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TRAUMA, RESILIENCE AND CULTURAL HEALING: HOW DO WE MOVE FORWARD?

With contributions from: Napoleon Adok; Jiovani Arias; Lucia Castelli; Lucie Cluver; Chris Coulter; Myriam Denov; Nick Heeren; Elizabeth Jareg; Diane Lukeman; Orlee Oudwin; Malia Robinson; Patrick Smith; Mike Wessells

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INTRODUCTION

In our April, 2006, edition of the psychosocial webpage we printed two papers which, at first sight, appeared to take conflicting approaches to psychosocial interventions with children affected by war: 'Let us light a new fire' by Alcinda Honwana (1998), and 'Is the culture always right?' (Dyregrov et al 2002).

When it first appeared in 1998, Honwana's paper represented a challenge to any who assumed that western bio-medical models of illness, and approaches to psychological well being (such as those employed in the psychiatric diagnosis and treatment of trauma), were universally appropriate. A central assertion of Alcinda Honwana's paper is that 'ill-health' is a social construction with its meaning and management shaped by social and cultural understanding. Honwana illustrates how, within Angolan society, ill-health is seen as having both a physical and social dimension, with both the living and the spiritual world playing a role in its causation and healing. Consequently, treatment, which takes place via familial and community rituals, incorporates both political and social elements. This approach is holistic, firstly because it aims to treat the person as a whole, and secondly because it regards the 'patient' primarily as a social being embedded within a familial and cultural structure. Traditional treatment, therefore, necessarily transcends the individual to encompass the collective body. Honwana sought increased recognition of the importance of local healing approaches which combine physical, social, political and religious elements to foster both individual and community well-being. Such recognition was to exert a major influence on some INGO psycho-social interventions in post-conflict non-western societies (see, e.g., Robinson, 2005)

The Coalition to Stop the Use of Child Soldiers unites national, regional and international organisations and Coalitions in Africa, Asia, Europe, Latin America and the Middle East. Its Steering Committee member organizations are Amnesty International, Defence for Children International, Human Rights Watch, International Federation Terre des Hommes, International Save the Children Alliance, Jesuit Refugee Service, and the Quaker United Nations Office-Geneva.

In contrast, Dyregrov and colleagues (2002), based on their clinical and research experiences in Rwanda and other war torn countries, asked readers to consider whether our inability to prevent war time atrocities and massacres has resulted, within the international community, in a collective denial of child trauma. Such denial, they suggest, can result in an undue emphasis on the healing achieved by local cultural healing systems and the natural resilience of children. In this way, we can avoid accepting our responsibility for the collective traumatization of children and its potential long term consequences.

Given the passage of time since both papers were originally published, we were interested in whether, and how, the field has moved on since then. Consequently, we sent both papers to a number of experts in the field of psychosocial interventions in war affected societies, requesting their comments. Our intention was to promote a dialogue on psychosocial interventions with children affected by armed conflict. In particular, we were interested in what might still be regarded as of value in the ideas put forward by the authors; what were the key issues which still needed to be addressed in this field?, and how the field might be moved forward.

The responses we received were diverse, reflecting differing professional backgrounds, theoretical positions and experiences in the field. Some respondents fixed their minds specifically on issues raised by the two papers, whilst others ranged more broadly in their responses, covering wider issues raised by their experiences in the field. Responses came in the form of telephone conversations, brief emails containing key points, and some lengthy and considered responses worthy of publication in their own right. Our thanks go to these very busy field practitioners who, in spite of their very heavy workloads, took time out to respond.

It is not possible to present all of these responses on our page, but in order to share this dialogue with our readers in a coherent way, we have summarised its main points under a series of relevant headings: *The nature of the current debate; Recognising and responding to child trauma; The importance of cultural concepts of well being; What form should psychosocial interventions take?, and Assessing the evidence.* In addition, we present in full the contributions by Mike Wessells (2007) *Trauma, culture and community: Getting beyond dichotomies,* and Myriam Denov (2007) *Is the culture always right? The dangers of reproducing gender stereotypes and inequalities*. Though referred to within this paper, these two responses are also posted separately on our website (www.child-soldiers.org/resources/psychosocial).

THE NATURE OF THE CURRENT DEBATE

Respondents were quick to point out that, in spite of their differences, the two papers had much in common – for example, both agree that where western knowledge and practices are applicable, they should be used to complement, rather than replace, established social and cultural healing mechanisms (e.g. Jiovani Arias; Lucia Castelli; Diane Lukeman; Mike Wessells, 2007). Respondents show less consensus on whether some of the published debate around the validity of the concept of post-traumatic stress disorder (PTSD)[1], and trauma focussed interventions, is now

[1] The term PTSD is used to describe the psychological and physical problems which can sometimes follow particular threatening or distressing events. These can include: repeated and intrusive memories of the distressing event(s); the experience of 'flashbacks' or nightmares; physical reactions such as sweating/shaking; avoidance of reminders of the distressing event(s); sleeping and/or concentration difficulties. For a fuller description of PTSD, and recommended guidelines for treatment responses, see Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children. National Institute for Clinical Excellence: http://www.nice.org.uk/pdf/CG026publicinfo.pdf

somewhat dated. As Patrick Smith reminds us "the constructionist/empiricist debate about PTSD has a long history"; while Malia Robinson comments that in contrast to the primacy once given in psychosocial work to psychological interventions for trauma, interventions today have moved to a position where "current UNICEF 'good practice' guidelines for psychosocial care and support do not advocate trauma healing as a starting point". So, is the debate still relevant, and what can we gain from discussing this area further?

The experiences of Mike Wessells suggest that the debate does remain relevant in terms of practice in the field. He notes that the two papers highlight "the considerable variation in approaches that characterize the field of psychosocial assistance for former child soldiers and other war-affected children" (Wessells, 2007, p1). One effect of this, Mike suggests, is that some donors will fund approaches focusing on trauma and related clinical issues, whilst others choose to fund wider ranging psychosocial programs which address issues such as family separation, stigmatization, loss of livelihoods and so forth. "Unfortunately, there is a tendency to dichotomize these approaches, as if an either-or choice had to be made" (Wessells, 2007, p1).

So it can be seen that while the debate at a theoretical level is of long standing, and while some INGOs have changed their psychosocial practice as a consequence of that debate, within the field both variations in practice and dichotomous thinking still persist. Against this background, therefore, what comments did our experts offer?

RECOGNISING AND RESPONDING TO CHILD TRAUMA

Children and trauma: Responses to the issues surrounding the recognition and diagnosis of trauma in children show some consensus. There is a general agreement that children can indeed be traumatized by their experiences of armed conflict; that biological symptoms of child trauma, such as arousal and disassociation, are common across different cultures and that children's distress should be recognised (e.g. Jiovani Arias; Elizabeth Jareg; Orlee Oudwin; Patrick Smith). For example, Patrick and Orlee point out that child post traumatic stress disorder (PTSD) has been documented and studied in a variety of cultures such as those found in Europe, central and southeast Asia and the Middle East. There is agreement, too, that as both Dyregrov and Honwana suggest, the cultural context will influence both how such stress/trauma reactions are expressed, and indeed how they will be interpreted (e.g. Jiovani Arias; Elizabeth Jareg; Patrick Smith). That is, the meaning of the symptoms to the child, their family and their community, will be influenced by cultural beliefs and attitudes.

Nonetheless, some concerns remain which centre around the limitations and drawbacks associated with the application of western diagnostic systems in non-western cultures. Additionally, some respondents register concern about the effects of psychiatric diagnoses upon children and their families. They point out that some expressions of child distress, which are subsumed under the heading of PTSD, represent normal physical, emotional and behavioural responses to extreme stress or trauma (Malia Robinson). Describing these responses as a psychiatric condition can result in the stigmatization and labelling of children and their families in a way which is not particularly helpful to them (Elizabeth Jareg; Malia Robinson).

Elizabeth Jareg raises two particular issues on diagnostic labelling. The first relates to how PTSD is presented to, and understood by, local communities. Elizabeth points out that when children receive a diagnosis of PTSD, their families will, in effect, be on the receiving end of *two conflicting messages*. The first message, which is inherent in any psychiatric diagnosis, is that the recipient is suffering from a mental health difficulty. This is a serious matter in some Ugandan communities where being regarded as 'mad' may well result in stigmatization and social exclusion. The second message stems from standard psychological approaches to intervention in PTSD. An essential first step in therapy with affected individuals is to reassure them that their 'psychiatric' symptoms, which can be frightening and 'crazy' both to themselves and those around them, are actually a perfectly *normal* response to extreme stress or trauma. Given these conflicting messages, Elizabeth suggests that in practice the social and psychological consequences for any child diagnosed with PTSD, may well depend on which of the two messages is accorded the most weight by their family and their community. Thus, the implications of making such a diagnosis need to be considered in the light of the local context.

Elizabeth's second point is that too much of the debate around PTSD has been concerned with *symptomatology* and its expression in different cultures. She reminds us that it is important to bear in mind that it is not just the expression of distress which varies across cultural contexts, but also *its effects.* The latter may be far more serious in poverty stricken post-conflict situations. In northern Uganda, for example, the consequences of trauma can be severe – affected children can drop out of school (with major consequences for their development and economic future), and infants may starve if traumatized mothers cannot breastfeed them.

Dyregrov et al remind us that trauma can provoke not just PTSD, but a variety of emotional and behavioural reactions in children. This contribution to the increase in our understanding of the effects of trauma upon children is generally welcomed by our respondents. Some point out, however, that focussing solely upon psychiatric symptomatology may limit our understanding of the wider impact of trauma. Thus, Wessells (2007), alerts us to the possibility of failing to recognise the extensive emotional distress and consequent suffering which occurs in post-conflict communities, but which does not reach the level of clinical disturbance. His concern is echoed by Jiovani Arias who draws upon his experiences in Colombia to suggest that socio-political acts of violence can have disorienting emotional effects which are wide ranging and affect not only the individual, but also the community and, indeed, groups of communities. These kinds of responses, while profound and far reaching in their effects upon all aspects of community daily life, cannot be captured by psychiatric diagnoses.

Resilience and the denial of child trauma: Is there a denial of child trauma which takes the form of an emphasis upon children's natural resilience as suggested by Dyregrov and colleagues? Responses to this issue take two forms. Some concern themselves directly with whether there is indeed a 'denial' of child distress by national and international agencies, while others explore which factors facilitate child resilience or well-being, particularly in relation to child soldiers.

There is some agreement with the *general idea* that institutions and groups can operate a collective 'denial' of realities they find unacceptable. Nick Heeren for example, in his previously published discussion of social attitudes towards disability in Sierra Leone, illustrates how collective denial of painful realities can operate in post-conflict situations (see Heeren, 2006). Jiovani Arias, too, thought that

Dyregrov's perspective resonated with his experiences of societal responses to ex-child soldiers seeking to return to normal life after participation in the prolonged and deteriorating armed conflict in Colombia. There was, not however, a great deal of acceptance of the idea that child trauma was being denied. Nick Heeren points to the work of organisations such as Handicap International (HI), which run intervention programs specifically for affected children, whether as aggressors or victims of violence. Nick goes a step further in suggesting that not only is it important to recognise and respond to today's traumatized children, but that we also need to recognise the potential intergenerational transmission of the effects of trauma. Such an effect is illustrated by case study reports on the trans-generational effects of trauma upon the children of Jewish survivors of Nazi concentration camps (see, e.g., Barocas & Barocas, 1989). For Nick, therefore, the challenge is not so much our failure to recognise trauma, but how adequate funding can be raised for appropriate interventions with affected children (see also Jareg's point on funding below).

Certainly, not all affected children get the help which they need. Elizabeth Jareg suggests several factors which may be relevant. First, in her experience, what is missing from most cultures is the notion that children can remember, articulate and ascribe meaning to their experiences. In the absence of such understanding, adults may not enquire about children's distress, nor believe that children can talk about matters which trouble them. Secondly, a failure to help children can stem not from a denial of their distress, but from practicalities on the ground. For example, affected children may not easily be physically accessible, or it may be difficult to find local partners to work with when wanting to set up community based interventions. Further, while donors may provide financial resources for 'crisis' or short-term interventions, sustained resources which would allow needed longer term interventions are extremely difficult to come by. Diane Lukeman believes that where denial of child trauma does exist, what is required is acknowledgement at a national level of what has happened to children in that society. In her view, public acknowledgement of their experiences with perhaps, appropriate commemoration days and memorial sites, could be an integral part of their psychological recovery process.

Nonetheless, even those respondents who do not accept that child trauma is in practice being denied by those on the ground, are in agreement with Dyregrov's central point, namely that we must be vigilant against adopting an undue emphasis on resilience as this carries the risk of overshadowing the serious effects of traumatic events (e.g. Elizabeth Jareg; Malia Robinson).

Other respondents discuss which factors influence child resilience, particularly in relation to child soldiers. There are a number of studies which demonstrate that many child soldiers are traumatized by the events which they have witnessed or participated in (see, e.g. Derluyn, et al 2004). But such traumatization is not inevitable and may be less common than is frequently supposed (see Wessells, 2007), raising questions as to why it is that some children/youth appear less severely affected than others.

Those who have worked with child soldiers, suggest a number of factors which influence the ways in which they respond to trauma. These include: their age and developmental level at the time of recruitment; the manner of their recruitment; their length of time in the armed group and the role they played within that group (Napoleon Adok; Elizabeth Jareg; Mike Wessells, 2007). Jiovani Arias adds that

gender, religious belief and ethnic and cultural factors also have an important role to play.

Elizabeth Jareg asserts that it is not helpful to regard children as either resilient or not. Rather, we need to view resilience as a “mobile capacity” to recover from stress. As such, resilience is not a fixed quality which children do or do not possess, but a capacity to respond positively to adversity if other supportive contextual elements have been/are being experienced. For example, one important factor will be the child’s experience of a caring, supportive adult. From Elizabeth’s perspective, therefore, fostering children’s resilience requires gaining a better understanding of the contextual factors which facilitate this capacity in children living in poor, war torn societies.

Napoleon Adok suggests that if we conceptualise ‘resilience’ broadly as the ability to recover or move on from violent or negative experiences, then the *post conflict context* in which a child soldier finds him/herself becomes very important. That is, those child soldiers who are reintegrated into a supportive context which provides them with opportunities for self-advancement will be more resilient than those who are not. He suggests that those who successfully reintegrate into their communities and who also have educational or economic opportunities available to them, will be more resilient to stress and trauma than those who do not. Given the support of their family and community, and opportunities to better themselves, child soldiers can develop a constructive orientation towards their future rather than their past. In contrast, demobilised child soldiers who find themselves in unsupportive contexts with little chance to improve their educational or economic prospects, will see their former life as a child soldier as more appealing than their current one. For these children/youth whose peer group remains other disenchanted ex-child soldiers, there are fewer opportunities to move forward and thus to deal with their memories or previous experiences in a positive or constructive way. Such youth remain vulnerable to further exploitation and re-recruitment.

THE IMPORTANCE OF CULTURAL CONCEPTS OF WELLBEING

The social construction of well being: Honwana’s emphasis on how our cultural beliefs and understanding shape our constructions of health and well being was seen as important by several respondents. Mike Wessells thinks that Honwana’s ethnographic approach highlights spiritual aspects of psychosocial well being which ‘stand outside the realm of what Western trained psychologists tend to think of” (Wessells, 2007, p4). Nick Heeren, drawing on Handicap International’s work with children disabled as a result of armed conflict, saw an analogy between social constructions of health and the social construction of disability. Both he concludes remain relevant today. To illustrate his point, he suggests that the extent to which a child is handicapped by a given disability is in part determined by local constructions of what it means to be disabled. For instance, if the child with a missing limb is fitted with a prosthetic limb *and* all aspects of the school environment take account of his/her needs, then s/he can attend school and benefit from education. The potentially handicapping effects of the disability have been limited. On the other hand, in societies where disability is regarded as a supernatural punishment upon the mother of the disabled child, a prosthetic limb and physical adaptation of the environment will not be sufficient for that child to become part of his/her community or society. The social construction of *why* the child is disabled can thus result in inclusion, or in social exclusion or rejection.

Jiovani Arias sees analogies between social constructions of health and how, in the context of armed conflicts, individuals or groups construct their own meanings about their identity – for example, about what it means to be a man or a woman, or to be at a given life stage. Social constructions of the self will reflect the social and communal relationships experienced by the individual or group. These constructions give meaning to the individual's experience and influence how they see the world. Such constructions will influence how they conceptualise and interpret violence, and their participation in it.

Clearly then, cultural and social constructions conceptualisations of self and of well-being have important ramifications in people's every day lives.

Traditional healing: The impact of 'traditional healing', particularly upon the well being of child soldiers, was addressed by several respondents. Along with Honwana, they saw existing cultural practices which address the reintegration and acceptance of returning child soldiers as of central importance. Napoleon Adok suggests that we cannot overestimate the importance of community acceptance to the psychological well being of child soldiers within societies where the sense of self is socially defined – i.e. it is determined by an individual's place within the social structure. Within such cultures, being accepted back into that social structure is crucial to sustained psychological wellbeing.

Community acceptance, however, is not always easily attained. It may require child soldiers to accept openly their responsibility for their past deeds. Where this includes participation in atrocities within their own or neighbouring communities, however, the child soldier's fear of stigmatization and rejection can pressurise him/her into remaining silent. The value of traditional healing practices in such situations, Napoleon suggests, is that they can offer child soldiers the opportunity to discuss their experiences without fear of stigmatization, and to enter into a 'safe' dialogue where both victims and perpetrators can talk of their experiences. Such processes offer the hope of receiving understanding and forgiveness. However, where former child soldiers' fears result in them remaining silent, this form of social acceptance is not open to them. Consequently, they may seek instead social acceptance from a peer group more similar to themselves such as other ex-child soldiers. But, such associations further decrease their chances of acceptance and reintegration within the larger community. From Napoleon's perspective, therefore, those child soldiers who cannot use accepted traditional avenues back into their communities are more at risk of continuing psychological distress.

The limitations of an over-emphasis upon culture: Our respondents recognise, therefore, that where traditional healing practices are already embedded within community life, they have the potential to promote a holistic 'healing' which can promote wellbeing by creating forgiveness and fostering reconciliation. At the same time, some remind us that we must take care not to *assume* either their prior existence or their benevolence.

There are, for example, warnings that NGOs can uncritically accept, or romanticize, 'traditional' rites and ceremonies even in situations where such practices have not previously existed as, for example, in some areas of Sierra Leone (Chris Coulter). This can influence funding policy, and several respondents suggest that inhabitants of poor war torn communities understandably soon start to produce the practices and programs which donors are willing to fund. This interplay, Chris suggests, means that local people quickly learn to speak the 'language of rights', while many NGO

personnel are looking only for projects that will lead to the sort of programs their NGO will fund (see also Shepler, 2005). It seems reasonable to ask, therefore, if such programs are not truly grounded in the local culture, how useful will they be in promoting psychosocial healing? Even where traditional practices existed previously, when external funding becomes attached to them, their effectiveness may in the longer term be reduced. As Mike Wessells clearly states, "when local healers receive stipends for services they had previously rendered without pay, the stage is set for undermining potentially valuable local supports" (see Wessells, 2007, p4).

An added complexity is the potential tension between support for traditional practices and the adoption of a 'rights based approach'. This can arise where existing beliefs, rites and practices can either harm participants and/or support existing power structures which do not accord equal rights to all groups – as for example in structures which incorporate gender inequities. An illustration is provided by Chris Coulter drawing on her experiences in post-war Sierra Leone (see also, Coulter, 2006). While there is the possibility that traditional male and female societies could be used successfully to foster the healing and reintegration of war affected children, Chris points out that in Sierra Leone "one needs to be clear that they are also extremely hierarchical and that for girls, circumcision is mandatory". In some contexts, therefore, "supporting certain 'traditional' institutions might only strengthen patrimonialism and gender inequalities in local communities". This point is reinforced by Myriam Denov's contribution (see Denov, 2007) which highlights that traditional cultural practices may accord automatic respect, power, and status to (older) males whilst simultaneously discriminating against women and girls, in both law and in custom, in the realms of social life, education, politics, and economics. Whilst recognising that a culture can buffer its members against stress, Myriam draws on her knowledge of sub-Saharan Africa to illustrate that culture can also perpetuate traditional gender stereotypes and cultural practices which limit the potential of *both* males and females.

WHAT FORM SHOULD PSYCHOSOCIAL INTERVENTIONS TAKE?

Clearly, the issue of which psychosocial intervention is appropriate in any given situation is a complex matter. As Chris Coulter points out, we perhaps need to begin by asking: what is the purpose of psychosocial interventions? Is it to heal the individual, to create forgiveness and reconciliation, and/or to foster the reintegration of war affected children and youth? These questions do in fact reflect the variety of ways in which our respondents addressed this issue, with some focussing on conceptual models and the broader cultural, social and political context (e.g. Napoleon Adok; Jiovani Arias; Mike Wessells, 2007); whilst others addressed issues arising out of psychotherapeutic interventions with traumatized or distressed children/youth (e.g. Elizabeth Jareg; Nick Heeren; Orlee Oudwin; Patrick Smith).

'One size' doesn't fit all: There is general agreement amongst our respondents that there is no single way to respond to the psychosocial needs of children in a post-conflict situation. There is a shared perception that children differ markedly in their needs, and that a plurality of approaches is required (Chris Coulter; Diane Lukeman, Patrick Smith; Mike Wessells, 2007). A thoughtful and detailed exposition of this position comes from Mike Wessells, who suggests a holistic approach which recognises that children differ, for instance, in their reactions to their experiences and situations; their coping resources; their social supports; their life situations and hence, their needs. Mike outlines a model of psychosocial intervention in post-conflict situations which conceptualises psychosocial need as a pyramid. The base

comprises some 50% of the population who are experiencing shock and grief, but whose psychological resilience means that their main requirements are for improvements in their economic, political and social conditions. The next layer comprises some 40% of the population. It includes vulnerable children, such as those with disabilities or survivors of sexual violence, who are more seriously psychologically affected and will become worse without some form of psychosocial support. This group would benefit from community based interventions which offer informal support and work directed at the sources of their vulnerability – for example, child protection for vulnerable children. At the top of the pyramid are approximately 15% of the population who require psychiatric intervention. These divisions between groups are not rigid – children can move between layers according to the supports available to them. In Mike's experience, child soldiers predominantly fall into the middle or bottom layer of this model – but can move into the top layer of very high vulnerability if their needs are not met. The model suggests, therefore, that a variety of types of intervention, which are balanced and co-ordinated across levels, is required (Wessells, 2007).

While the model Mike discusses outlines the need for balanced and co-ordinated services, the reality on the ground may be rather different. As outlined in the introduction, patterns of funding can foster dichotomous, rather than integrated, field practice. This problem is compounded by NGOs working at different levels of the intervention pyramid without co-ordinating activities between themselves. This "often leads to significant gaps in coverage and a lack of proportionality in response to needs at different levels of the pyramid" (Mike Wessells, personal communication). Such difficulties will be exacerbated when a similar lack of coordination is found across the various professional groupings which are providing psychosocial intervention at different levels of the pyramid. It may be that within each level of intervention, coordination groups exist – but there is a lack of communication with other groupings at different levels of intervention. Thus, psychiatrists working with mental health problems and severely affected people on the one hand, and social workers/psychologists providing psychosocial support to 'at risk' groups on the other, may work alongside each other without knowing of the other group's existence. The pressing need for more effective co-ordination, and for appropriate guidance on how to provide an effective emergency response, has been addressed by the Inter Agency Standing Committee (IASC) Task Force on Mental Health and Psychosocial Support in Emergency Settings. This group has recently developed guidelines which will be extensively field tested over the coming year. (For further information, see http://www.humanitarianinfo.org/iasc; then go to 'subsidiary bodies' for the task force report). It is anticipated that the finalized guidance will be available on the site from the end of December, 2006.

Assessing and building upon local resources: Whatever the needs of any given child, several respondents emphasise that before any intervention takes place, it is necessary to assess the extent and type of existing local resources available to support children (Napoleon Adok; Lucia Castelli). Concerns were expressed that if western models of intervention are imposed upon local communities without such an assessment, they can effectively undermine existing capacities to help children (Malia Robinson; Wessells, 2007). It is important, therefore, to avoid approaches based on an undue deference for western models which can result in disempowering local people. The sustainability of psychosocial interventions over the longer term will be based upon restoring the community's sense of control and self-efficacy.

These initial stages of assessment should, from the point of view of Napoleon Adok, include discussions with local child experts (elders, parents and teachers) to gain an understanding of their views on questions such as: What is regarded as 'normal' child behaviour within that society? How is trauma conceptualised? How are children who need help recognised locally? What are the traditional avenues for helping distressed or disturbed children? Accessing local knowledge of this kind offers the potential to develop shared programs which may take a variety of forms, but which will proceed with a sense of local ownership (Lucia Castelli).

Increasing community acceptance: As outlined earlier in the section on culture, social reintegration and acceptance confers psychological benefits on children/youth in post-conflict situations. It is important, therefore, to assess whether non-harmful traditional 'healing' practices with a history of promoting social integration and acceptance are available locally. As Napoleon Adok points out, some such ceremonies also give victims an opportunity to tell what has happened to them, and offer the possibility of an agreement with local people on some form of justice and reparation. Jiovani Arias suggests that accessing the truth and obtaining forgiveness can both restore human dignity and foster reconciliation which are also essential elements in the psychological wellbeing of local communities. At this level, in addition to assessing local resources, an important aspect of psychosocial interventions for ex-child soldiers, therefore, is preparing the community in advance for their return and potential reintegration (Napoleon Adok). Additionally, as Chris Coulter points out the type of psychosocial interventions offered to those who have returned can, in of itself, influence community acceptance. In Sierra Leone, for example, participation in vocational training programs improved family acceptance of girl ex-combatants who could now be seen as potential bread-winners. The combination of new skills, acceptance by the family and the supportive peer group offered by other programme participants, resulted in improved well-being and self-esteem. Difficulties can arise for these young women, however, if programs do not lead to sustained employment of some kind. The subsequent loss of income can lead to family rejection, heightened isolation, involvement in the sex trade and a resultant deterioration in mental, physical and social health (see Coulter, 2006).

Psychotherapeutic interventions: Respondents showed an appreciation of the advances in mental health interventions for children with trauma/stress symptoms which were outlined by Dyregrov and colleagues. In particular there was support for their advocacy of interventions which do not concentrate on individualised therapy or medication, but rather work with groups of children in community and educational settings (Elizabeth Jareg; Diane Lukeman; Orlee Oudwin; Patrick Smith). Other developments in psychological approaches which were welcomed, included the recognition by the authors of the need for ethical standards to protect the wellbeing of traumatized children interviewed for clinical/research purposes (Elizabeth Jareg). Concern was expressed, however, that broader psychological models are not always implemented in times of extreme crisis – for example following the Tsunami, where it seems that some visiting western and non-Achenese Indonesian practitioners employed predominantly medical and individualised therapeutic approaches. Of particular concern, were those practitioners who dispensed medication in the absence of a therapeutic relationship with the recipients, and/or who stayed in the area for extremely brief periods of time, seemingly without implementing plans for longer term follow-up (Malia Robinson). Such occurrences should not, however, overshadow the changes in psychological practice which have taken place over the last ten to fifteen years. These include integrating into practice our awareness of the ways in which family structures, beliefs and practices, along with social and cultural

influences, act to buffer children against the effects of trauma, or sometimes to increase their vulnerability. Modern western psychology is firmly anchored in an awareness of the crucial role played by the child's family, community, social structure and culture, in the promotion of their wellbeing.

What contributions can western psychology make to the treatment of trauma in other cultures? Patrick Smith and Orlee Oudwin remind us that psychologists have developed ways of addressing the effects of trauma which have been shown to be effective across cultures – for instance, using cognitive-behaviour therapy and narrative exposure therapy (see, e.g. Schauer, Neuner and Elbert, 2005). The challenge is for those using such methods to ensure that they are presented in ways which are meaningful and appropriate at the local level.

The debate on psychological interventions in post-conflict situations has largely focussed on the treatment of trauma. Equally important, however, is the issue of childhood bereavement, so common in post-conflict situations, and which can also impact upon children's emotional well-being (Dowdney, 2005). Some traditional healing practices outlined in the Honwana paper do appear to provide children with important opportunities to grieve their multiple losses, and in this way to make another contribution to their healing. The need to widen our focus to include other aspects of child distress is emphasised by Elizabeth Jareg who urges us not to "get waylaid by trauma". That is, whilst recognising that traumatized children do need appropriate treatment, we should ensure that, as in competent western psychological practice, therapeutic interventions begin with an open minded assessment of what lies behind the distress of any given child. Even in post-conflict situations, their distress may primarily be related to every day factors such as being denied necessary school books, not being fully accepted within a step-family, having parents with alcohol problems, or indeed being sexually abused at home. Local screening can identify distressed children who are in need of help, for example, those identified by their teachers as withdrawn.

Again, in such situations, as in the west, forming a supportive relationship with distressed children is central to good therapeutic practice. Within such relationships, the therapist can be guided by the child and can give the message that it is for *the child to decide* if and when they wish to talk about their experiences. If they do, it can be with any trusted person – anyone with whom they feel safe. This type of therapeutic approach mirrors the approach to larger scale psychosocial interventions discussed above, which derive their strengths from empowering local communities through dialogue and respect for their knowledge. In particular, this therapeutic approach emphasises the importance of recognising that children (locals) can and will talk about things which are important to them and it allows the child's (local) voice to be heard, understood and responded to, and gives the child (locals) back a sense of control. Equally, it recognises the importance of the child's social network and friendship patterns, and sees that interventions which build upon and support these are of great importance in communities such as those in northern Uganda. This does, of course, require therapists to be fully versed in local social practices and customs, and to be willing when training local personnel to go beyond concentrating solely on the imparting of techniques for dealing with trauma, to thinking about open minded enquiry and how to build trust and facilitate the relationships essential to the child's well being. As Chris Coulter points out, it is important to recognise that a narrow focus on the individual child in situations where the individual is constituted by and through their kinship group is unlikely to be useful. Therapeutic approaches, such as those derived from, e.g., family therapy, which address the structures within

which the child is embedded, seem more appropriate (see, e.g. an early paper from this field by Bott and Hodes, 1989). Elizabeth Jareg, however, also asks us to beware of assuming that the psychosocial care of vulnerable children is necessarily delivered by highly trained professionals such as psychologists and psychiatrists. The realities of field conditions, and funding constraints, mean that such care is often delivered by field workers with fairly basic training. Providing sufficient support and training for such workers wherever possible, is, therefore, an important part of striving to provide adequate psychosocial care for affected children.

A blended approach: The responses suggest a role for western psychological models in non-western societies – but with an awareness that it is important not to devalue effective local approaches which do not fall within the compass of such models. There is general agreement with the position of Dyregrov et al (2002) and Honwana (1998), that where psychological interventions do prove to be necessary, a combination of western and traditional approaches has great potential utility (Jiovani Arias; Lucia Castelli; Diane Lukeman; Orlee Oudwin; Patrick Smith and Mike Wessells, 2007). Though how, and in what way, such combinations in general would develop was not discussed in detail.

Jiovani Arias expresses support for Dyregrov et al's advocacy of incorporating cultural tools and approaches into psychosocial approaches. He also agrees with Honwana's stance that, if certain cultural activities/rituals are not performed, this can be a major obstacle to the appropriate processing of pain. In this respect, he finds that two things are of particular importance in his own work. First, that the emotional consequences of violence are recognised. Secondly, that any cultural expressions/practices which are incorporated into therapy are those which are relevant to, and make sense in the light of, the community's own recovery efforts. Nonetheless, it is important to recognise that cultural expression alone may not be sufficient to bring about emotional recovery. It is important to assess whether the effects of violence have been effectively addressed and, if not, to assess what other form of psychosocial intervention needs to take place (for further detail of this approach see Arias, 2005).

The specifics of whether and how local healers could be incorporated into such combined approaches to children's distress are not, however, addressed by our respondents. Nick Heeren points to situations where their role may be limited by out of the ordinary circumstances - for instance, where large scale trauma encompasses much of the population, such as the genocide in Rwanda or the atrocities in Sierra Leone. In such situations Nick argues that a third party 'neutral' therapist from outside that society is better placed to provide a space for listening to survivors' accounts and helping them to 'make sense' of their experiences. Traditional healers from within are limited by themselves being part of the affected population. In the model adopted by Handicap International in Sierra Leone, expatriate therapists were accompanied by local therapists who acted as translators – both in terms of language and in terms of helping affected individuals articulate their experiences. This does not imply that 'outside help' should remain there longer term, as local staff can be trained to take over their role. Finally, Wessells (2007) points out that combining both western and traditional practices is not always a straightforward matter as local dynamics and politics can come into play and affect discussions on the appropriateness of various interventions.

Spanning all these aspects of psychosocial intervention is the issue of gender which is not addressed in either paper. Myriam Denov (2007) identifies a series of

questions it is essential for psychosocial interventions to address, such as: how do interventions for boys and girls differ? How do local customs influence who receives interventions? Are girls more likely than boys to be the subject of collective denial?

ASSESSING THE EVIDENCE

Finally, our respondents point out the need for evaluating the effectiveness of whatever form of psychosocial intervention is to be employed (e.g. Jiovani Arias; Lucie Cluver; Orlee Oudwin; Malia Robinson; Patrick Smith; Wessells, 2007). It is clear to Jiovani that some interventions lack either a solid conceptual basis or rigour, and fail to measure their outcomes. They may not, therefore, successfully address the harm at either the individual or community level. Perhaps, as Patrick suggests, one fundamental question is not which intervention is 'best', but which combination will be most effective? As Malia suggests, we need to adopt an 'outcome' focussed approach (see Williamson and Robinson, 2006).

The question of the effectiveness of our interventions in reducing child distress is not primarily a theoretical question, but largely an empirical one (Lucie Cluver). Stringent evaluations of interventions, including both positive and negative child reactions, can over time, result in the accumulation of evidence as to their effectiveness. Once the need for such an evidence base is accepted, there arises immediately, a series of further questions such as: Which approach works (is effective) for whom? What is the rationale for any given approach and how is its effectiveness to be measured? What kinds of evidence are acceptable – for example, is it sufficient for participants to say they feel they have benefited, or do we need additional empirically based measures of change or development? Lucie Cluver supports empirically based outcome measures, regarding these as especially important "because some trauma interventions, such as psychological debriefing, have been shown to have negative impacts on mental health despite positive feedback from participants" (see van Emmerik et al, 2002)

Is there another potential debate here about the nature of acceptable evidence, and the qualitative vs the quantitative measurement divide? Whatever the answers to these questions, there is general agreement amongst our respondents that we need to ensure that we do not provide either harmful or ineffective interventions. The either-or thinking which has fuelled some of the debate on psychosocial interventions has had a dichotomizing effect which, in the words of Mike Wessells "is often backed by ideological fervor, which flourishes in the absence of a solid evidence base. It is an understatement to say that the evidence base in the field of psychosocial assistance is weak and in need of development" (Wessells, 2007, p1). Clearly the accumulation of an evidence base for the effectiveness of psychosocial interventions of whatever kind must be a priority for the future.

References:

Arias Morales F.J. (2005) Psychosocial care of demobilized child soldiers in Colombia : conceptual and methodological aspects. www.child-soldiers.org/resources/psychosocial

Barocas, H. A., & Barocas, C. B. (1989). Separation–individuation conflicts in children of Holocaust survivors. Journal of Contemporary Psychotherapy, 11, 6–14

Bott, David and Matthew Hodes. 1989. Structural therapy for a West African family. Journal of Family Therapy. 11(2), pp169-179

Coulter, C. (2006). Being a Bush Wife: Women's lives through war and peace in northern Sierra Leone. Doctoral dissertation, Uppsala University. ISBN 91-506-1887-3

Denov, M. (2007). Is the culture always right? The dangers of reproducing gender stereotypes and inequalities in psychosocial interventions for war-affected children. www.child-soldiers.org/resources/psychosocial

Derluyn I., Broekaert E., Schuyten G., Temmerman E.D. (2004). Post-traumatic stress in former Ugandan child soldiers. The Lancet Vol. 363 (9412), pp 861-863

Dowdney, L. (2005). Children bereaved by parent or sibling death. Psychiatry 4:9, pp 118-123

Dyregrov, M., Gupta, L., Gjestad, R. and Raundalen, M. (2002). Is the culture always right? Traumatology 8 (3), pp 135-145. Reproduced on: www.child-soldiers.org/resources/psychosocial

Heeren, N. (2006). Sierra Leone and civil war: neglected trauma and forgotten children. www.child-soldiers.org/resources/psychosocial

Honwana, A.(1998). Okusiakala ondalo yokalye: Let us light a new Fire. Local knowledge in the post-war healing and reintegration of war-affected children in Angola. Christian Children's Fund (CCF)/Angola. Reproduced on: www.child-soldiers.org/resources/psychosocial

Robinson, M (June, 2005). Review and analysis of psychosocial programs for children affected by armed conflict and children affected by AIDS: Learning from experiences and good practices of psychosocial work done in both emergency and non-emergency contexts. UNICEF expert consultation, Entebbe, Uganda

Schauer, M. / Neuner, F. / Elbert, T. (2005). Narrative Exposure Therapy (NET). A short-term intervention for traumatic stress disorders after war, terror, or torture. Hogrefe & Huber. See also http://www.vivofoundation.net/eng_narrative_exposure_therapy.php

Shepler,S. (2005). The Rites of the Child: Global Discourses of Youth and Reintegrating Child Soldiers in Sierra Leone. The Journal of Human Rights. 4(2)

van Emmerik, A. A. P., Kamphuis, J. H., Hulsbosch, A. M., & Emmelkamp, P. M. G. (2002). Single session debriefing after psychological trauma: a meta-analysis. The Lancet, 360(9335), 766-771

Wessells, M.G. (2007). Trauma, culture and community: Getting beyond dichotomies. www.child-soldiers.org/resources/psychosocial

Williamson, J. and Robinson, M. (2006). Psychosocial interventions, or integrated programming for well-being? Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed conflict, 4(1) pp 004-025