CHAPTER 1

Is trauma-focused therapy helpful for survivors of war and conflict?

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Few would argue that war and conflict do not affect those involved, either at the time or afterwards. The useful question to consider is: what are their psychological effects and what are the most appropriate paradigms and descriptors to use for these effects that will be both meaningful and useful to survivors wherever they may be living?

People affected by war and conflict often face a whole series of challenges. In addition to dangers to life and limb, there may be loss of family members, loss of financial security and personal safety, loss of property and of livelihood; there may also be existential losses such as hopes and plans for the future. That war can cause psychological distress appears incontrovertible, but whether this is best described within a narrowly individualistic, medicalised psychiatric framework and symbolised by a diagnosis of post-traumatic stress disorder (PTSD), or within a wider framework that accounts for practical and human loss and distress at the individual and community level is contested in the literature (for a full review of this debate see Bracken & Petty, 1998; Summerfield, 1999; Yule, 1999; Rousseau & Measham, 2007).

Concepts of trauma and traumatisation are, of course, broader than just PTSD but this term has been widely and sometimes uncritically used in relation to war and conflict. The word trauma has been used to explain both an event such as war and a reaction to it, perhaps erroneously linking cause and effect in a rather less complicated way than is found in reality. So the language and descriptors have not always been as accurate as they might be, perhaps adding to confusion about ways of working with individuals or communities after the event and sometimes leading to an over-medicalised discourse. Some believe that war and conflict can traumatise entire communities, whereas others believe that very few people actually develop symptoms that would lead to a diagnosis of PTSD (Summerfield, 1999). Bracken (1998) and Summerfield (1999) have noted the difficulties associated with the concept of PTSD, which include the unquestioning use of a Western world view and the imposition of this in what might be viewed as a patronising manner. In addition, 'PTSD' may describe what is actually a normal human response to abnormal events, promoting a label of individual pathology. Time is also an intervening variable, as is the fact

that each individual will react differently to war and conflict. Protective factors include the meanings attributed by individuals and communities affected by war and conflict, the support systems available, and resilience at the individual and community level. The paradigms and descriptors used may define what kind of help is offered and to whom.

Collective trauma or war-time spirit?

Somasundaram (2007) developed the notion of collective trauma on the basis of his work during civil wars in Cambodia and Sri Lanka. It describes the situation in which entire communities are affected by conflict and fail to function as successfully as they did before. Every layer of a community can be disturbed. For example, family relationships, peer groups and social structures can become fragmented and altered. Alternatively, a 'war-time spirit' can emerge, when communities feel strengthened and emboldened by a sense of collective engagement, purpose and support. By its very persistence, an ongoing war is different in nature from a one-off incident such as a train crash (McNally, 2010). People living in a war zone may develop ways of coping at the individual and collective level, although these may not always be psychologically healthy (Somasundaram, 2007). Such ways of thinking about conflict and the mind move away from an individualised model and raise for the psychiatrist challenges concerning interventions and help that will maximise recovery of individuals and their communities. In long-running wars and conflicts, young people may have no experience of living in a peaceful society, which poses special challenges for any engagement.

The debate is further complicated by the matter of the appropriateness of applying Western international psychiatric diagnostic categories to people from communities that have their own descriptors and ways of managing distress (which are not necessarily predicated on a psychiatric framework) in terms, for example, of cultural or religious practices (see Chapter 9, this volume). Humanitarian agencies have often (and with the best of intentions) tried to export, from one population to another, methods of working with people and communities who have been through traumatic events. However, these are not always culturally appropriate and they can undermine traditional systems of coping and help. It has been argued that this is a form of neo-colonialism which assumes that Western models are best and treats individuals as passive recipients in need of external help (Summerfield, 1999). The active participation of communities and internally displaced people has often been missing in work with communities and individuals affected by war and conflict (Weerackody & Fernando, 2011). This is at odds with good clinical and community practice and governance and the development of appropriate services or resources.

At the end of 2010, an estimated 43.7 million people worldwide were forcibly displaced by war and civil conflict (Office of the United Nations

High Commissioner for Refugees, 2011). Families may be dispersed and parents can become practically and psychologically unavailable to their children. In its guidance on treating PTSD, the National Institute for Health and Clinical Excellence (NICE) specifically states that 'Being a refugee is not a diagnosis, and refugees may present with any of the psychiatric disorders or none at all' (National Collaborating Centre for Mental Health, 2006: p. 120).

An equal and respectful dialogue between people from different cultures needs to be established, to ensure that an equal partnership is in place and that any mental health help is meaningful, and culturally and resource appropriate. If an intervention is not meaningful or culturally appropriate it is unlikely to be taken up or be viewed as being of benefit to potential users. Services should build on what individuals and communities know about their own survival and coping systems, and strategies based on these are likely to be both more appropriate and more effective (Tribe & de Silva, 1999; Wessells, 1999). The importance of community engagement in improving health in the UK population has been noted by NICE, which has developed specific guidance on the subject (National Institute for Health and Clinical Excellence, 2008). In addition, best practice in health and social care services stresses the role of service user involvement to ensure that services are appropriate and accessible. Although research shows that this is often more an ambition than a reality (Crawford *et al*, 2003), it should still be a goal.

Many UK and international organisations offer information, guidance and support for people affected by war and conflict and for services helping them (Box 1.1). However, as touched on above, international responses to catastrophe can result in aid and personnel being flown in and imposed on the local community. Dawes & Cairns (1998) draw attention to the fact that differential power relations between local and foreign helpers and systems can affect the effectiveness of psychosocial interventions. There are many examples of people from high-income countries imposing models such as trauma counselling on people from other cultures, for whom they are not always appropriate or helpful (Bracken, 1998). The Inter-Agency Standing Committee (IASC) was established in 1992 in response to a United Nations resolution that called for strengthened coordination of humanitarian emergency assistance (United Nations General Assembly, 1991). The resolution identified the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters.

Guidelines have been developed by a range of UN and non-UN humanitarian organisations to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial well-being in emergency settings (Inter-Agency Standing Committee, 2007). They propose a model that embeds psychological support within a framework of other measures.

Box 1.1 Organisations offering information, guidance and support

Children and War Foundation
Ensures that knowledge about children can be gathered and used to improve the care of all children affected by war and disaster (www.childrenandwar.org)

Freedom from Torture (Medical Foundation for the Care of Victims of Torture)
Provides information for people working with survivors of torture and organised violence, including how to make a clinical referral and a referral for medico-legal reports (www.freedomfromtorture.org)

International Committee of the Red Cross/Red Crescent
Runs a tracing service for people who have lost contact with family members through a war or on any other grounds (www.icrc.org/familylinks)

International Society for Traumatic Stress Studies
International, interdisciplinary professional organisation that promotes the advancement and exchange of knowledge about traumatic stress (www.istss.org)

Refugee Council
Provides multilingual information for asylum seekers and refugees, news, up-to-date policy and information briefings, guidance for advisors and service providers, specialist country information and a free emailed weekly newsletter about issues relevant to refugees and those working alongside them in the UK (www.refugeecouncil.org.uk)

Refugee Legal Centre
Offers legal advice and representation for asylum seekers and refugees, delivers training and support to those giving advice/representation and seeks to promote the interests of clients individually and through law and public policy. The service is free for those who do not have to pay for legal representation. It also provides advice for detained asylum seekers (www.refugee-legal-centre.org.uk)

United Nations High Commission on Refugees (UNHCR)
Provides press releases and information about refugee situations worldwide, regional overviews and background information as well as statistical and other resources (www.unhcr.org)

World Health Organization (WHO)
The WHO's Humanitarian Health Action states that 'The primary objective in an emergency, whether natural or man-made, is to reduce avoidable loss of life and the burden of disease and disability […] During crises, humanitarian health partners, led by the Inter-Agency Standing Committee (IASC) Health Cluster under the leadership of WHO will empower humanitarian country teams to better address the health aspects and crises' (http://www.who.int/hac/about/faqs/en/index.html). Its 2001 World Health Report focuses on mental health (www.who.int/whr2001/2001)

The six core principles of action are to:

- ensure human rights and equity
- maximise the participation of the affected population
- do no harm

- build on available resources and capacities
- ensure integrated support systems
- develop multilayered, complementary supports.

Services in the UK

Certain asylum seekers and refugees in the UK may benefit from Tier 3 services that specialise in traumatic stress and use a biomedical and diagnostic model. (The UK Trauma Group lists local resources at www.uktrauma.org.uk/ukservcs.html.) However, for the specific treatment of PTSD, the NICE guidelines recommend cognitive–behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR), but refer to 'barriers to treatment' for refugees and asylum seekers. Consequently, special consideration needs to be given to the requirements of these individuals and to the appropriateness of treatments. One that might usefully deconstruct the phrase 'barriers to treatment' here, as it seems to imply that the asylum seekers are a problem for the treatment, rather than that the treatment might not be the most appropriate for their needs. This is an area of debate in the literature and among professionals.

Other services have developed a more holistic approach, viewing context and culture as organising concepts and regarding the stress of living through war and conflict as extremely challenging but not an experience that leads to a diagnosis of PTSD. Trauma-focused therapy can inadvertently minimise survival skills and resourcefulness and give individuals a diagnostic label that may not be beneficial to their recovery and long-term well-being. This can happen if the treatment is offered indiscriminately and does not account for contextual and cultural factors as well as coping strategies.

Diverse cultures position individuals with psychiatric diagnoses in particular ways. The dilemma, however, is that a psychiatric diagnosis is often a gateway to resources in a system that is often politicised and can be antagonistic to an asylum seeker's needs and even their very presence in the UK. For example, a PTSD diagnosis might be perceived to lend credence to a claim of persecution, thus supporting a request for refugee status under the 1951 UN Convention Relating to the Status of Refugees. This can be highly beneficial to an asylum seeker and may in itself offer significant mental health benefits, as the individual knows that they will not be deported from the UK to their country of origin. Therefore obtaining this diagnosis could be seen as highly functional for the individual. The role of the psychiatrist is therefore a complex one that requires careful consideration and reflection.

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