychosocial intervention is an umbrella term used for interventions addressing psychological and social impacts of war and other disasters in humanitarian aid. It is a product of the evolution of humanitarianism as it expanded its focus from mainly physical health and material forms of assistance to attention toward psychological and mental health needs of affected

75

communities. This expansion in forms of aid came about following the Cold War in response to the changing nature of violent conflict. Psychosocial interventions span a wide range of different perspectives and approaches to aid depending on its understanding of the needs in war-affected communities. I describe polar ends of this spectrum between interventions that are designed to be generalisable and those that are unique to a specific context; interventions that employ technical knowledge and those enabling the use of indigenous knowledge; and interventions that are targeted at specific populations and individuals and those that are community-based. These ends are represented by mental health aid and psychosocial programs. There are strong critiques and ethical questions at both ends of this spectrum and a 'fierce discussion' between them is now apparent in the literature (Kienzler, 2008).

I also describe a third, encompassing approach proposed by the IASC (2007) in MHPSS which resolves some of the medical, moral and cultural debates in the literature, affirming the complementary use of both perspectives and approaches. MHPSS aims to address different levels of needs and use of different interventions in the progression of events following acute reactions to complex emergencies. The MHPSS guidelines are comprehensive and multi-sectoral and it addresses the need for external agencies to coordinate their actions and participate in interventions together. The shortcomings of MHPSS highlight the dilemmas around humanitarian aid regime itself and its role in perpetuating the very cycles of violence psychosocial interventions try to eliminate.

In Chapter IV, I introduce conflict transformation from the field of Peace Studies that gives a helpful perspective on relationships that the affected community concentrates on in a complex emergency. The relationship between victim and perpetrator

communities and the relationship between the intervening external and affected communities are both examined. Conflict transformation proposes an alternative perspective on the causes of complex emergencies and suggests methods of understanding individual and community needs. It is a people-centered and relationship-centered process that meets the urgent desire for change in contemporary violence by first building personal and social capacities to face, hold and understand the present moment. Transformation as a perspective gives hope in creating constructive change through conflict by framing them as opportunities to address destructive relational patterns while providing concrete solutions (Lederach, 2003).

This theoretical research is limited by its need for empirical studies to validate the use of Conflict Transformation in psychosocial interventions, as discussed. The study's main limitation is that the literature used, though reflecting a wide range of perspectives, is all validated and for the most part written by scholars in the West which comprises the external communities in humanitarian intervention situations. Recommendations for future research in this area include empirical research that may consolidate conflict transformation as an appropriate and necessary inclusion in psychosocial interventions in war-affected communities in this context of globalization. I also recommend finding or creating literature or other media by the voices within affected communities that reflects their own creative thoughts, ideas and recommendations for work toward psychosocial well-being.

Implications for International Social Work and Social Work Contributions

International social work is an amorphous grouping of diverse approaches and activities including practice with different populations like refugees, and exchanges of

77

social work theory and practice (Alphonse et al., 2008). Working in international humanitarian organizations is a large part of this work and all forms of international social work entails working across cultural, linguistic or ideological differences. The humanitarian ideals that I have mentioned in previous chapters are congruent with social work's mission of helping others, preventing harm and actively participating in the pursuit of social justice. However social work is a profession that also embodies a moral principle that is not expressly used in humanitarian aid: its dedication to empowerment and the respect for clients as being the "experts" on their own life situations (Taylor, 1999). This fundamental and instrumental value helps to operationalize social justice, placing equal emphasis on the expectation for the individual to better their own situations and the need for structural reform and collective responsibility (Taylor, 1999).

Social work is in the position to bring these principles to humanitarian work in communities affected by contemporary war. They may successfully use conflict transformation practices and skills in advocating for groups and individuals with unmet needs for psychosocial well-being. International social work with the support of conflict transformation may lessen the intensity of the debate in the discourse by promoting a more nuanced view of perceived needs, bringing focus and intention to meet relational and personal needs of war-affected communities in psychosocial interventions. Having self-awareness, listening and empathic skills, and being able to sit with dissonance caused by contradictory and interdependent factors, are required skills in humanitarian aid work in complex emergencies that are adequately and appropriately met by trained social workers.

Social work is a contextual profession (Taylor, 1999) – a diverse arena of aid that is defined by social, economic, political and cultural realities. Having more understanding of the intersections of globalization, violence and psychosocial well-being through this study leads me to conclude that international humanitarian assistance is defined additionally by temporal and power-relational realities. Conflict transformation, with its multiple lens perspective, places the experiences of those affected by contemporary wars within a continuum of time and experiences that are defined by its peaceful and unpeaceful relationships.

Conflict transformation is also a method consisting of a set of empowering practices that help to transform naturally occurring conflicts within human relationships into opportunities for positive change. The current pattern of conflicts favors negative outcomes of change for communities directly affected by contemporary conflict, and benefits external communities. The present-day context of globalization gives favorable power to the liberal and industrialized nation-states that comprise these external communities (the West), and the processes of globalization over self-government and emphasis of local communities. The increase in violence and war around the world, and the rise of globalization are closely related. This imbalance of power in the dialectic and the way it is maintained through contemporary war needs to be acknowledged and assessed. The place and region in the world where conflict takes place makes a difference in how and what might be useful in a psychosocial intervention; a universal mental health aid approach that mirrors and favors the effects of globalization already experienced by a war-affected community may cause more harm than good. International social work and humanitarian aid must consider the power-relational context with their assessment of

their targeted community and allow that the work may vary widely depending on its result.

Researchers in the West have examined human suffering of war-affected populations primarily as an individualized phenomenon. But human suffering might be better understood as a collective phenomenon in today's global context of protracted violent conflicts, globalization, emergencies of increasing and compounded complexity, and demands for effective international aid work. Attention toward the relational patterns that perpetuate the augmenting levels of violence and consistent presence of unpeaceful resolution to conflict is well overdue in humanitarian aid. Its discourse on psychosocial interventions is constituted by competing perspectives in which the need for peace is often eluded. Conflict transformation is a well-developed theory and practice that will bring a hopeful perspective and useful practices to the work between war-affected communities and external humanitarian assistance in complex emergencies.

REFERENCES

Abramovitz, S. (2009). Healing in peril: A critical debate over ex-combatant rehabilitation. *Anthropology News,* (May 2009), 14-15.

Abramowitz, S. & Kleinman, A. (2008). Humanitarian intervention and Cultural translation: A review of the 'IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.' *Intervention. 6*(3), 219-227.

Ager, A. (1997). Tensions in the psychosocial discourse: Implications for the planning of interventions with war-affected populations. *Development in Practice, 7*(4), 402-407.

Ager, A. (2005). Toward a consensus protocol for psychosocial response in complex emergencies. In G. Reyes & G. A. Jacobs (Eds.). *Handbook of International Disaster Psychology – Volume 1 Fundamentals and Overview.* Westport, CT: Praeger Publishers.

Ager, A., Strang, A., & Abebe, B. (2005). Conceptualizing community development in war-affected populations: Illustrations from Tigray. *Community Development Journal, 40*(2), 158-168.

Almedom, A. (2004). Factors that mitigate war-induced anxiety and mental distress. *Journal of Biosocial Science, 36,* 445-461.

Almedom, A. M. & Summerfield, D. (2004). Mental well-being in settings of 'complex emergency': An overview. *Journal of Biosocial Science, 36,* 381-388.

Alphonse, M., George, P. & Moffatt, K. (2008). Redefining social work standards in the context of globalization: lessons from India. *International Social Work, 51*(2), 145-158.

Botes, J. (2003). Conflict transformation: a debate over semantics or a crucial shift in the theory and practice of peace and conflict studies? *The International Journal of Peace Studies, 8*(2), 25-47.

Bracken, P., Giller, J. E. & Summerfield, D. (1997). Rethinking mental health work with survivors of wartime violence and refugees. *Journal of Refugee Studies, 10*(4), 431-442.

Chandler, D. (2001). The road to military humanitarianism: How the human rights NGOs shaped a new humanitarian agenda. *Human Rights Quarterly, 23*, 678-700.

Corbin, J. & Miller, J. (2009). Collaborative psychosocial capacity building in Northern Uganda. *Families in Society, 90*(1), 102-109.

De Jong, K., Kleber, R. J., & Puratic, V. (2000). Mental health programs in areas of armed conflict: The Medecins Sans Frontieres counselling centres in Bosnia-Hercegovina. *International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 1*(1), 14-32.

Desjarlais, R., & Kleinman, A. (1997). Violence and well-being. *Social Science Medicine, 45*(8), 1143-1145.

Duffield, M. (2002). Social reconstruction and the radicalization of development: Aid as a relation of global liberal governance. *Development and Change, 33*(5), 1049-1071.

Duffield, M., Macrae, J. & Curtis, D. (2001). Editorial: Politics and humanitarian aid. *Disasters, 25*(4), 269-274.

Dybdahl, R. (2001). Children and mothers in war: An outcome study of a psychosocial intervention program. *Child Development, 72*(1), 1214-1230.

Eisenbruch, M., de Jong, J.T.V.M. & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. *Journal of Traumatic Stress, 17*(2), 123-131.

Elcheroth, G. (2006). Individual-level and community-level effects of war trauma on social representations related to humanitarian law. *European Journal of Social Psyhcology, 36*, 907-930.

Eyber, C. (2003). FMO thematic guide: Psychosocial issues. Retrieved on November 19, 2007 from http://www.hhri.org/?keyword=7&region=254&search=Search

Farwell, N. (2004). In war's wake: Contextualizing trauma experiences of psychosocial well-being among Eritrean youth. *International Journal of Mental Health, 32*(4), 20-50.

Farwell, N. & Cole, J. B. (2002). Community as a context of healing: Psychosocial recovery of children affected by war and political violence. *International Journal of Mental Health, 30*(4), 19-41.

Fox, F. (2001). New Humanitarianism: Does it provide a moral banner for the 21st century? *Disasters, 25*(4), 275-289.

Francis, D. (2002). *People, peace and power: Conflict transformation in action*. London: Pluto Press.

Galappatti, A. (2003). What is psychosocial intervention? Mapping the field in Sri Lanka. *Intervention, 1*(2), 3-17.

Gilbert, J. (1999). Responding to mental distress in the third world: Cultural imperialism or the struggle for synthesis? *Development in Practice, 9*(3), 287-295.

Greenaway, S. (1999). Post-modern conflict and humanitarian action: Questioning the paradigm. Retrieved April 14, 2009 at www.jha.ac/articles/a053.htm

Herman, H., Saxena, S. & Moodie,R. (Eds.). (2005). Promoting mental health: Concepts, emerging evidence, practice: Report of the World Health Organization (Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne). Geneva: World Health Organization.

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention empirical evidence. *Psychiatry, 70*(4), 283-315.

Inter-Agency Standing Committee (2007). The IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: IASC

Inter-Agency Standing Committee (1994). Working paper on the definition of complex emergencies. New York: Inter-Agency Standing Committee Secretariat

Jones, L. (2000). What are the psychosocial domain and the role of mental health professional in conflict and post-conflict situations? *Psychosocial Notebook, 1*(2000), 61-70.

Julia, M. & Kondrat, M.E. (2005). Health care in the social development context: indigenous, participatory and empowering approaches. *International Social Work, 48*(5), 537-552.

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science and Medicine, 67*, 218-227.

Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-culture on illness. *British journal of psychiatry, 151,* 447-454.

Kleinman, A. & Cohen, A. (1997). Psychiatry's global challenge. *Scientific American, 276*(3), 86-89.

Lederach, J.P. (2003). The little book of conflict transformation. Intercourse, PA: Good Books.

Macrae, J. and Leader, N. (2000). Shifting sands: the search for coherence between political and humanitarian responses to complex emergencies. *HPG Report, 8*. London: Overseas Development Institute.

Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry, 76*(4), 409-422.

Mitchels, B. (2003). Healing the wounds of war and more: An integrative approach to peace – the work of Adam Curle and others with Mir I dobro in Zupanja, Croatia. *British Journal of Guidance and Counseling, 31*(4), 403-416.

Mollica, R. F., Lopes Cardozo, B., Osofsky, H. J., Raphael, B., Ager, A. & Salama, P. (2004). Mental health in complex emergencies. Lancet 364, (2004), 2058-67.

Norris, F. H. & Stevens, S. P. (2007). Community resilience and the principles of mass trauma intervention. *Psychiatry, 70*(4), 320-328.

Pederson, D. (2002). Political violence, ethnic conflict, and contemporary wars: Broad implications for health and social well-being. *Social Science & Medicine, 55*, 175-190.

Perren-Klingler, G. (2000). The integration of traumatic experiences: Culture and resources. In J. M. Violanti, D. Patton, & C. Dunning (Eds.), *Posttraumatic stress intervention* (p 43-64). Springfield, IL: Charles Thomas.

Piachaud, J. (2008). Globalization, conflict and mental health. *Global Social Policy, 8*(3), 315-329.

Piachaud, J. (2007). Mass violence and mental health – Training implications. *International Review of Psychiatry 19*(3). 303-311.

Psychosocial Working Group (2003a). Psychosocial intervention in complex emergencies: a framework for practice – working paper. Retrieved November 3, 2007 at www.forcedmigration.org/psychosocial

Psychosocial Working Group (2003b). Psychosocial intervention in complex emergencies: a conceptual framework – working paper. Retrieved November 3, 2007 at www.forcedmigration.org/psychosocial

Pupavac, V. (2001). Therapeutic governance: The politics of psychosocial intervention and trauma risk management. *Disasters, 25*(4), 358-372.

Pupavac, V. (2004a). War on the couch: The emotionology of the new international security paradigm. *European Journal of Social Theory, 7*(2), 149-170.

Pupavac, V. (2004b). Psychosocial interventions and the demoralization of humanitarianism. *Journal of Biosocial Science, 36*, 491-504.

Rupesinghe, K. (1995). Conflict Transformation. K. Rupesinghe (Ed.) *Conflict Transformation* (p 65-92). New York: St. Martin's Press, Inc.

Schloms, M. (2003). Humanitarian NGOs in peace processes. *International Peacekeeping, 10*(1), 40-55.

Seybolt, J. (1996). The myth of neutrality. *Peace Review, 9*(4), 521-528.

Shnabel, N. & Nadler, A. (2008). A needs-based model of reconciliation: Satisfying the differential emotional needs of victim and perpetrator as a key to promoting reconciliation. *Journal of Personality and Social Psychology, 94*(1), 115-132.

Silove, D., Steel, Z. & Bauman, A. (2007). Mass psychological trauma and PTSD: Epidemic or cultural illusion? In J. P. Wilson, & C. S. Tang (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (page). Springer.

Somasundaram, D. (2006). Disaster mental health care in Sri Lanka. In J. O. Pewitt Diaz, R. S. Murthy, & R. Lakshminarayana (Eds.), Advances in disaster mental health and psychological support. New Delhi: Voluntary Health Association of India Press.

Summerfield, D. (1995). Technical notes – assisting survivors of war and atrocity: notes on'psycho-social' issues for NGO workers. *Development in Practice, 5*(4), 352-356.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48,* 1449-1462.

Summerfield, D. (2000). War and mental health: A brief overview. *British Medical Journal, 321,* 232-235.

Summerfield, D. (2002). Effects of war: moral knowledge, revenge, reconciliation, and medicalised concepts of "recovery". *British Medical Journal, 325,* 1105-1107.

Strang, A. B. & Ager, A. (2002). Building a conceptual framework for psychosocial intervention in complex emergencies: Reporting on the work of the psychosocial working group. Edinburgh: Centre for International Health Studies, Queen Margaret University Hospital. Retrieved on December 13, 2007 from http://www.ishhr.org/conference/articles/strang.pdf

Taylor, Z. (1999). Values, theories and methods in social work education: A culturally transferable core? *International Social Work, 42*(3), 309-318.

Tolfree, D. (1997). Children, conflict, and displacement. *Development in Practice, 7*(1), 94-96.

UNICEF (1997). Symposium on the prevention of recruitment of children into the armed forces and demobilization and social reintegration of child soldiers in Africa. New York: UNICEF.

Vazquez, C. & Perez-Sales, P. (2007). Planning needs and services after collective trauma: Should we look for the symptoms of PTSD? *Intervention, 5*(1), 27-40.

Wessells, M. G. (1999). Culture, power and community: Intercultural approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow, & B. H. Stamm. (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss*. Philadelphia, PA: Taylor & Francis.

Wickramage, K. (2007). Hands in relief, eyes on development: Challenges and community responses in the delivery of humanitarian aid in conflict affected and tsunami ravaged districts in Northern Sri Lanka. *Asia Pacific Journal of Public Health, 19*(Special Issue), 25-34.

Willis, K. (2005). *Theories and practices of development.* New York: Routledge.

Wright, W. A. (2004). John Paul Lederach: A peacebuilder bibliography. Retrieved on June 5, 2009 on www.mediate.com/pfriendly/cfm?id=1567

Yoder, C. (2005). *The little book of trauma healing: When violence strikes and community security is threatened.* Intercourse, PA: Good Books.

Yule, W. (2006). Theory, training and timing: Psychosocial interventions in complex emergencies. *International Review of Psychiatry, 18*(3), 259-264.