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# PERSONAL AND COMMUNITY RECONSTRUCTION, RESILIENCE, AND EMPOWERMENT IN TIMES OF ETHNOPOLITICAL CONFLICT



**A report on an international  
conference on integrating  
approaches to psychosocial  
humanitarian assistance  
– July 2002 –**

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# In memory of Clara Rabinowitz



*The conference and related projects were sponsored in large part by the Clara Rabinowitz Global Peace Fund, established in memory of this founding member of Psychologists for Social Responsibility.*

Clara Rabinowitz was an extraordinary person, a psychologist and social worker, a founding member of Psychologists for Social Responsibility, and a social activist who worked from behind the scenes to empower others, who had a vision of the world in which peace through hard work eventually could be possible. She spent her life on this quest and we dedicate our conference to her.

Ms. Rabinowitz was born in Woodbine, New Jersey, an experimental immigrant community designed to help Jewish immigrant groups find rural homes in the United States in the late 1800's and early twentieth century. Ms. Rabinowitz earned her B.S. Degree (1921) and her Masters in Social Work (1939) from the University of Pennsylvania. Her graduate thesis, *The Meaning of Agency Form and Structure in the Case Work Process of a Child Guidance Clinic*, laid the groundwork for her later explorations of structures and systems. She attended graduate school at New York University in the 1930's and 1940's in educational sociology and



clinical psychology. She also attended the William Alanson White Institute of Psychiatry from 1943 to 1947, receiving certification in Applied Psychiatry and becoming a lay analyst. There she received training with innovative thinkers such as her supervisor, Frieda Fromm-Reichmann. She became a licensed psychologist in New York City.

Her work experience was rich, first as a researcher and caseworker in Philadelphia and then as an organizer of a children's service in St. Louis, Missouri. From 1931-1934 she supervised graduate students for the Graduate School of Jewish Social Work in New York and then continued to teach, supervise, and administer services for social agencies. During World War II, she was on loan as a researcher for services to soldiers to the Jewish Welfare Board. She also worked for the National Committee on Mental Hygiene and the New York Committee on Mental Hygiene, conducting research related to the needs of servicemen both working in the war effort and those discharged for psychological reasons.

While at the William Alanson White Institute, she provided psychotherapy for young adults at the Washington Institute for Mental Hygiene and in 1946, became part of the volunteer staff of the Northside Center for Child Development where she

worked with emotionally troubled children from disadvantaged backgrounds alongside clinician-researchers-social activists such as Mamie and Kenneth Clark. There she wrote a paper, *Socially Deprived Children* in *Children* III: 3-8, 1956, presaging the family and community work to come. The paper was one of the first of its kind to examine the needs of economically deprived children in psychotherapy. It was rich with innovative and practical suggestions regarding the application of the therapy of the day, the psychoanalytic, in new, creative ways that incorporated the inclusion of community need, values, and strengths as well as implicitly describing the beginnings of a systems approach to intervention. This was a theme she would continue to develop.

In the mid-1950's, Ms. Rabinowitz worked with Salvador Minuchin at the Wyltwick Research Project, studying families of delinquent, emotionally troubled children from economically deprived backgrounds. She was one of the four therapists whose work was incorporated in Minuchin's seminal work exploring family systems, *Families of the Slums*.

For ten years, starting in 1962, Ms. Rabinowitz was on the editorial board of the *American Journal of Orthopsychiatry*. In that position, she, with Helen Wortis, edited a collection of writings on the budding women's health movement, most probably the first academic compilation in mental health of women by women with a feminist perspective. She also wrote and presented papers that propelled the field of mental health further, seeing the complex interconnectedness between economic and social ills with mental health problems.

She continued in her seventies to publish, lecture, write, and supervise in addition to developing new ways of both conceptualizing and tackling mental health problems. The latter included serving on a multi-disciplinary mental health team, led by Clifford Sager, which developed an innovative partial-hospitalization program for emotionally

troubled adults.

In 1982, she, with a small group of other psychologists, organized the New York Psychologists for Social Responsibility and when the national organization needed an "ad hoc Steering Committee" to bring psychologists together to confront the threat of nuclear war, she joined at the national level where she continued to serve on the Advisory Board well into her 90's. She traveled internationally and helped create networks among psychologists in the interest of peace both for PsySR and for other groups. Additionally, she worked abroad to better understand and improve mental health practices, at times, as a representative of the United States government.

She is not "known" in the sense that she leaves a legacy of published works. Rather, Clara Rabinowitz is remembered for her visionary thinking, her hard work. She also is remembered for her mentoring of others who continue to serve as clinicians and in the peace effort, and for her wise counsel in using systems thinking and other innovative models to advance the practice of psychology. She, too, will be recalled as a clinician who worked to identify and treat mental dysfunction in ways that recognized the complex roots and variables associated with what is called mental disorder. Through us, Ms. Rabinowitz will continue to serve as a model for mental health professionals who value social action. Without needing recognition, she quietly sought and discovered ways that would make the world safer and more humane, a place where mental dysfunction is better understood and reduced. For what she was and for what she strove, we honor her.



# About Psychologists for Social Responsibility (PsySR)

## Building Peace with Social Justice since 1982

PsySR was born in 1982, during the height of the Cold War, with the mission of using psychological skills and knowledge to reduce the threat of nuclear war. For twenty years now we have been working to promote peace and reduce violent conflict. PsySR's first major project was developing a presenter's manual, *Dismantling the Mask of Enmity: An Educational Resource Manual on the Psychology of Enemy Images*, by Brett Silverstein. Members used it for public education on the distortions in thinking that can occur when adversaries are endowed with exaggerated enemy images.

With the fall of the Berlin Wall and the Soviet Union, we expanded our mission to focus on peacebuilding and social justice. We offered commentaries on the problems with cross-cultural communication leading up to the Gulf War, on the value of realistic empathy in assessing an adversary's motives, and contributed to the dialogue on building a durable peace.

In response to the outbreak of violence in the Balkans, we developed a short, self-help educational brochure on *War Trauma and Recovery*, which was widely distributed and used as a basis for group discussion in all the languages and alphabets used by people in the former Yugoslavia. The brochure is now available in several other languages. We consulted with the International Criminal Tribunal for the former

Yugoslavia and Rwanda on reduction of retraumatization of women providing testimony on gender-specific war crimes.

Our members continue to be concerned about the lack of effective, collaborative, cross-cultural communication and work with colleagues around the world, many of whom are carrying out useful and creative projects that contribute to peacebuilding in their locales. In 1996, we established an International Peace Practitioners Network (IPPN) in cooperation with The Society for the Study of Peace, Conflict, and Violence (Division 48 of APA). The IPPN now has participants in some 40 countries.

We were also pleased to participate in the development of the Joint APA/CPA Initiative on Ethnopolitical Warfare. Our national office served as the secretariat for the development of a *Graduate Level Curriculum for Trauma Intervention and Conflict Resolution in Ethnopolitical Warfare*. The multi-dimensional focus of this work was on trauma response, peace education, cross-cultural psychology and conflict resolution, themes that describe PsySR's approach to building a more peaceful world.

# EXECUTIVE SUMMARY

Psychologists and other mental health professionals are increasingly involved in assisting individuals and communities affected by ethnopolitical warfare and other contemporary forms of violent conflict. Due to the widespread impact of these forms of violence and the complex sociohistorical situations in which they occur, those offering assistance have faced enormous challenges. They are called to respond to trauma and suffering far beyond the scope of their professional training – and they often confront language barriers, logistical chaos, threats to their safety, and the inadequate housing and facilities that characterize post-conflict areas and refugee camps.

Humanitarian assistance addressing the emotional well being of communities affected by ethnopolitical conflict takes many different forms. It can range from individual counseling and group therapy to community-level programs for reconciliation and economic development. In the urgency of responding to crisis after crisis, little time or space has been available for dialogue among those gaining experience in various modes of psychosocial assistance. The result has been a lack of cross-fertilization and integration in the planning, implementation, and evaluation of psychosocial programs. Little is known about what is working and why. Serious concerns are being raised about harm that may be done by well-intentioned international workers. Furthermore, coordination between psychosocial programs with other levels of assistance, such as those attending to security, medical, human rights, special

populations, and employment needs, has also been difficult to accomplish.

Psychologists for Social Responsibility (PsySR) is committed to bringing clarity into this complex scene through a series of projects that began with the conference whose results are described here. In July 2002, over fifty administrators, researchers, and practitioners experienced in the provision of psychosocial assistance were assembled at the University of Maine for a three-day conference. All major conflict regions of recent decades were represented, for example, the Balkans, Central Asia, the Middle East, Southeast Asia, Sub-Saharan Africa, and Latin America. The objective was simple – to create a space for dialogue among the practitioners of different approaches in order to advance our collective understanding of what is at stake in this work. Specifically, the core goals of the conference were:

To share, compare, and discuss promising approaches to psychosocial assistance to communities affected by ethnopolitical violence

To identify strategies for assessing the effectiveness and impact of psychosocial programs in these communities

To develop a set of guidelines to improve the design, implementation, and evaluation of psychosocial humanitarian assistance

The consensus regarding the conference, according to the formal evaluation, was that it constituted a significant step toward the accomplishment of these goals, but that much work lies ahead. Guidelines for best practice would be difficult to establish at this point. The conference served primarily to highlight an array of ethical, practical, cultural, and political questions that need to be addressed in an ongoing manner in order to deliver assistance conscientiously.

Given the variety of training backgrounds and experience that participants brought to the conference, achieving understanding across different program models and levels of intervention was difficult. In general, assumptions underlying program models were not discussed in depth, but there was evidence among participants of questioning regarding their own assumptions and practices. Many participants expressed the need to rethink how they are working and the scope of their work. Differences among perspectives emerged in the degree of emphasis placed on medical/psychiatric models and on scientific methods in assessment and evaluation. A general appreciation developed regarding the importance of linking immediate post-conflict assistance to sustainable long-term programs. With regard to best psychosocial practices, the conference exposed as much divergence as commonality. The primary areas of consensus and disagreement are detailed in this report. The task of integration among approaches and across phases of assistance remains a challenge for the future.

In light of these difficulties, conference participants enthusiastically came to consensus around the awareness that we urgently need to develop

education and training programs to meet the multiple needs of practitioners who put their lives and professions on the line when they respond to communities affected by ethnopolitical conflict. The complexities they meet in each particular situation require multiple skills and complex understanding in order to intervene successfully and do no harm. Furthermore, training must equip these 'hybrid' professionals of the future to foster collaboration and cooperation among all those who have a stake in community restoration and peacebuilding. This will require not only broad interdisciplinary training, but also considerable attention to cultural competence and sociopolitical acuity.

For updates on PsySR's efforts to contribute in this vein, please contact us.



# INTRODUCTION

## The “Clara” Project

Providers of psychosocial assistance to communities affected by ethno-political conflict often note that such assistance is based on diverse perspectives about what is needed for personal and community reconstruction. Interventions function on different levels, ranging from psychiatric-medical work with individuals to community development strategies that are primarily economic in scope. Approaches also differ with regard to their theories of what traumatized individuals and communities need to do in order for healing to occur. Just as concerns about the cultural appropriateness of treatment and intervention are raised in the mental health field in general, these are also now raised frequently in connection with “Western” modes of humanitarian assistance in non-Western societies. There is an understandable tendency to transfer professional training relevant to everyday situations to the more complex situations of conflict-torn societies.

Guidelines for professional training in trauma work have only recently been drafted ([www.istss.org/guidelines.htm](http://www.istss.org/guidelines.htm)). Insufficient feedback from outcome and impact evaluations of psychosocial assistance also hinders the development of consensus and coverage of the inevitable gaps in assistance. As a result, there are

few shared answers to questions about what strategies really work. There is even less consensus about how different approaches should be integrated to assess and address the needs of traumatized individual and communities in a comprehensive manner.

In light of this situation, the Trauma, Resilience and Social Reintegration Action Committee of Psychologists for Social Responsibility began to design a project to address the need for improvement in the field of psychosocial humanitarian assistance. Funding that served as a seed for the “Clara Project” was donated in the memory of Clara Rabinowitz (see her biography in the fore matter), a founding member of Psychologists for Social Responsibility. Additional funding to cover expenses for travel, research, publication, and dissemination were supplied through a grant from the United States Institute of Peace (USIP-729) [see [www.usip.org](http://www.usip.org)].

The first phase of the “Clara Project” shaped up as a multi-stage process. First, professionals with field experience in communities affected by ethnopolitical violence would be surveyed via Internet and by phone regarding issues and concerns in the delivery of psychosocial humanitarian assistance. The results of the survey

would then be used by a steering committee to design a conference to bring practitioners, researchers, and administrators into extensive dialogue about concerns and issues raised in the survey as well as their own. The original objectives of the conference were stated as follows:

*The objectives of the conference are to improve the effectiveness of psychosocial humanitarian assistance programs by organizing conference participants to:*

- *Clarify theoretical constructs and assumptions underlying intervention models*
- *Review methods for community needs assessments*
- *Consider feedback drawn from a survey of experienced field workers*
- *Examine the cultural appropriateness of interventions*
- *Identify gaps between psychosocial assistance approaches*
- *Work toward the further development of practical guidelines and integrated best practices for program design, implementation, monitoring, and evaluation*
- *Lay the groundwork for a widely disseminated document on current state of psychosocial humanitarian assistance.*

## **Web survey of field workers and administrators**

Several months before the conference, PsySR designed and implemented a web-based survey of field workers and administrators in psychosocial programs (see Appendix for a list of the survey

questions. The purpose of this survey was to capture a sense of the state of the field and of the most pressing issues.

Fifty persons from around the world responded to the survey. This was a smaller number than anticipated. Numerous follow-up invitations to respond to the survey were sent to organizational networks to no avail. This meant that the sample could not be considered representative and the responses were analyzed in terms of common themes rather than to portray an objective picture of the prevalence of certain methods or attitudes in the field. The analysis was facilitated by a dozen phone interviews in which practitioners were asked the questions from the web survey and then probed for deeper explanations of their responses. Areas represented were sub-Saharan Africa, Southeast Asia, the Balkans, the Middle East, Central and South America, and Central Asia. Most of the respondents were program managers, project directors, and professionals (counselors and social workers) in humanitarian non-governmental organizations.

The primary themes arising in the responses to the survey and phone interviews were the following:

- Psychosocial programs tend not to be related to specific theoretical assumptions or formal program designs. The programs appear to be based on what appears necessary to help the community based on some form of community assessment, including interviews or questionnaires frequently read aloud, meeting with elders, other group leaders, previous life experience of the assessor, with some reliance on parts of psychological methods for working with emotional difficulties.

- Formal assessment tools are either used and found and not helpful or are avoided altogether. Interviewer and use of informants or data from sources from previously involved with the community seems to be standard. Program leaders describe relying on life experience, other project work, and discussion with community. More technologically advanced countries receiving immigrants who have been through trauma have clearer protocols and systems into which immigrants are incorporated. In areas in which conflict/trauma has been experienced, emphasis is on finding the strengths and resources in the communities and using whatever local material and mental resources exist to mobilize the community. The process becomes one of stabilizing and facilitating the community's taking on responsibility for its members. The sharing of personal narratives was mentioned frequently as a means for building community.
- As projects evolve, there is emphasis on changing needs and recognition that programs must be modified as these needs are identified. In technologically advanced countries, there is greater emphasis in fitting people into existing structures. In contrast, in areas experiencing conflict/trauma, there is more emphasis on finding ways for community to develop own strategies for advancement.
- Respondents described the complexity of this work and the realization that political and economic factors heavily determine community situations. One cannot look only at mental health. A few respondents mentioned the importance of advocacy within the political structure of the country.
- Education of the population in order to understand the roots of violence, methods for conflict resolution, and nature of emotional reactions to stress was often stressed.
- In non-Western countries, respondents talked about the lack of utility or limitations of Western conceptualizations, models, rating techniques, and general way of working with the populations. One respondent referred to the complementarities between western and other ways of thinking, suggesting that both must be fit into design and implementation of programs. Workers working within their own countries did not describe cultural problems between the population and the program design, its implementation or with the staff. On the contrary, some Westerners working in non-western settings spoke of difficulties in implementing programs and of aspects of programs that were culturally alien to the population, e.g., use of written tests for illiterate people, using interview protocols that used language, even when translated, that is meaningless to the interviewee, the shame associated with admitting certain mental vulnerabilities, the importance of status in the community and the unwillingness to reveal the information that might lower one's position in the community.
- Regarding 'tools' that professionals should bring to the communities in need, the idea of individual and group works in a therapy situation for those with PTSD and general anxiety and depression was stressed. Education also is seen as important. Occasionally, respondents referred to beginning to develop an approach toward peace and forgiveness.

- The lack of training and good supervision, especially in the non-technologically advanced, war-torn societies, was described. Respondents described the need for debriefing, shorter periods of working, and the greater need for time off and recreation.
  - Frequent mention was made of the arrogance of the medical model as a way of working with people who are recovering from abnormal, devastating trauma, even when the community has been subjected to such trauma for years. Seeing people as sick and providing one-on-one treatment was seen as not necessarily useful. The importance of looking at the larger community, its needs and potential to support its own members, was discussed.
  - Many respondents emphasized the importance of working in a way that is respectful of local culture. Assessment of the cultural appropriateness of interventions is, however, extremely complicated.
  - The importance of coming to a community without preconceived ideas and learning from the community was stressed. One needs to learn as one proceeds.
  - What is the role of healers coming to communities? Some see themselves as providing short-term intervention, some longer and more involved with the political nature of the problems and larger infrastructure of the society. There may be conflict between specialization and treatment for trauma and the needs of the general society. Individual work, still largely the focus of intervention, may be viewed as a luxury and community work is seen as "politics." We need to re-think what short interventions regarding psychological problems should really address.
  - Additional issues: Proper pay, discrepancies between salaries for those from within the country and those from outside the country. The lack of money to make changes, e.g., in many situations, children need to pay to go to school. The interplay and competition between local groups for survival. The idea that trauma continues to play out in the behavior of community members and therefore is perpetuated. The importance of advocacy, working with larger political structures also was raised. Also, respondents raised questions about how to prevent infighting among NGOs.
  - Helping the population to access past successes and failures in coping and what can work now in their post-conflict society cannot be disregarded. Development and rebuilding infrastructure cannot be effected without addressing psychosocial issues. Community members need to learn how to work together, how to set aside differences and seek commonalities and find ways to resolve conflict. Without learning the importance of change and reconciliation, communities cannot progress and humanitarian work is useless.
- In sum, dozens of issues remain to be resolved by those who have dedicated themselves to work in this field. The difficulty and complexity of psychosocial work leads many toward cynicism. One respondent expressed this very powerfully:

*I have become far more cynical about the role of the international community as a result of this work. I feel that it will only be through a long-term integrated community-based approach stewarded but not completely controlled by foreigners that such communities will recover – more than recover – and go on to develop. With the current approach, there is great danger that the programs will not be effective and will, rather, make matters worse. There seems to be an extreme short-sightedness on the part of those making policy both at local and international levels.*

*The great problem, as I see it, is that of vision. It seems that the international community's objective is to get in and out as quickly as possible and to provide a positive image of itself rather than actually accomplishing the goal of long-term rehabilitation and reconciliation. There also seems to be more competition than cooperation among NGOs. This leads to gaps and duplication. It also leads to NGOs following crises like rats – going in at a time of crisis when the pickings are good and leaving when the money is gone, whether or not the problems have been resolved.*

The conference organizers took all these issues into account and presented them to conference participants as they convened at the University of Maine.

## **Initial questions for dialogue sessions**

Roughly two months prior to the conference, confirmed participants were asked to suggest questions to focus our dialogues on pressing issues. The following questions were distilled from

those submitted. These were printed in the conference program to prime participants' thinking for the dialogue sessions.

## **Needs assessment and planning**

What do you do to prepare yourself for psychosocial work in and with a community affected by conflict and violence? What do you take with you?

What do we mean by "mental health" when working with communities experiencing the effects of ethnopolitical warfare?

What are our basic assumptions regarding usefulness of behavioral intervention in emergencies? How do we separate out need assessment from immediate response to crisis?

What is our role in incorporating a mental health component into planning in complex emergencies? More specifically, where and under what circumstances does a mental health component fit into the initial conceptualization of the needs of the community in complex situations? If not, when and under what circumstances would this component (however we define it) be incorporated in the over - all planning and needs assessment? Or should it remain separate?

What are the main problems and ethical issues associated with assessment in complex emergencies? What specifically for mental health assessment?

In what ways are assessments currently being conducted? What constitutes best practices under

what conditions? What do we need to know about the community before we enter it? How do we decide who should be targeted? In what ways is a standard protocol desirable or counter-productive? How do we know if we are getting an accurate picture of need? How do we control for our own bias? How can cultural relevance of the intervention be maximized?

What means are most effective for a focused assessment of children's psychosocial needs?

Who does the assessment? How is it supervised? Should an outsider do the assessment? Should a pilot program be conducted before program implementation?

Assuming that there are differences in approaches between the designers (Psychosocial experts) and the hands-on implementers (the field workers), how can these best be bridged?

What additional steps should organizations devise before reaching the conclusion that a program is ready for implementation? What is the place for designing outcome evaluations prior to implementing a program?

How does our work interface with other organizations working along side us?

Everyone favors participatory planning, but what does that really mean and entail? What are most effective ways to invite "cultural brokers" to identify unmet individual and community needs? What are the issues that make such a process, if used, go more smoothly? What are the drawbacks?

Are there ways that different theoretical and practical approaches toward planning and assessment can be brought together to improve the process? Where are the gaps that we can all agree exist?

## **Implementation and intervention**

What issues of culture and power arise in implementation and intervention?

How do local ideas and practices about gender, religion, social system structure, political structure, ideological structure, and beliefs about healing fit into implementation strategies? How are ideas about local culture obtained? How much is the obtaining of that information determined by how the community is organized (who are spokes people, how individuals, families, and larger groups interact and influence decisions on a community level.) and how much is done based on other ways of looking at need?

How does one conceptualize capacity building and sustainability in emergency situations? Should capacity building be a major objective of all psychosocial programs? If capacity building is important, what works?

Is it possible to develop best practices guidelines for real community-driven programs?

How do we best combine a clinical and human rights approach to practices in the context of ethno-political warfare?

How does the emergency situation tie to the next phase of partnership with the community? Is it considered and if so, what needs to be built into the interventions? What tools might be used?

How can psychosocial interventions be linked with other basic services in emergency situations (from community perspective, working with other NGO's and governmental groups)? What are the internal program management structures that best facilitate a multi-disciplinarian team approach to psychosocial programs?

What training and capacity strategies are most effective and appropriate? How are the best carried out? How many "generations" of training the trainers can one plan without jeopardizing the quality of services?

How can we best handle communication problems between "inside" and "outside" professionals?

What is the place of the community in designing and implementing programs? How can programs be implemented so that they are "owned" by the beneficiaries?

How can programming best adapt to changes in the external environment?

## **Monitoring and evaluation**

What methods and initiatives to incorporate local cultural/traditional ways of addressing mental health have been successful and why? What tools work? In what instances have psychosocial programs proved to be harmful and what can we

learn from these instances? What tools do not work?

How does one conceptualize program impact, long-term as well as shorter-term?

Who decides what the main impacts of programs should be? What are roles of those collaborating with this person(s)?

What are the main issues of evaluation currently? How can apparent improvement be correctly attributed to the correct source(s)? On what levels we evaluate "success"? That is, do we look for changes in the individual, family, and community? Are client descriptions that interventions "helped" in the absence of other data significant?

What data should be collected to monitor and evaluate benefits of a multi-disciplinary approach?

What should be the role of youth, women, the elderly, the local leaders and other local group groups (teachers, priests, the marginalized, etc) in the evaluation process? How should their inclusion best be incorporated? What kinds of ways would such incorporation be shared with the community if such incorporation is thought important?

How are unexpected outcomes measured and integrated into findings?

What new approaches to evaluation need to be applied to advance and mature the field? How do we further the development of accurate indicators of program achievement?

## **Integration of approaches and models; Collaboration**

How do we best combine a clinical and human rights approach to practices in the context of ethnopolitical warfare?

What strategies could be most useful in enhancing coordination and collaboration in complex emergencies?

Is integration of psychosocial assistance a desirable goal or should we pursue entrenchment of psychosocial support as a fourth or fifth pillar of humanitarian assistance? What guidelines or standards could lead the integration effort? What exemplars or examples of effective, integrated practice could guide us?

Coming out of the experience, do we see holes in thinking that have not been addressed to-date in models and program implementation? Do you see consistencies that exist across approaches or inconsistencies that need further exploration?

What ways would best keep us collaborating to find a better practices approach? Can discussions like the ones raised in this conference help in the development of new ways of conceptualizing issues and if so, how? What could make the process of collaboration and creating new approaches better?

Where is the place for real interdisciplinary approaches that incorporate other disciplines? How do we decide under what circumstances to collaborate with which disciplines?

What methods can be utilized to get essential stakeholders to “buy into” the program at various levels, e.g., communities, regions, and governments?

How can funders become more involved in using best practices guidelines when deciding what to fund? And how can we promote collaboration between actors competing for funding and visibility? Are these part of our mission?

Are there disadvantages to collaboration that need to be addressed?



## THE CONFERENCE

The conference process was designed to encourage participants to share the lessons they had learned from their work in the field in a manner that would generate a collective sense of points of convergence and divergence. The participants were divided into five groups of ten for dialogues that were facilitated by clinical psychologists. To prime each of the small group dialogues, brief introductory remarks were made to the plenary group by several participants who had been invited to raise a few key issues. The conference was thus revolved through a pattern of plenary-small group-plenary sessions. This pattern was repeated four times prior to the final morning of consensus work (see Appendices for full conference schedule). Each phase addressed a particular aspect of psychosocial humanitarian assistance, in the following order:

Assessment and Planning

Implementation and Intervention

Monitoring and Evaluation

Integration and Collaboration

On the final day of the conference, small and large group sessions were devoted to a process of consensus formation on the priorities facing the field and relevant actions to be taken in order to carry forward the work of the conference. The results of this three-day process are reported below.

All sessions of the conference, including small group sessions, were either video taped or audio taped for later review, with the full written consent of the participants. Observers took process and content notes on both large and small group sessions. The videotapes were later viewed to clarify issues raised in small group observer notes and to develop the longer "Report on Conference Process" available at [www.psysr.org](http://www.psysr.org). Investigators with legitimate research interests may contact PsySR to determine if access to the conference recordings can be arranged.

The next section summarizes observations of the conference process and integrates findings from the conference process evaluation. The section after that synthesizes conference themes and conclusions.

## Observations and Evaluation of Conference Process

[Prepared by Julie Levitt, Ph.D. and Deanna Beech, Ph.D.]

A subset of goals for the conference included: 1) how the conference design itself could be a vehicle for communication and dialogue and 2) how it could serve to create momentum for further group deliberation and action. Therefore, the conference organizers planned a process evaluation to understand how comfortable participants felt when raising controversial ideas and discussing difficult topics and whether they saw the alternating large and small group format as useful in building the dialogue process. In addition, we asked ourselves what if any interventions were helpful in building the sense of community that could continue past the conference. It was hoped that the conference could serve as a springboard for further group initiatives and we wanted to explore how this could occur.

Two aspects integral to the process were the physical surroundings and the format/facilitation of the conference. We chose the University of Maine at Orono because it provided a peaceful, comfortable space in which to work. We wanted our participants to be comfortable and emphasized service as part of what we offered. We drew from the Public Conversations Project (PCP) and Appreciative Inquiry (AI) dialogue models. The PCP model provided a structure for the small groups and facilitated the development of norms that we saw as useful in establishing respect for group members, such as careful listening and the participation of all members. The AI model was

used to frame questions in a positive, forward-thinking way.

The steps for assuring that the participants felt comfortable included the creation of a “level playing field” to assure that they were not intimidated by differences in work-related hierarchy, academic degrees, number of authored publications, etc. All were invited to share publications with one another prior to the conference, name tags made no mention of degree or title, there were no formal paper presentations, and small groups were composed of people with varying amounts of and different kinds of field experience and training.

To assure that we were aware of the how the conference process was evolving; participants completed surveys before the conference began, at the end of each day and at the conclusion of the conference. This feedback process allowed the participants to identify and convey to the staff the aspects of the conference process that were both beneficial and detrimental. As a result, the staff was able to modify both the structure and facilitation of the conference to bring the process closer to participant wishes on the second day. The PCP technique of time-structured participation in the groups was almost universally rejected as too rigid, with a few of the small groups unwilling to continue using the model even on the first conference day. Many participants were also frustrated that the positive focus on what they found exciting about their work made in-depth discussion of the true differences in approach

difficult to address. Finally, there was a clear majority of participants who described the small group sessions as too short (at 90 minutes). The staff also observed that the presentations in the large group that were supposed to demonstrate thoughtful and provocative reflection on the questions to be posed in the small groups were not working as we had planned. The presentations tended to be somewhat formal.

On the second day the conference format was modified in the following ways: 1) the PCP technique and the AI orientation were dropped and the small group facilitators were instructed to facilitate an open dialogue on the intended topic, 2) small group sessions were given more time, and 3) presentations made in the large group were to be shorter and should include a few provocative observations/statements related to the content area about which they were to address. Further analysis of what participants felt worked and did not work in the groups is discussed below.

## Findings

Despite almost universal criticism of the PCP model, the model almost immediately benefited the conference in several ways. Its use may have created an opportunity for the small groups to unify as members coalescing around their dislike of the approach facilitating group identity and cohesion. Another benefit of the PCP model was the establishment of group rules that both allowed the participants to offer their opinions and ideas without fear of personal attack, and allowed others to constructively disagree with those positions. In addition, the initial timed rounds for responding, while almost consistently discontinued by the end

of the second small group session, created norms for responding in the groups such that monopolizing group time was dissuaded and participation of all group members was encouraged. This finding, based on staff observation and participant comments, was supported by the survey data.

The formatting changes appear to have had both positive and negative effects on the conference process. The percentage of participants that felt there was insufficient time for the small group discussion decreased and many group members commented on their amazement that the staff implemented changes based on participant feedback. However, participant satisfaction with both large and small group processes also went down during Day 2. Some of these changes can be attributed to the reduction in structure but it is likely that much of this dissatisfaction actually reflects the increasing depth and intensity that was present in the discussions of differences between strongly held belief systems.

That the participants were listening and carefully reflecting on their own work was evident in observations of the large group. The response to the large group meetings was not affected by format changes and in fact, the group expressed positions more candidly. It is believed that as the staff addressed the participants' tendency to avoid dealing with the differences between their ideas and approaches, they began to discuss their positions more candidly, using language that suggested more passion and investment. By building the emotional space for the members to offer their sincerely held ideas and beliefs and to constructively address differences with one

another's points of view, a capacity was created in the membership that openly reflected underlying assumptions in their work. For example, towards the end of the second day of the conference members remarked in the large group, "I wonder if I have helped anyone through my work" and "Maybe we need a quantum shift in the field." These comments suggest the members' openness to looking critically at their own work and considering new ideas and positions.

Group openness and interest in collaboration was most notable on Day 3 when participants identified what they believed were the most important directions for collaborative humanitarian work to continue to advance the field. The content section above indicates a number of initiatives that move beyond individual approaches and perspectives such as an e-mail listserv, a follow-up conference, and the compilation of a list of specialties and interests among participants that could be made available to organizations needing assistance. These ideas were elicited in the final large meeting and further solicited in the concluding survey.

Participants reported some difficulties with the small group facilitation process. After the elimination of the PCP model, some participants felt that there was confusion about topics and focus of the small groups. Others expressed a desire to see a greater depth and variety of perspectives present, particularly those that would represent areas affected by conflict. Participants also raised the need for discussion that moves more from general theory to concrete specifics, and longer conference duration with a narrower focus and clearer articulation of outcome expectation.

On the other hand, participants, in their final survey, described the small group process as accomplishing the following:

- Setting the ground rules for the group in the first session
- Providing a loose structured context for dialogue facilitated by a group leader who was flexible, empathic, and able to keep the group on task
- Providing sufficient time for the members to fully discuss the topic without feeling overly pressured
- Surveying the participants by offering concrete opportunities for them to express their thoughts about how the conference process was going
- Being flexible and willing to change approaches and structures if the participants feel that the task would be better accomplished using a different approach

With regard to whether our approach to group process had utility, the participants responded favorably to the conference as a whole. They universally viewed it as well organized and expressed that they felt welcomed. The majority agreed that they had opportunities to express opinions that the priorities identified on the last day were reflective of the group consensus, and described that the process for reaching consensus was effective.

With respect to whether the conference had an impact on the participants, a majority described the conference as meeting their expectations and enabling them to acquire information helpful to their work, a new appreciation of different approaches, and new perspectives related to their own activities.

In relation to the conference itself participants reported that they enjoyed their time together, and rated the opportunity for interpersonal exchanges as the most important outcome. They also expressed interest in and suggestions for continuing the group collaboration. This interest has been further supported by a considerable email activity following the conference that continues to express interest in further work. It is clear that this group wants to maintain its connections and momentum.

As to why this conference was successful in creating dialogue and collaboration, one can look to a number of factors. We were willing to modify the format to respect and meet the needs of our participants. Our small group format was from the beginning diametrically opposed to the traditional formal meeting with speakers and presentations of papers. We began the dialogue process prior to the conference by asking participants for their input in the conference preparation. And, our participants were experienced leaders in their fields working with experienced small group facilitators. Most importantly the ensuing unstructured open dialogue process that came about on the second day of the conference allowed the groups to openly discuss areas of similarity and difference without perceiving the discussion as threatening or taking offense.

We will be further analyzing the videotapes of the conference to ascertain whether and to what extent leadership style and group mix contributed to a deeper, more open, more collaborative, and successful process. In addition, in their final surveys, participants described feeling welcomed, treated well, and comfortable with the conference logistics. We feel an important area of inquiry, requiring further investigation, is the place of service in contributing to a sense of well being, participation, and willingness to work together during and beyond the actual conference.



## Synthesis of Conference Themes and Conclusions

The following sections synthesize the most salient themes, issues, and conclusions that were brought back from the small group dialogues to the large group sessions. Discussions in the large group sessions then revolved around these points as part of informal testing for consensus. This synthesis is followed by the results of a brainstorming and consensus process on priorities for action.

### Assessment and Planning

*In this phase, the questions for dialogue were: What approaches to assessing needs are working well? How can we ensure the cultural relevance of the approaches? How can community members be meaningfully involved? How are needs assessments taken into account in planning for intervention?*

General consensus emerged on the following points:

- Collaboration with local organizations is essential.
- Modes of assessment that provide access to subjective experience (interviews, narratives, focus groups) are preferred to standardized, quantitative measures that assess exposure to trauma and symptoms.
- Planning should be done on the basis of community values and assets as well as individual resources and coping skills, rather than deficits.
- A holistic approach to personal and community well-being, rather than a narrow psychological or psychiatric approach is recommended.
- Indigenous knowledge and practice about healing and reconstruction must be integrated into planning for intervention.
- The assessment phase is a time for observation, for determining who is helping at the local level and then accompanying them and following up with resources.
- The long-term sustainability of assistance must be taken into consideration in initial planning of interventions.
- Assessment and planning need to be ongoing and connected to monitoring and evaluation, not just an initial phase. Those who conduct assessments should also be involved in planning and implementation.

Divergent perspectives were expressed on these issues:

- The scope of “psychosocial” work.
- The degree to which psychosocial assessment is possible or effective during the emergency phase.
- The relative emphasis that should be placed on the implementation of established professional assessment practices versus an exploratory “ethnographic” and politically sensitive mode of understanding a post-conflict situation.

Ethical issues and practical questions arose in these areas:

- Given that knowledge is power, what problematic power relations are established in the process of assessment conducted by outsiders?
- How should those offering psychosocial assistance define their mission and present themselves to communities? Since assessments raise expectations for services, this must be taken into account before conducting assessments.
- What can be done about the fact that certain assessment tools (e.g., interviews related to human rights abuses) produce information that can lead to political reprisals?
- The definition of a community as “traumatized” imposes a Western psychiatric worldview. How can this be taken into account?
- Whose interests are really being served in the delivery of psychosocial humanitarian assistance? What would greater clarity

about personal and organizational motives imply? How can hidden agendas be avoided?

- How can sexual violence and violence against children be assessed in ethical ways?

## Implementation and Intervention

*In this second phase, the questions suggested for discussion were: What tools or methods of intervention work? Can they be adapted for use in other situations or are they culture specific? How can the quality of interventions be sustained?*

General consensus emerged on the following:

- A wide range of basic interventions have proven useful, many of which rely on established cultural practices (story telling, knitting circles, healing rituals, etc.).
- Several competing models of intervention exist. In general, these are:
  - Clinical (addressing psychological trauma)
  - Community (focusing on conflict management and development)
  - Human Rights (seeking reconciliation and social justice)
- Best practices depend on the phase of work in which one is engaged, e.g., emergency, rehabilitation, or capacity building.
- Various structural and situational factors interfere with intervention:
  - Security hazards
  - Limited budgets
  - Lack of integration of programs

- Short time frames
- Issues of professional identity
- Difficulties in convincing donor agencies to support the integrated work that needs to be done
- Dissemination of information regarding assistance needs to be coordinated much better.
- Indigenous practices for recovery and healing are neither simplistic, nor ineffective.
- Prevention of further conflict is essential and involves careful work with local and foreign governments.
- Intervention recipients need to be thoroughly informed and involved in choosing the intervention in which they will participate.

Divergent perspectives were expressed on these issues:

- To what extent should communities be left to rely on natural and spontaneous healing processes?
- Are specialized techniques of intervention and treatment a luxury that has no place in humanitarian emergencies? Even simple interventions are actually complicated when viewed from cultural and political perspectives.

Ethical issues and practical questions arose in these areas:

- There are few mechanisms for institutionalizing the lessons learned in responding to previous humanitarian crises. Errors are repeated; systems have to be re-invented.

- Short funding cycles lead to numerous broken promises and dashed hopes.
- How much can really be accomplished? Unrealistic expectations of personal and organizational capacity lead to burnout and interpersonal problems in the field.
- What are the proper places for expertise and grassroots participation?
- Remembering and forgetting: what are the roles of each in recovery?

## Monitoring and Evaluation

*In the third phase, the dialogue questions were: How can the impact of a program be measured at various levels – individual, family, community? How can evaluation be made more useful for planning and future program design?*

General consensus emerged on the following:

- Systems for monitoring and evaluation need to be built into the program concept and design from the beginning.
- Evaluation needs to move beyond symptom counting and individual-level assessment.
- Donors need to be educated about the irrelevance of some of the indicators they would hope to see as signs of effectiveness.
- Systematic evaluation of the effectiveness of cultural healing practices will be difficult, and perhaps should not be attempted.
- Evaluations need to be designed to inform planning and project management in direct ways.
- Emergency situations often make well-

planned evaluations impossible. In such cases, daily notes can be very useful afterwards. At any rate, retrospective evaluation is crucial and it is not done enough.

- Issues of qualitative versus quantitative evaluation can only be answered relative to specific situations and needs.

Ethical issues and practical questions arose in these areas:

- Serious issues arise in the cross-cultural use of questionnaires and standardized instruments.
- Evaluations often serve to perpetuate programs rather than transform them.

## Integration and Collaboration

In the fourth phase, the questions suggested for dialogue were: What forms of collaboration among stakeholders are especially promising? In what areas do we need to be thinking about bridging gaps and integrating approaches?

General consensus emerged on the following:

- The various models of intervention compete for resources. Practitioners of these models should work collaboratively in order to increase overall effectiveness.
- A focus on the prevention of further violence could be a key to integrating diverse approaches.

- Collaboration needs to be developed between three levels of goals: alleviating suffering through program delivery, changing the institutions of humanitarian assistance, and preventing conflict and human rights abuses.
- Moving from a pathologizing model to a well-being model needs to be followed by a move toward collaboration and integration of levels of work.

Divergent perspectives were expressed on these issues:

- To what extent, if at all, does the modern 'scientific' approach to humanitarian crises need to be supplanted by a 'postmodern' approach that emphasizes historical, political, and cultural aspects of a post-conflict situation?
- How can the disjuncture between trauma approaches, empowerment strategies, and resilience-focused interventions be transcended?
- To the extent that psychosocial humanitarian assistance has become an "industry" and a "profession," can it be justified?
- Should psychosocial workers shift a large portion of their attention to addressing the geopolitical factors that sustain regional conflicts?

Ethical issues and questions arose in these areas:

- Considerable discomfort exists among experienced practitioners regarding current approaches to humanitarian assistance. New forms of training are necessary and new modes of interface with communities.

## Priorities for Action

In the final phase of the conference, participants were invited to collect their thoughts individually and decide on one key recommendation to share with the group. These recommendations were written on newsheet and posted around the conference room. The participants were then asked to assess the priority of each recommendation by distributing a set number of votes (in the form of self-adhesive dots) among them. The following recommendations emerged as the top priorities for action, each receiving approval from at least two-thirds of the participants:

- Practitioners need to assess their own motives in order to avoid ethnocentrism and imposition on others. They must be actively critical of their own worlds and reflect on their own country's role in the suffering they find elsewhere.
  - Approaches should be based on models of well-being rather than pathology. This implies understanding and mobilizing local resources and sources of resilience.
  - Clinical, community, and human rights approaches need to be more fully integrated. This can begin with the training of 'hybrid' practitioners with interdisciplinary perspectives and collaboration skills.
  - Practitioners need to develop ways to work with groups in conflict to prevent further violence.
- Understandings gained from work with communities affected by ethnopolitical violence should be widely shared and followed by work to change processes in the larger political arena.



## APPENDICES

### Biographical Sketches of Conference Participants and Organizers

**Inger Agger**, Ph.D. is presently working as an international consultant with Nordic Consulting Group, based in her home country, Denmark. Her main research interests focus on healing methods in contexts of political violence, and she has completed post-doctoral research on the Human Rights Movement in Chile. From 1993-97 she worked in the former Yugoslavia as the European Union Coordinator for Psychosocial Projects during and after the war. In recent years, she has carried out consulting missions to Palestine, South Eastern Europe, the Caucasus and Africa.

**Anne Anderson**, MSW, a licensed independent clinical social worker. She has been the National Coordinator of Psychologists for Social Responsibility since 1984 and has also been in private practice since 1974. Her practice interests include feminist psychotherapy, work with seriously emotionally disturbed children, couples, and families. She also serves as part of the International Technical Assistance Group for Christian Children's Fund, focusing on integrating psychosocial perspectives into their ongoing program.

**Ahmad Baker**, Ph.D.: I am professor of psychology at Birzeit University where I served there as Academic Vice President and Dean of the Faculty of Arts. My professional work has centered within the past 15 years on children traumatized by political and military repression. The plight of traumatized women has been a recent professional and research interests.

**Judy Barsalou**, Ph.D., is the director of the Grant Program at the United States Institute of Peace. Previously a program officer at the Jerusalem Fund, Center for Policy Analysis on Palestine, she has over two decades of experience working on and researching Middle East issues. From 1996-99, she served as executive director of the Middle East Research and Information Project, which publishes Middle East Report. Prior to that, from 1992-95, she was director of academic programs at the Institute of Government Affairs, University of California at Davis. From 1982-90, she served as a program officer with the Ford Foundation.

**Deanna Beech**, Ph.D.: I am a private practitioner in Maryland. I worked in Bosnia in 1998 where I evaluated mental health programs for children and conducted training workshops for the local providers who were running the programs. While in Bosnia I also worked for the 'Commission for Real Property,' established under the Dayton Peace Accords to resolve property disputes, where I established an on-going active research methodology that facilitates communication between the refugees and displaced people and the international community regarding the disposition of their property. In 1999 I worked in Montenegro for World Vision International designing and implementing their mental health programs for individuals displaced by the war in Kosovo.

**Jenny Bent**, a Nicaraguan, works with the Miskito communities in Bluefields on the Atlantic Coast of Nicaragua.

**Rony Berger**, a clinical psychologist, is a member of the international faculty of New York University's Trauma Studies Program and a researcher at the Harry Truman Center for the Advancement of Peace at Hebrew University of Jerusalem. He is director of clinical services for Natal, the Israel Trauma Center for Victims of Terror and War, and specializes in dealing with the psychological preparation and aftermath of terrorist attack. He also co-directed a Trauma Center at Al Quds University, Palestine, where he was a Visiting Professor of Psychology and Behavioral Medicine, working with both the Jewish and Arab communities within Israel.

**Patricia Blakeney**, Ph.D., is a clinical psychologist and director of Psychological and Psychiatric Services at Shriners Hospital for Children in Galveston, Texas. In the late 1990s she served as Consultant to the Psychosocial Trauma Recovery Program of Catholic Relief Services in Sarajevo, Bosnia.

Tamara Blanco lives in Caracas, Venezuela. She founded the Department of Well-being at Santa Rosa University. She gives workshops on stress management, violence prevention, sexuality, and empowerment.

**Paul Bolton**, Ph.D.: I live in Scituate, Massachusetts and work for the Center for International Emergency, Disaster, and Refugee Studies at the Johns Hopkins University Bloomberg School of Public Health. My major work is in Africa in the development of field based approaches for assessment of community and individual mental health problems. The purpose of these assessments is to measure need and the impact of interventions. The work grew out of the lack of valid assessment methods for use across cultures and the subsequent lack of evidence for the effectiveness of many interventions currently used for mental health problems in developing countries.

**Eileen Borris**, Ph.D: I am a licensed clinical psychologist, political psychologist and educator/trainer committed to the work of peacebuilding, conflict resolution and reconciliation especially in emerging democracies. I live in Paradise Valley, Arizona. I work with ethnic and regional groups in conflict, working in the framework of multi-track diplomacy. A special interest area is in incorporating forgiveness and reconciliation processes within the broader context of conflict resolution. I founded Peace Initiatives in 1992, which is a non-profit organization that promotes peacemaking and conflict resolution with ethnic and regional groups in conflict. I currently conduct trainings for the Institute for Multi-Track Diplomacy in Washington DC and around the world.

**Jo Boyden**, Ph.D., is a social anthropologist and was trained at the universities of London and Cambridge. For 20 years she worked as a consultant to a range of international and national organizations, specializing in training, research and program and policy development, and is now a senior research officer at the Refugee Studies Centre, University of Oxford. Her research and written work has focused mainly on child labor, children affected by armed conflict and forced migration and the support provided by the aid community to children who are exposed to severe adversity. She has undertaken research on war-affected children in Cambodia, Burma and Sri Lanka. Her most recent work has concentrated on cultural understandings of and approaches to misfortune, patterns of social healing and children's moral and social learning in the context of political violence.

**Phyllis Brazee**, Ed.D.: I have been a progressive educator for 30 years, and am currently the director of the Peace Studies Program at the University of Maine. The program is built on the concept that the human community needs to build a culture of peace from the personal to the international. Within my program, I teach a web-based course on forgiveness and peace.

**Manuel Carballo** is a citizen of Gibraltar. He is Executive Director of the International Centre for Migration and Health (ICMH). Among its many programs, the ICMH developed a training program on reproductive health in crisis situations and is now developing training materials on HIV/AIDS prevention. He is a Professor of Clinical Public Health at Columbia University where he is responsible for psychosocial health in the Forced Migration Program. He went to Bosnia in 1993 and remained until 1995 as the WHO Public Health Advisor.

**Claudia Carrillo** is a clinical psychologist who since 1999 has been working in Psychosocial Support in Disasters and the Department of Planning and Preparation for Disasters of the American Red Cross in Venezuela. She is currently conducting research at the Universidad Central de Venezuela on training teachers to provide psychological first aid in disasters.

**Alexander Cheryomuhkin**, M.S., clinical psychologist, is the founder of the first psychological association in Azerbaijan (APA), vice-president and director of the international department and board member of the Institute for International Connections For Personal and Cultural Growth (USA). He has coordinated various projects in the area of psycho-social rehabilitation and psychotherapy, including the first training course on working with trauma in refugee communities, families and individuals. He also coordinated the Surviving Trauma With Dignity International Conference held in Baku, July 5-19, 2002. This was the first international event where experts from 11 countries discussed work with trauma and planned joint rehabilitation projects for refugees, women and other vulnerable groups.

**Joan Condon**: I am co-director and International Coordinator of Capacitar Incorporated located in Watsonville, CA. I am the former executive director of International Medical Relief Fund. Capacitar works nationally and internationally with people who suffer from trauma.

**Thida Chak**, M.D.: After graduating from medical school, I worked in Phnom-Penh at the health center as a chief. At that, I worked at the clinic and in the community (serving about 40,000 people in five districts.) From 1997-1998, I was a chief of the Psychosocial Rehabilitation Center, again in Phnom-Penh. I worked with the social services component, which conducts home visits and follow-up care of patients in the community. In 1998, I was recruited for a three-year psychiatric residency. During my training, I worked with mentally ill patients as part of a mobile team unit working in the provinces and also at the Psychosocial Rehabilitation Center. I also worked for one month with the Child Trauma Project at the Khmer-Thai border. After becoming a psychiatrist, I returned to the Phnom-Penh Municipal Health Department, serving as a chief of the Psychiatric OPD of the Referral Hospital and as supervisor of the Psychosocial Rehabilitation Center.

**Dinka Corkalo**, Ph.D., is an assistant professor at the Department of Psychology, University of Zagreb, Croatia. She teaches experimental psychology and psychology of persuasion and propaganda. Participated and evaluated several programs of psychosocial assistance for refugees and other victims of war in Croatia. Director or co-director of research programs on ethnic identity and political culture. Research interests in social reconstruction of war-torn communities and reconciliation among conflicting ethnic groups. Expertise in minority rights issues and ethnic identity.

**Daniel Creson** is Clinical Professor at the University of Texas-Houston Health Science Center. He holds an MD and a PhD in anthropology and has worked for thirty years in psychosocial rehabilitation in communities affected by complex emergencies.

**Lynne Cripe** currently serves as a Regional Technical Advisor for the Displaced Children and Orphans Fund (DCOF) and Leahy War Victims Fund (LWVF) of the U.S. Agency for International Development. She is based in Nairobi, Kenya. Between 1997-2000 she worked on USAID's Greater Horn of Africa Initiative, the goal of which was to strengthen African capacity to prevent and mitigate conflict and enhance food security. She has also lived and worked in the Philippines.

**Leila Dane**, Ph.D., recently celebrated her 15th year as director of IVT, a small NGO based in McLean, VA that organizes activities in support of victims of political violence, and runs a hotline. A change agent par excellence (also clinical psychologist), she pressured the US government in the 1970's to make mental health services available to families abroad. When finally credentialed in the mid 80's she joined the World Federation for Mental Health and drafted a resolution for mental health services for victims of community violence (now policy) where she mandated that the task of every mental health professional is to promote the concepts of conflict resolution at every opportunity. She has been President of APA Division 48 (Peace Psychology).

**Marie de la Soudiere** has participated in and written papers for numerous international workshops and conferences on psychosocial care and protection of refugee and other children in especially difficult circumstances. She is the author of a monograph on child labor in Pakistan "Discover the Working Child", and a children's story book, "Les Ailes de Nidi," intended to help Rwandan unaccompanied children overcome their loss. She has consulted for UNHCR on several occasions and has worked many years with UNICEF.

Fourteen years ago, when in the Philippines with her husband who worked for UNHCR, she also created a wholly self-supporting NGO for the prevention of street children which focused on economic and social uplifting of destitute families in the squatters areas of Manila. This NGO manufactures and exports fine garments, which Ms. de la Soudiere also designs.

**Gordon Dodge**, Ph.D., is the clinical director for Lakes Area Human Services, Inc., Forest Lake, Minnesota. He has over 35 years experience as a psychologist in clinical, consultative, and educational services. He also heads up the Trauma Division of his agency which addresses workplace and community crises and trauma. As a disaster psychologist, he has extensive experience working with private industry, emergency services personnel, and other public agencies on a local, national and international basis. He has had several assignments in the former Yugoslavia during their war, Kosovo, Albania, the Gujarat earthquake in India, the KAL crash in Guam, two trips to Nairobi in follow-up to the embassy bomb blast, an Oklahoma city hotline, several natural disaster responses in the U.S. for the American Red Cross, serves on the AIR team, and was assigned to New York following the World Trade Center attack. He has written and lectured, and provided training extensively on many aspects of trauma and disaster psychology.

**John Ehrenreich**: I am Professor of Psychology and Director of the Center for Psychology and Society at the State University of New York, College at Old Westbury. I wrote "Coping With Disasters: A Guidebook to Psychosocial Intervention" (on the Internet at <http://www.mhwwb.org/disasters.htm>). More recently I've completed a handbook and bibliography on managing stress and vicarious traumatization in humanitarian aid workers, human rights workers and others working on a daily basis with traumatized populations.

**Peter Elsass**, D.M.Sc., is professor of clinical psychology at the University of Copenhagen, Denmark. For 25 years, he has been working with Indian populations in Colombia and Venezuela. Among other things he has doing research of the process and outcome of psychotherapeutic treatment of torture survivors and done psychosocial work in Kosova, and India (Tibetan refugees). He is author of *Strategies for survival. The psychology of cultural resilience in ethnic minorities and Treating victims of torture and violence. Theoretical, cross-cultural and clinical implications.*

**Carola Eyber**, Ph.D.: I am currently working at the Refugee Studies Centre at the University of Oxford, conducting research on psychosocial approaches to assisting war-affected populations. I have worked with refugees for a number of years in South Africa and Angola and have a special interest in working with young people. Recently I completed my PhD thesis on cultural and spiritual healing approaches in Angola.

**Aranca Garcia**, lives in Philadelphia and has worked for the Solomon Asch Center for the study of ethno-political conflict (Director of Refugees Initiatives) since January 2002. She has worked teaching sociology at the University of Salamanca (Spain), and on Refugee Psycho-Social programs at several Humanitarian Aid and Development programs. She has applied experience working with refugee and displaced (psychosocial and human rights as well as regular development infrastructure projects) in the Balkans and Algeria, with several NGOs.

**Amber Gray**, Ph.D., lives in Denver, Colorado, where she is Clinical Director of the Rocky Mountain Survivors Center, a treatment center for survivors of war trauma and torture. Past work experience includes public health and international relief and development work (Peace Corps, Care, American Refugee Committee, Gay Men's Health Crisis) and nine years in private practice in bodywork and movement reeducation for survivors of trauma. Her expertise is in non-verbal,

kinesthetic and creative arts approaches to working with severe trauma, and creating large group and community experientials and interventions for adult and child survivors. She has worked in Haiti, Rwanda, Kosovo, and presents her work nationally and internationally.

**Jon Hubbard** is the Director of Research and a psychotherapist at the Center for Victims of Torture in Minneapolis, Minnesota. He received his Ph.D. in Developmental and Clinical Psychology from the University of Minnesota. He has conducted research on the long-term consequences of exposure to torture and massive trauma in cross-cultural populations for over a decade. His research includes developing measures for studying the impact of torture and war trauma on survivors with a particular focus on how these traumatic events affect functional adaptation (e.g., spiritual, social, academic or job functioning). He has also been developing assessment techniques and program evaluation methods and procedures that work across diverse cultures and contexts.

**Davidson O. Jonah**: I live in Sierra Leone and have worked there for Christian Children's Fund for the past 17 years. I have also visited many other CCF countries with situation that relates to the theme of this conference. I am a member of CCF's emergency task Group (EMTAG) and The Technical Assistance Group for Psychosocial (TAG) Force and Psychosocial working Group. My work as Country Director in Sierra Leone involves planning and implementing programs for post war communities. I have worked in The Gambia where I helped to set up emergency psychosocial programs for refugee children and also trained Gambia security personnel going on peacekeeping missions in Sierra Leone and East Timor. I was also involved in the review of programs for Kosova. I set up the Christian Children's Fund Office in Conakry Guinea during the influx of Sierra Leone Refugees and also planned and implemented Cross Border operations between Guinea and Sierra Leone.

**Buti Kale** is Senior Protection (Legal) Officer for UNHCR in Ottawa, Canada. He has served 10 years as Legal Officer for UNHCR. Facilitator for UN course on Early Warning and Preventive Measures. Prior to joining UNHCR, he spent several years teaching (France); as a banker in South Africa and human rights activist.

**Nila Kapor-Stanulovic, Ph.D.:** I live in Novi Sad, Yugoslavia where I work as professor of Human Development and Mental Health at the University of Novi Sad. In addition to my teaching activities, I have been deeply involved in design and implementation of psychosocial programs (including training) for victims of armed conflicts that took place in the countries of ex-Yugoslavia and ex-Soviet Union. I worked for UNICEF, UNHCR and many other international organizations.

**Rose Kasina:** I work at Amani Crisis Mental Health Programme established after the US Embassy bombing in Nairobi Kenya on 8th August 1998. I serve as counseling coordinator and at times act as the program manager. My program worked extensively on economic, political and cultural aspects of assessment and treatment.

**Julie Levitt, Ph.D.:** I live outside of Philadelphia. I am a clinical psychologist who works with individuals, couples, families and children. A focus has been on trauma and chronic disease in both children and adults. Prior to my private practice work, I received training and worked at the Philadelphia Child Guidance Center where I taught, supervised, and ran the services for families experiencing abuse. More recently, I was a clinical associate at the Penn Council for Relationships, University of Pennsylvania School of Medicine, Division of Family Studies, where I trained graduate level students in the areas of individual, couples and family therapy. My work in trauma includes an in-depth interview study of Holocaust survivors, their children, and grandchildren, looking at resilience and coping.

**Stuart Lustig, M.D.:** I am a child and adolescent psychiatrist at Boston University Medical Center. I am also affiliated with Children's Hospital of Boston and Harvard medical School. My work includes a mix of psychiatric care (medication management and psychotherapy), school consultation, teaching, administration, and research focused on treatments for traumatic stress. My main research interest is adapting testimonial psychotherapy for adolescent refugees. I also participate in the Physicians for Human Rights Asylum Network, assisting attorneys who represent asylum seekers.

**M. Brinton Lykes, Ph.D.:** I am a Professor of Community/Social Psychology at the Lynch School of Education at Boston College/USA. From 1999-2001, I was Chair of Psychology at the University of the Witwatersrand in Johannesburg, South Africa. I am an activist scholar and teacher and have lived and worked among women and child survivors of state-sponsored violence and war and their wake in rural Guatemala since 1987. My research explores the interstices of indigenous cultural beliefs and practices and those of Western psychology, towards creating community-based responses to the effects of war and state-sponsored violence. One example of this work is a recent photo-text that I co-authored, with the Association of Maya Ixil Women – New Dawn, *Voces e imágenes: Mujeres Mayas Ixiles de Chajul/ Voices and images: Maya Ixil women of Chajul.*

**Ketso Moorosi Mabusela** is a clinical forensic psychologist and senior lecturer at the Medical University of Southern Africa. She has worked with children and adults with mental illness and with people living with HIV/AIDS and suffering post-traumatic stress disorders.

**Heather MacLeod** is International Child Protection Coordinator for World Vision International. She develops training materials and conducts programs for World Vision's leadership, country directors and staff around the world. She collaborates with national offices, government agencies and

non-governmental organizations on issues related to child abuse and exploitation and children's rights. Her work has taken her to Sierra Leone, Burundi, Somalia, Rwanda, Tanzania, Ghana, northern Uganda, southern Sudan, Albania and Kosovo. Programs include the reintegration of child soldiers, community-based support to child-headed households, children and institutions, aid for separated children and psychosocial support groups geared toward children. She earned a diploma in nursing from Christchurch Technical Institute in New Zealand and has done post-graduate studies at Massey University.

**David Ndetei**, M.D., lives in the outskirts of Nairobi. He works at the University of Nairobi where he holds the Chair of Psychiatry. He was involved in the Training of Trainers on psychotrauma following the genocide in Rwanda. He trained 500 psychotrauma counselors following the terrorist attack at the Nairobi American Embassy and has since then played a key role in the mental health program of the survivors where he is an implementing partner.

**John Parsley**: I live in Fayetteville, NC (just outside Fort Bragg). This is my first job as a psychologist since completing graduate school and internship. I have worked in the Army before and have lived in Japan and Korea. I have also been on two peacekeeping missions to Bosnia, one in 1997 as a Civil Affairs Officer and one this past year as a Psychologist.

**Laurie Pearlman** lives in Holyoke, Massachusetts. She is co-director of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC and president of the Trauma Research, Education, and Training Institute, Inc. in South Windsor, CT. For the past four years, she has collaborated with Ervin Staub to provide trauma education for community workers, leaders, and journalists in Rwanda.

**Lin Piwowarczyk**: I am the Co-Director of the Boston Center for Refugee Health and Human Rights in Boston, Mass. USA. We are a collaboration of the clinical departments of Boston Medical Center, and the Boston University Schools of Medicine, Public Health, Law, and Dentistry. We provide direct services to refugees, asylum seekers, and asylees from over 40 countries - over 90% are torture survivors or their families. I have worked in Haiti and Cambodia, and lived through martial law in Poland.

**Marion Pratt**: I am the Social Science Advisor for the Office of Foreign Disaster Assistance at the U.S. Agency for International Development, based in Washington, D.C. Most of my fieldwork has been in Africa (North, Southern, East, and West), but also in Southeast Asia and Eastern Europe. Part of my job as a social science advisor is to inform my colleagues and our implementing partners on the growing importance of addressing psycho-social issues in disaster and post-disaster settings.

**Raija Leena Punamäki**, Ph.D., is a professor of Psychology in University of Tampere, Finland. She also works as an international partner of the Gaza Community Mental Health Programme, Research Department. Her main interests are in the developmental psychology, especially the Issues of recovery of traumatic experiences, family dynamics and resiliency. Her expertise of Mental health interventions among war-traumatized populations involve active participation in the Projects of the Finnish Psychologists for Social Responsibility, and lecturing and supervising colleagues in Palestine and Kurdistan.

**Gil Reyes**, Ph.D., is an assistant professor of clinical psychology at the Disaster Mental Health Institute, University of South Dakota. He contributed to the development of the "WHO tool for the Rapid Assessment of Mental Health Needs of Refugees and Displaced Populations and Resources, in

Conflict and Post-Conflict Situations.” Dr. Reyes is presently reviewing the empirical literature on refugee mental health for a meta-analysis.

**Marc Sageman**, M.D.: I am a practicing clinical and forensic psychiatrist, who teaches at the University of Pennsylvania. I am also a former U.S. diplomat, who dealt with Afghan refugees in the late 1980's. I am very interested in the history and cross cultural manifestations of traumatic disorders and am in the process of writing a book on the history of the concept of emotional trauma.

**Ann Sanson**, Ph.D.: I live in Melbourne, Australia. I am currently Deputy Director at the Australian Institute of Family Studies (AIFS), having taken leave from the Dept of Psychology at the University of Melbourne. My work is around children's development in their family, community and cultural contexts, as well as various aspects of peace psychology. I've acted as a consultant for CCF, particularly in East Timor. At AIFS, I'm project director for a new large longitudinal study of Australian children, and helping with the Stronger Families Learning Exchange, which is supporting a number of community-based projects, many in remote Aboriginal communities.

**Tod Sloan**, Ph.D.: Formerly professor and chair of psychology at the University of Tulsa in Oklahoma, he now serves as co-coordinator of Psychologists for Social Responsibility. He is the author of *Damaged Life: The Crisis of the Modern Psyche* and co-editor of *Psychology for the Third World (Journal of Social Issues 1990)*. He has held Fulbright teaching and research grants in Venezuela and Nicaragua, and specializes in issues in international critical psychology, in particular, the psychosocial impact of modernization and globalization.

**Ervin Staub**, Ph.D., is a Professor of Psychology at the University of Massachusetts at Amherst. Since the early

1980s, he has been studying the origins of human destructiveness. His book, *The Roots of Evil: The Origins of Genocide and Other Group Violence*, develops a conceptualization of the origins of genocide and mass killing that is applied to four Twentieth Century holocausts. As part of his research, he also has examined the origins of youth and mob violence. His recent work in Rwanda has been on projects promoting healing, forgiveness, and reconciliation.

**Nora Sveaass**, D. psychol., is a specialist in clinical psychology, chief psychologist at the Psychosocial Centre for Refugees at the University of Oslo. This is a centre of excellence for psychosocial work with traumatized refugees living in Norway, with objectives regarding training and supervision for health personnel, and finally, research and developmental work. Nora Sveaass has been affiliated to the centre since 1987. Her Ph.D. thesis is entitled *Restructuring meaning after uprooting and violence. Psychosocial interventions in refugee receiving and post-conflict societies*, and is based on clinical work in Norway and on an interview study in Central America. Sveaass has specialized in family therapy with refugee families. She is research coordinator for a collaborate research project in Nicaragua on psychosocial consequences of organized violence and forced migration. She was elected Secretary General of the International Society for Health and Human Rights in December 1998. She is chairperson of the Human Rights Committee in the Norwegian Psychological Association.

**Mike Wessells** lives in Ashland, Virginia and serves as Psychosocial Advisor for Christian Children's Fund and as Professor of Psychology at Randolph-Macon College. Worldwide, he works in zones of armed conflict in developing, supporting, and evaluating community-based psychosocial assistance for war-affected children and families. He has special interest in interweaving indigenous and Western approaches and in improved impact analysis and documentation.



## **Survey for Directors and Field Workers in Mental Health and Psycho-Social Programs in Areas of Ethno-Political Conflict**

The purpose of this survey is to gather information on the current state of humanitarian assistance programs related to mental health and psychosocial well-being. The survey is intended for professionals who have worked or are currently working in areas affected by ethno-political conflict.

The findings of this survey will be used to inform those who design, implement, monitor, and evaluate psychosocial assistance programs. In particular, a summary of the survey responses will be utilized at a conference sponsored by Psychologists for Social Responsibility (PsySR) during July 2002 on integrating approaches to psychosocial humanitarian assistance in areas affected by ethno-political conflict. For more information on PsySR, go to [www.psysr.org](http://www.psysr.org). Later in 2002, a book-length report on the results of the conference and responses from leading researchers, planners, and practitioners will be published. In appreciation for your help with this survey, we will send you a copy of the report and a summary of the survey results. To receive these items, please send your mailing address in a separate e-mail message to [psysr2@aol.com](mailto:psysr2@aol.com). Please inform colleagues about the opportunity to participate in this survey and receive these materials by forwarding this website address to them.

If you respond to this survey, you are indicating that you are aware of and agree to the following:

The information you provide will be compiled and summarized in a manner that maintains the anonymity and confidentiality of your responses. You may choose not to respond to some or all questions. The website on which your responses to this survey are being collected is set up in a manner that makes it impossible for us to link your responses here to your identity or organization.

Thank you in advance for your assistance with this important project.

INSTRUCTIONS: Please type your responses directly into the boxes below the questions. After each question, click on the 'submit' button. This will save your response and open up a window with the next question. It is probably not necessary to take more than a minute or two for each question. To help us summarize your information accurately and compare it with other responses, please be as specific as possible. It is not necessary to provide details that would allow recognition of your organization. Please respond to these questions with reference to your most recent major work experience in an area affected by ethno-political conflict.

1. With what type of psychosocial program are you associated? For example, mental health outreach program, community organizing, inpatient clinic.
2. Where (country, region) is your program located? Is this primarily a rural or urban area?
3. What are the primary types of assistance or intervention offered by your program? Examples: psychotherapy, group discussion, material needs, etc.
4. What is your role in this program? Examples: Director, clinical service provider, trainer, evaluator, etc.
5. How long have you been working in this role? How long have you been working in the field of humanitarian psychosocial assistance?
6. What academic degrees do you hold? Apart from your general professional training, what sorts of training have you received specifically for psychosocial humanitarian assistance?
7. What is your country of origin and ethnicity?
8. What sectors (age, gender, ethnicity) of the population does your program aim to serve?
9. How did you assess or learn about the needs of this population?
10. What, if any, formal assessment tools (questionnaires, instruments, interviews) did you use? In your view, how well are these tools working?

11. Briefly describe the general physical and mental health status of the population when you began working there.
12. What were the most common problems and/or symptoms among the population you were serving?
13. How did you create or choose the model/program being implemented? If you chose a pre-designed model, what model and/or what parts of other programs were incorporated? If you created your program, on what existing theoretical or practical models did you base your program?
14. What are the goals or objectives of the program? Please be as specific as possible.
15. How did you assess the cultural appropriateness of the program/model that you are using in relation to the specific community that you are working with? Briefly, what sorts of issues arise in your work because of cultural differences?
16. How do you assess the effectiveness of the program and its impact on the community you are serving?
17. In what ways has the program been modified since it was first implemented?
18. How have your ideas or philosophies regarding how to work with communities affected by ethno-political conflict changed as a result of your experiences? What do you do or plan to do differently in light of these changes in your thinking?
19. What sort of psychosocial support does your organization provide for its workers?
20. Please use this space to share any other important concerns you may have about the field of psychosocial humanitarian assistance.

# Conference Schedule

## University of Maine at Orono

### Friday, July 26

8:00 - 8:50 am	Breakfast
9:00 - 9:50 am	Opening Session
10:00 - 10:50 am	Small Groups: Introductions
11:00 - 11:30 am	Large Group: Assessment and Planning
11:30 - 11:45 am	Break
11:45 - 1:00 pm	Small Groups: Assessment and Planning
1:00 - 2:15 pm	Lunch
2:15 - 3:15 pm	Large Group: Reports from Small Groups
3:15 - 3:30 pm	Break
3:30 - 4:00 pm	Large Group: Implementation and Intervention
4:00 - 4:15 pm	Break
4:15 - 5:30 pm	Small Group: Implementation and Intervention
7:00	Reception followed by Dinner

11:00 - 12:15 pm	Small Groups: Monitoring and Evaluation
12:15 - 1:30 pm	Lunch
1:30 - 2:30 pm	Large Group: Reports from Small Groups
2:30 - 2:45 pm	Break
2:45 - 3:15 pm	Large Group: Integration and Collaboration
3:15 - 3:30 pm	Break
3:30 - 4:45 pm	Small Groups: Integration and Collaboration
4:45 - 5:00 pm	Break
5:00 - 6:00 pm	Large Group: Reports from Small Groups
7:00 pm	Reception followed by a Lobster Banquet

### Saturday, July 27

8:00 - 8:45 am	Breakfast
8:45 - 9:00 am	Orientation to the Day
9:00 - 10:00 am	Large Group: Reports from Small Group
10:00 - 10:15 am	Break
10:15 - 10:45 am	Large Group: Monitoring and Evaluation
10:45 - 11:00 am	Break

### Sunday, July 28

7:00 - 7:45 am	Breakfast
7:45 - 8:00 am	Orientation to the Morning's Work
8:00 - 9:15 am	Large Group: Setting Priorities
9:15 - 9:30 am	Break
9:30 - 10:30 am	Small Groups: Final Thoughts
10:30 - 11:00 am	Evaluation
11:00 - 11:15 am	Break
11:15 - 12:00 am	Large Group: Closing (Going Forward)
12:00	Lunch

