IN DEFENSE OF A COMMUNITY PSYCHOLOGY MODEL FOR INTERNATIONAL PSYCHOSOCIAL INTERVENTION

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Over the past 35 years my professional work has been centered in community based mental health interventions, and for the last 15 years I have had the fortune of concentrating on domestic and international trauma and disaster work. Towards the betterment of those efforts it has been important to me to stay abreast of relevant theory, research, and best practice from the field. My trust has been that others interested in identifying effective methods and improving on them will at least do the same. Unfortunately, I have too often found expression of opinion without rationale, bureaucratic and political interests, arrogance, and close mindedness guiding decisions in the international psychosocial arena. Certainly, given the infancy of the field, these characteristics are understandable, but nonetheless unacceptable. We have an ethical and moral responsibility to the recipients of our services to do better.

Fortunately the time is ripe for improving our international services. There is a growing interest and understanding among our researchers and academicians, an increasing awareness within NGOs of the possible relevance of psychosocial services to their missions, and an expanding capacity and desire across disciplines and cultures to learn from each other. For our part, if we proceed with an open mind, flexibility, creativity, objectivity, and humility we can be part of this frontier of opportunity to collectively with our fellow world citizens reduce the psychological damage following trauma and disasters.

A hiatus is also occurring for me with reference to international work. With assignments in 2001 of assessing and planning intervention responses to the Gujarat earthquake in India, evaluating a psychosocial program in Kosovo, working in New York in September following the World Trade Center attack, serving on an international psychosocial working group, presenting at some half dozen domestic and international conferences, plus the usual local trauma and other clinical work resulted in my appreciating a relatively quiet 2002 so far to collect my thoughts and refine my direction for the next several years. This paper serves to summarize my conclusions and questions regarding international psychosocial work, this being helpful to me, and perhaps to others with similar interests. Obviously there is so much we do not know about what approaches are useful, and correspondingly the confidence I have in the conclusions below varies extensively. Based upon my acquaintenship with work performed by others as well as my own work I will try and qualify my conclusions as to degree of confidence, but for purposes of this paper I am not going to attempt citing relevant research and program evaluation references, this being an essay of personal conclusions and not a major scientific treatise.

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First, can we in our Western cultures and training be of any use to peoples in other parts of the world in meeting trauma and disaster mental health needs? This is a complex question, but given the right modifications, sensitivities, and limitations the overall answer is yes. There is a large and increasing body of knowledge that the effects of trauma and loss are experienced with considerable similarity in much of the world. Secondly, by better understanding the cultural variations in the expression of trauma effects and the acceptable modes of intervention some of what we have learned is beginning to demonstrate helpfulness in various international settings. Also of benefit is that we have returned with a better awareness of what approaches are useful with differing groups, this applicable with the increasing numbers and varieties of immigrant populations we are requested to serve in our own countries. Psychological effects of trauma are expressed in grief, somatic complaints, spiritual struggle, fears, depression, and various stress disorders, the latter areas likely where we have the most to offer in useful principles of intervention.

How do we continue to improve our international work? The answer seems obvious, but typically is ignored. Many of our clinical and educational research models are sufficiently well developed to be adapted to international settings, and we have established precedence in other fields such as public health and agriculture. Cooperative research and evaluation agreements between countries and their respective academic and humanitarian organizations need to be a priority. Similarly, program evaluation, if it is to be at all useful in improving effectiveness of services, must be designed and implemented at the beginning of an intervention program, not an after the fact activity. Exchange programs, scholarships, and international internships will also add to our interest and knowledge base. Common forums for exchange of both research and applied findings have been increasing over the past several years, but sponsorships for participants from less affluent countries is minimal.

When is it best to intervene? This is as much a policy question as an empirical one. Some NGOs limit their overall involvement to short term interventions such as medical care, food, and shelter in the emergency phase following a disaster, so that psychosocial interventions likely need to fit within that overall parameter if they are to be offered. Other NGOs may, for example, provide a range of services in a given refugee camp for many years. Many organizations have policy limits on types of services, such as educational or health, others by type of recipient, be it children, elderly, and so forth. The point is that psychosocial services internationally will typically need to be provided within the overall mission of an organization. This may be seen as a limitation, but I think in many ways it is a developmental strength for our work, as will be explained later. Now, with this awareness in mind I can go back to the question of, in general, when to intervene.

Several reasons can be posited in support of providing psychosocial services in acute periods, often referred to as the emergency phase, following a disaster. There typically are immediate psychosocial needs. These needs can at least partially be met in conjunction with and through the provision of other emergency services, such as mass care and health services. Early intervention likely reduces some of the long -term effects, and at least helps survivors and staff know what to be aware of and address if they later may need to, this being a preventive and educational role. We have an increasingly useful body of knowledge to guide us in both better identifying those who are at risk for long-

term complications, and what can be helpful in early stages. Early intervention allows for assessment, planning, and training for evolving psychosocial program needs. Early involvement also provides for building an awareness of the importance of psychosocial services and for establishing necessary trust and working relationships with the survivor population as well as with the many other organizations participating in response services. Staff themselves often have psychosocial needs from the beginning which can be addressed constructively to reduce vicarious traumatization, burn-out, organizational fatigue, and other stress related complications.

Argument however also can be presented against early involvement. Since, in the emergency phase, we typically have less information available on the individuals, communities, and cultures involved and we are in situations where rapid decisions need to be made there is greater risk of making errors in judgment, and the "do no harm" principle becomes more of a challenge. Within this risk arise concerns of undermining natural and spontaneous recovery phenomena, creating dependency, and stigmatizing, Furthermore, organizations who are usually involved in emergency phases have historically provided basic life preserving services such as food, shelter, medical care, water and sanitation; and with limited financial resources will argue that these need to come before mental health care or even education. These concerns are strong within the international humanitarian community, may certainly have legitimacy, and need to be addressed thoroughly and objectively. Even within the mental health field itself there is a tenable position that we are best at working with established clinical conditions so why not wait and use our limited resources with those who do not recover through other existing resources. In general, however, with careful assessment criteria and processes, there are often emergency phase disaster situations which can significantly benefit from one or more psychosocial interventions, descriptions of which will be provided later in this paper.

How and when to conduct a psychosocial needs assessment is a topic sufficient for a volume or two in itself. About two years ago, on behalf of the American Red Cross I conducted a thorough literature review on this topic, and developed an in depth psychosocial needs assessment protocol, this based on an initial assessment with the Kosovo Crisis, and further field tested following the Gujarat earthquake. The World Health Organization also has developed a protocol, similar in content and purpose. Since the last field test of my protocol I have made some additional recommendations to apply assessment procedures at various phases, this allowing more accurate planning for subsequent services. Suffice it to say that most NGOs now at least have an awareness of the existence of psychosocial needs assessment methodology, and some are incorporating that methodology into their overall assessment models. What is lacking is a forum for exchange of assessment experiences, and interorganizational training in psychosocial needs assessment.

Given accurate needs assessments, awareness of resources available to meet those needs, and knowledge of what interventions likely will be most effective in meeting the identified needs, an organization can implement services accordingly. I will now summarize various intervention models which have been discussed and applied sufficiently often to warrant serious consideration.

There is a preventive model which has considerable acceptance internationally. This is sometimes referred to as psychological first aid or psychological support, and includes the training of organizational staff in basics of stress management, communication skills, supportive counseling , crisis intervention, initial individual assessment, and referral. Often this is carried out on a train the trainers basis so that its utilization can be implemented rapidly and at relatively low cost throughout an organization even on a countrywide basis. Attempt is usually made to modify the curriculum content to make it culturally acceptable to the locale where it is taught. This has been applied in post-disaster settings and also in disaster preparedness training in various countries. In some applications of this model incorporation of awareness of post-trauma effects have been included, with general suggestions of what may be useful in response. Critical incident stress debriefing training , which has been taught quite extensively internationally, is much more specific and limited in its scope and intent than the general psychological first aid model, but nonetheless fits within this preventive concept. The disaster mental health model used by the American Red Cross in response to domestic disasters also incorporates these basic concepts in emergency phase application along with other more specialized services.

Two premises are involved in this model. The first is that the survivors of a disaster are understandably distraught or distressed, and that temporary supportive interventions help them get through the period until their lives can get back to normal or until local resources can be accessed if they need such. Although I know of no empirical support for this conclusion there is popular recipient, professional, and organizational support for this contention. The second premise is that such interventions reduce the severity and frequency of long term complications such as PTSD, depression, and traumatic grief. Obviously this conclusion is more difficult to reach, with mixed research findings, post-disaster support however identified as a significant variable in general. The opposing argument is that money may be better spent more precisely identifying those who are at highest risk for long term complications and working more intensively with them, assuming that the majority of the population does not really need general support services other than what spontaneously occurs without designed psychological intervention. Later in the paper I will suggest in greater detail that this often doesn't have to be an either-or question, in that general psychological support interventions, in addition to providing temporary relief may also serve as educational and identification methods to begin assisting those who indeed are at higher risk for long term complications.

Psychological triage and crisis intervention services are often provided, either in conjunction with general support services, or often as a parallel to medical clinical services. This is more common and acceptable in western cultures and usually presupposes the availability of pharmaceutical and facility resources for those needing such, this not the case in many international disaster incidents. Also, many cultures do not have an acquaintanceship or trust in this model and even people in acute psychological crisis in those settings will avoid crisis intervention resources of a clinical model when provided. In situations where medical services are utilized by recipients the incorporation of crisis intervention into those services can be partially effective, but requires specialized training, cooperation, and flexible temperament with the staff involved. The work done by MSF, Doctors Without Borders, has used this model in some international missions.

Clinical model services also can be provided on a long-term basis, either in a typical western format, or modified for more cultural effectiveness. Obviously, the more we modify in our format and translation the less sure we are of the potential usefulness because of our inability to generalize from the original effectiveness research. This is costly and complex work, takes literally years of commitment, and a willingness to spend extended periods of time working in hardship and sometimes dangerous conditions. However, when this does occur I think some highly useful progress can be made for the potential beneficial incorporation of western knowledge in other settings. The Center for Victims of Torture in Minneapolis has a project in western Africa which is an example of this approach. The incorporation of cognitive-behavioral therapeutic methods for PTSD into culturally acceptable models has had more attention than work with other clinical areas of concern following disasters such as depression, traumatic grief, psychosomatic disorders, and spiritual conflict. A complication which often occurs with long term clinical programs as they gain acceptance in international settings which have limited mental health resources is pressure to provide those services to the chronically mentally ill, who are also usually indigent. Obviously this population is in need of assistance, but attending to the extensive needs of this group can quickly deplete program resources.

Another long-term model which has considerable appeal in the international humanitarian community focuses on building or restoring resiliency. This is liked because it is not pathologically defined, and thus involves less stigmatizing. There are difficulties with this approach though in that we really have little knowledge of how to identify and foster key characteristics of resiliency, especially in cultural settings which have less reliance on individualism and autonomy than western cultures. It is probably best to view the resiliency model as one of sufficient hypothetical worth to evaluate through further applied research along with better exploration of what constitutes resiliency in various cultures. The work being done especially in post-conflict settings in developing mediation and conflict resolution skills has relevance to resiliency efforts, and least from a societal perspective.

Mass education is an approach which can be applied on a preventive, early intervention, or long-term basis. It can be initiated quickly and with low cost as long as there are written or oral modes of communication available to reach the populations of concern. Care of course needs to be taken to have respectful and meaningful translation of materials used. In this regard, and to help maintain supportive local social structures , where possible it is best to provide mass education through existing indigenous community and leadership resources. Basic information on typical effects of trauma, and what can be helpful for ourselves, our children, and our communities are examples of this approach commonly used, and typically appreciated. Pamphlets, newspaper articles, radio and TV presentations, and public meeting forums all can be utilized.

It is important to know that general information which provides access to resources, connection with family and friends, knowledge of the status of conditions "back home", flood levels, peace negotiations, etc. can have a profoundly calming effect on people following a disaster. ICRC for example distributed inexpensive radios among Kosovar refugees in Albania and provided a variety of useful information to these groups. The savvy person developing mental health services in a disaster situation will be aware of such dynamics, and encourage these and similar informal interventions. As an aside, this is a working example of a psychosocial intervention.

A number of international psychosocial programs fit under a social rehabilitation model. These include such efforts as including "healing" activities into public school settings, craft and garden clubs, drama groups, sewing and computer classes. The therapeutic principles underlying these approaches emphasize group support, confidence building, relaxation, and ventilation through a safe and acceptable activity. Many non-western cultures prefer access to troubling thoughts and feelings through indirect rather than straight discussion approaches, and respond more readily on a group and community basis than one on one, thus the appeal of these methods. In a few initiatives, for similar reasons, mental health programs are blended with social welfare programs. What is lacking in social rehabilitation approaches is documentation of their psychological therapeutic effectiveness, or in most situations, measurement of functional improvement. Perhaps one of the best developed programs which fits under the social rehabilitation umbrella and has evolved documentation of clinical and functional improvement is the CABAC initiative and its offsprings. These are school-based interventions with conflict; affected children and involves the training of teachers and other school staff in therapeutic group activities wiith most of these program efforts in the Balkans over the last ten years.

There is also a psychosocial community organizational model. This has variations in organizational and institutional development, but typically incorporates a primary goal of capacity building so that the target institutions can continue services or be capable of handling the next disaster after external resources are withdrawn. Many humanitarian organizations and governmental entities support if not require this approach. This usually requires a long-term availability from a project, programs flexibility, and staff competence in community development. Most mental health personnel do not have these skills, and to be effective in this model either need additional training, or need to work in partnership with personnel who have that capacity and role. In recent years there have been some attempts at least in some organizations to combine psychosocial efforts with other capacity building resources but good models of this are lacking. Ironically, the inclusion of an evaluation of even two or three psychosocial capacity building efforts on an international basis likely would do more for the consideration and awareness of psychosocial programs among NGOs and governmental entities than any other similar level of effort.

The extent to which staff care may influence beneficiary mental health warrants discussion as an intervention model. Most people agree that providing any post disaster service with respect, empathy, calmness, and dependability usually has reassuring effects on the recipients of those services as compared with not displaying those characteristics. Creating a calm and supportive environment may be a worthwhile short-term mental health programmatic goal. A corollary premise is that maintaining physically and emotionally healthy staff is also to the advantage of the service recipients. This is the basis, in general, for employee assistance programs, and occupational stress management programs. Disaster and humanitarian workers, no matter how well selected and trained, because of the nature of their work, are considered to be at higher risk for critical incident and cumulative stress, thus the added rationale for a comprehensive occupational stress management program, including on-site services if the disaster is of significant stress. There has been some interorganizational discussion on this topic, and a few publications. I am acquainted with two organizations, on an international basis, which have attempted

to provide some field staff mental health support at times, these being World Vision International and ICRC. However, what is lacking is an evaluation of actual benefits of an occupational stress management program not only for the organization and its staff, but even for the disaster service beneficiaries themselves. An evaluation design for this question is certainly feasible. Greater barriers are encountered in convincing organizational decisionmakers of its potential usefulness, and the requirement of obtaining support across organizational functions such as human resources, security, desk officers, and the donor community. In my mind, more effective staff care may well be the most cost efficient mental health international psychosocial intervention.

So, where does all of the above leave us? Obviously there is so much we do not know about our usefulness or otherwise in our international endeavors that openness to many possibilities along with professional and theoretical humility are the first characteristics needed. With these cautions in mind, though, I am of the opinion that we know enough to begin guiding our focus and emphasis with several theoretical and professional principles of intervention. An initial needs assessment is needed to provide for accurate decision-making on whether or not psychological assistance is warranted and the best approaches given all critical variables. In most major disaster circumstances some level of intervention will be indicated, increasingly so of course depending on the severity of human loss. For staff care, needs assessment, general psychological support, triage and crisis care, development of interorganizational and community trust and agreement, the identification of high risk individuals and communities and possible reduction and prevention efforts, and capacity-building purposes psychosocial participation in emergency phase interventions will most often be indicated over delaying involvement for several months. Working through established disaster relief services, activities, and personnel, both indigenous and those provided by external organizations will in general be more acceptable, efficient, and effective as compared with independent clinical services. This is likely valid not only in early stages of intervention, but also in many if not most non-Western settings whenever our work is provided. This approach, however, requires us to as accurately as possible identify what activities and opportunities exist within a given community, tribe, country, or other affected social structure which have therapeutic validity to establish. The transfer of what we already know is helpful into locally functional models of intervention is our biggest challenge, but also where we can be of the greatest use. As psychologists we are in the best position to work with others in that psychological transformation process. Even if the therapeutic approaches are grounded in educational, occupational, religious, play, or other acceptable social activities demonstration of their usefulness is in improved individual behavior, this being an appropriate domain for psychologists. Just as an example, if "telling our stories" under safe and supportive circumstances is a useful exposure therapeutic approach in a given setting in order to justify including that activity in a post-disaster program we will want to demonstrate that it helped the participants, either by reducing symptoms, increasing functional capacity, or both. In the United States that discussion may take place in a group therapy program at a clinic, in another country perhaps during a sewing class or drama group. Desensitization to certain sounds or smells following traumatic exposure may constructively be incorporated into training or work projects. Cognitive restructuring can be part of religious ritual or community healing festivals. Openness, imagination,

understanding of community, individual, and therapeutic dynamics all come together here.

If we dig out our old community psychology text books and dust them off(some of us have more years of dust than others) we can find those definitional characteristics of community psychology. Societal improvement, furthering normal development, prevention, professional-community collaboration, multidisciplinary approaches, innovative research methodology, and applied psychology keep popping up. Not only understanding the conceptual link between individual and society, but how to constructively intervene to improve human functioning and emotional well-being differentiates community psychology from social psychology. That our final unit of analysis is change in individual behavior differentiates psychology from other fields of intervention such as social work, although joint programming with disaster social welfare efforts often is a useful concept. Truth be known, community psychology by its need to not forget its clinical psychology groundings while staying cognizant of social psychology, organizational development, and developmental psychology as well as related disciplines of social work, sociology, economics, education, and anthropology, has had a difficult time maintaining its identity and focus. By definition, international psychosocial work does not "belong" to community psychology. However, if the reader recalls or glances back over the descriptions of psychosocial work as provided earlier in this paper they fit convincingly with acceptable definitions of community psychology. This has been a pleasant and reassuring evolving realization for me, and helpful at times like this when I am quietly reflecting, as well as when I am listening to political opinion from a street vendor expressed through an interpretor companion some 9000 miles from here.