



## **Psychosocial Support (PSS) in War-affected Countries: A Literature Review**

**Costanza Torre**



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## **Introduction**

During the last few decades, psychosocial support (PSS) has become a frequent component of assistance programmes in ongoing and post-conflict contexts, and is increasingly becoming an area of interest and action for agencies working in such environments. A growing body of literature advocates for war-affected populations' need for PSS programmes, and argues their relevance in post-conflict reconstruction processes, peacebuilding and social healing.

In light of the rising interest in and widespread implementation of PSS programmes, their key elements, history, and population impact deserves examination. Therefore, this literature review presents an overview of the origins, evolution, and embedded assumptions of psycho-social support in war-affected areas and examines existing evidence of the impact of PSS on targeted populations.

## **Methods**

The data provided in this review was gathered between February 2017 to and May 2017 and includes both academic and grey literature. We searched the following academic databases searches: Google Scholar, JSTOR, Web of Science, SAGE, PubMed, PsycInfo, PsycArticles, ScienceDirect, and PILOTS and looked for several combinations of terms including: "psychosocial" and "support" or "intervention", "mental health", "war", "armed conflict", "post-conflict", "political violence", "PTSD", "PSS", and "MHPSS". The grey literature search was conducted through Google, several databases (e.g. ReliefWeb, MHPSS.net, World Bank Open Data) and the websites of key organizations working in this field (e.g. World Health Organization (WHO), International Medical Corps (IMC), International Organization for Migration (IOM), International Federation of Red Cross and Red Crescent (IFRC), United Nations High Council for Refugees (UNHCR), United Nations Children's Fund (UNICEF), Inter-Agency Standing Committee (IASC), Médecins Sans Frontières (MSF), Psychosocial Working Group (PWG) and HealthNet (TPO)). This portion of the search used the same combination of terms as was used in the academic database search. A "snowball search" was then conducted through the bibliographies of resources that were identified as particularly relevant.

## **History of Psychosocial Support (PSS)**

Existing literature suggests that the history of psychosocial support (PSS) started with the aftermath of the Cold War, when politics heavily restricted cross-border humanitarian intervention. Programmes implemented during this time followed a "disaster model" where humanitarian aid was limited to the provision of material aid (Kienzler and Pedersen 2012; Fassin and Rechtman 2009; Mollica et al. 2004).

Fassin and Rechtman (2009) pinpoint the emergence of "humanitarian psychiatry" on 7 December 1988, when northern Armenia was struck by a devastating earthquake measuring 6.9 on the Richter scale and a team of psychiatrists were

included in the international humanitarian response. This practice was soon to become the norm; during the 1990s, psychological trauma and the consequences of exposure to conflict and violence on mental health became more salient, receiving increased attention.

It has been argued that, from the very beginning, the history of PSS in war-afflicted countries has been closely linked to the diagnosis of Post-Traumatic Stress Disorder (PTSD), particularly in the aftermath of the Vietnam War in the United States (Young 1995; Summerfield 2001; Bracken 2002). In 1980, when PTSD first appeared in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the disorder became a prominent cultural model for understanding the suffering caused by a wide range of traumatic experiences. However, a number of researchers claim that the emergence of PTSD is much less a “discovery” than it is an “invention” (Summerfield 2001; Breslau 2004; Bracken et al. 1995; Bracken 2002). Post-traumatic stress was an appealing concept after the Vietnam War, and served as a tool of expiation for the atrocities committed by American soldiers during the conflict; it identified the soldiers as victims and explained their actions and reactions, thereby publicly legitimizing their suffering. Its prominence in courtrooms, medical clinics, and public discourse was immediate. In the words of Nancy Andreasen, editor of the *American Journal of Psychiatry* between 1993 and 2006: “The concept of PTSD took off like a rocket, and in ways that had not initially been anticipated.” (Andreasen 2004)

It is thanks to humanitarian aid, however, that PTSD entered the “global arena” (Breslau 2004) as the focus of many mental health programmes. With the end of the Cold War in the early 1990s, a notable increase in cooperation between NGOs and UN peacekeeping operations facilitated humanitarian intervention in war-affected areas. Humanitarian aid no longer supplied mere palliative support nor was it politically neutral; rather it was increasingly associated with peacebuilding processes focusing on human rights, protection of victims, and advocacy (Kienzler and Pedersen 2012). This politicization of the nature and priorities of humanitarian aid and the use of PTSD in non-Western countries has been discussed by De Waal (1997) and Calhoun (2010). It has been argued that by adopting PTSD as one of the main tools of intervention, humanitarian aid acquires the power to determine who are victims and what types of suffering are justified. Given this newly-acquired power, post-traumatic stress disorder can be described as a form of “political currency” within the humanitarian field (Breslau 2004). James’ work on NGO operations in Haiti (2011) substantiates such analysis and argues that the legitimizing power of PTSD influences the relationship between NGOs and their donors and between NGOs and their clients, especially when there are benefits associated with a PTSD diagnosis.

Both post-genocide Rwanda and post-war areas in the former Yugoslavia were among the first contexts where psychosocial trauma-focused programmes were carried out; for example, UNICEF trained over 6,000 “trauma advisors” in Rwanda (United Nations 1996), and the UNHCR supported nearly 40 mental health projects in Bosnia and Croatia alone (Summerfield 1997). With the rise in PSS interventions in non-Western countries, there came a wider application of the PTSD diagnosis; however, the literature identifies several limitations in the cross-cultural application of this diagnosis.

Post-traumatic stress disorder has been described as built on very context-specific Western assumptions. The disorder consists of a clear etiology (a *traumatic* event) and three main symptoms: *reexperiencing* of such event (e.g. nightmares,

flashbacks), *hyperarousal* (e.g. sleep and concentration problems) and *withdrawal* (e.g. avoidance of reminders of the event). A very distinct sense of time is embedded in the logic of PTSD because the theory has a positivist view of the mind and describes the self as made up of memories (Young 1995; Bracken 2002; Summerfield 1999).

These 'Western' aspects of PTSD have raised questions about the applicability of the diagnosis in non-Western contexts. Authors such as Almedom and Summerfield (2004), Pupavac (2001), Beneduce (2010), Eisenbruch (1991), Kirmayer (1998) have argued that the cross-cultural application of the PTSD diagnosis risks becoming what Kleinman (1977) has referred to as a "category fallacy." "Trauma" – the ever-present cause of PTSD – has been portrayed as similar to a physical wound in a number of studies advocating for the usefulness of the diagnosis (e.g. Roberts et al. 2009; Mels et al. 2009; Dyregrov et al. 2000). A study conducted in Uganda among South Sudanese refugees (Neuner et al., 2004) claims that "if the cumulative exposure to traumatic events is high enough, these results indicate that anybody will develop chronic PTSD". Such defences of the diagnosis have been labelled as simplistic, in that they do not take into account the active way in which an individual engages with the context. Summerfield (1999) has noted that although a range of symptoms can be observed among a given population, it does not mean that they are relevant for the people who experience them.

Furthermore, with its standardized list of symptoms, PTSD has been criticized as an objectification of suffering insofar as it proposes a universal set of responses and turns these responses into a "technical tool" (the so-called "traumatization") – a biomedical entity with prescribed solutions. Such inference mirrors cognitive and positivist views of the mind which, according to PTSD critics, are often not found in non-Western cultural settings however relevant they may be in the 'Global North'.

It has been pointed out that, although PTSD emerged in a context permeated heavily by Western individualism, it assumes that the causes of suffering and the recovery process are at the individual level. However, this assumption does not consider the impact of present, socio-economic and political stressors that are a part of "complex emergencies" and often constitute the core preoccupations of affected individuals (O'Callaghan et al. 2015; Miller and Rasmussen 2010; Ayazi et al. 2012); nor does it acknowledge that healing processes in war-affected communities tend to occur primarily at a social level, through the resumption and restoration of social practices and networks (Summerfield 1997; 1999; Bracken et al. 1995; Moghimi 2012). Instead, a narrow focus on trauma emphasizes individual past experiences, therefore picturing recovery as something that happens inside the individual, rather than in the social processes and construction of meaning that take place at a collective level..

### **The psychologization of humanitarian aid**

The wide application of the post-traumatic stress disorder category, often a "taken for granted dimension" in PSS (Breslau 2004), is not the only aspect worth noting in this field - nor is the focus on trauma the only one that has been applied in psychosocial support. Nevertheless, its huge success reveals some tendencies that can be identified in both PSS per se, and in humanitarian aid at large.

Since the 1990s, the shift in focus of humanitarian aid from material support to human rights and reduction of suffering has resulted in the broad implementation of psychosocial programmes in war-affected settings. Scholars argue that the very idea of emergency has changed – the picture of the "hungry child" has been replaced by the "traumatized child" in representations of crisis by the media and NGOs.

In the last three decades, the rise of psychosocial support as one of the main areas of humanitarian aid is indicative of a phenomenon that has been critically referred to as a “psychologization” of non-Western populations (Enomoto 2011; Pupavac 2005). This often translates as imposing Western definitions of well-being, mental health, and, especially, mental illness on non-Western populations. The introduction and application of PTSD is one clear example of this imposition. Such processes of “psychologization” reveal a tendency to think of wars as “mental health epidemics” (Summerfield 1999) and of psychological suffering as the inevitable “invisible wounds” they cause. A simple Google search of the terms “war” and “invisible wound” shows a considerable amount of literature painting such a picture.

The psychologization of humanitarian aid mirrors the preoccupation of contemporary Western culture with emotions this preoccupation resulting results in the adoption of the same perspective in the aftermath of a crisis; more importantly, it tends to accentuate the elements of vulnerability in the population affected by the crisis, be it natural or man-made. It can be argued that the focus on vulnerability, enhanced by what Fassin (2013) refers to as “humanitarian sentiment”, acts at the expense of the notion of resilience in at least two ways. The first one consists of humanitarian aid targeting populations – often described as “traumatized” and “brutalized” – with interventions that adopt a therapeutic, curative perspective, not so much aimed at strengthening existing resources and support networks as at providing treatment. The second one echoes Hacking’s (1995) concept of the “looping effect”; a populations described as victimized and deprived of agency is likely to adopt the same category in its definition of itself (Armstrong 2008), thereby further undermining its possibilities and sources of self-organization, empowerment, and, ultimately, resilience.

Almedom and Glandon (2007) have also highlighted how resilience, despite being a complex, multidimensional concept rooted more in the theory of salutogenesis (origin of health) than in the one of pathogenesis (origin of diseases), has often been interpreted by humanitarian aid as the mere absence of PTSD. A study on demobilized Ugandan child soldiers by Klasen et al. (2010) goes as far as to use the concept of “posttraumatic resilience”, indicating not a focus on a positive outcome, but rather on the absence of a negative one which is seen as likely to be found. A further consequence of the “psychologization” of humanitarian aid is the tendency to medicalize human experience, as it pathologizes forms of suffering that are actually appropriate, even adaptive, to the situation. A widely cited study by MSF (2000) in Sierra Leone found that 99% of the participants could be diagnosed with PTSD; Derluyn et al. (2004) found a similar rate (97%) for former child soldiers in Uganda. Applying a pathologizing label to reactions that occur with such high frequency results in the medicalization (and stigmatization) of the human experience of pain and grief – whose adaptive complexity can and should not be reduced to a sterile series of symptoms. It also been argued that such medicalization risks detracting attention away from those (usually few) individuals who are indeed in need of psychiatric care and whose symptoms do not fall within a traumatic theoretical framework (Almedom and Summerfield 2004).

Moreover, literature indicates (Summerfield 1999; Moghimi 2012; IASC 2007) that such medicalization is all the more serious as PSS programmes have not been indicated as a need by the affected populations. Psychosocial programmes – and especially trauma-focused ones – are implemented by identifying **exterior needs (e.g. assessment scales, treatments)** that are used to deal with such issues

(Breslau 2004). In light of these facts, questions have been raised regarding the actual relevance of these issues as outlined in the following section.

The tendency towards “pathologization”, however, is not limited to normal reactions to stressful and possibly painful events. Summerfield (2002) has argued that the process of recovery has been medicalized as well, in that it is represented as solely an individual experience and often dependent on the “catharsis” – brought about by talking about the traumatic event. Such mechanistic views constitute the underlying assumptions of cognitive trauma-focused treatments such as Narrative Exposure Therapy (NET; Schauer M., Schauer M., Elbert and Neuner 2011) and Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT; Cohen, Mannarino and Deblinger 2012) and it again mirrors a positivist and context-specific idea of the mind (Bracken et al. 1995). It has been noted that this perspective tends to disregard the fact that in many non-Western cultural contexts people understand (and express) distress in response to disruptions to social and moral order and do not see internal and individual emotional factors as capable of causing illness (Kirmayer 1989).

Lastly, the “psychologization of humanitarian aid” and its tendency to pathologize non-Western populations manifest in the medicalization of feelings of revenge and retaliation, often associated with war-affected communities. It has been pointed out that the idea of revenge as harmful and confession and forgiveness as desirable is strictly linked to the Judaeo-Christian tradition (Summerfield 2002). War-affected populations, often described as “traumatized” and “brutalized”, are expected to be vengeful. A number of studies (namely the ones by Bayer et al. (2007) on former child soldiers in Uganda and the DRC, and by Jonis et al. (2009) in Cambodia) have looked for links between PTSD and feelings of revenge, often confirming the correlation. These studies also find a negative correlation between PTSD and openness to forgiveness. Similar arguments advocate the need to treat “trauma” in order to prevent it from triggering new “cycles of violence” (Almedom and Summerfield 2004).

However, such a perspective is unable to distinguish between the individual and the social world, and especially has a tendency to transform the social world into a biological one (Summerfield 1999). This discourse indicates that the wide application of PTSD diagnoses becomes a powerful tool that justifies and legitimates humanitarian aid in the form of psychosocial interventions.

The “psychologization of humanitarian aid” can also be observed when examining the change in the terms that have been used over the years to refer to “psychosocial support”. The shift from the expression “psychosocial rehabilitation” to the now broadly used expression “mental health and psychosocial support” or “MHPSS” (IASC 2007), is in fact very descriptive of the tendency discussed above. The emergence of the “MHPSS” acronym makes a strong statement concerning the pervasive way in which psychological perspectives have become inseparable from humanitarian programmes. To use Summerfield’s words: “The prefix ‘psycho-’ in psychosocial has fostered basic misconceptions and diverted us from the collective focus required” (1997: 20). Furthermore, the shift from a “rehabilitation” perspective to one of “support” indicates a change in the interventions delivered, which will be discussed later in this paper.

The debate around the themes presented above has highlighted several points and raised various questions on the feasibility, validity, and ethics of psychosocial interventions. Nevertheless, during the last three decades the field of psychosocial support in war-affected countries has seen a steady rise.

## Assessment scales

The literature examined for this review demonstrates the use of assessment scales in the planning phases of psychosocial interventions as a very common practice. The widespread application of these scales has received extensive questioning and investigation. An example of the many challenges these scales face includes Breslau's (2004) objection to the use of the Harvard Trauma Questionnaire (Mollica et al. 1992), a tool diagnosing PTSD that was first applied in a cross-cultural context in Cambodia in the early 1990s. Breslau argues that introducing a measurement of a disorder in a new setting requires the introduction of the disorder and its frame of reference. The application of the Harvard Trauma Questionnaire in the Cambodian context therefore represents a very strong example of the assumed universality of PTSD.

The Harvard Trauma Questionnaire (HTQ) consists of a checklist of 31 traumatic events that an individual may have witnessed, and of traumatic symptoms experienced, mostly drawn from the DSM-IV definition of PTSD. It has been noted that, in line with what has been described above, the distribution of the questionnaire tends to pathologize the population. By adopting a "deficit perspective", it regards only allegedly traumatic events and does not emphasize the protective factors or an individual's potential of resilience (Bracken et al, 1995; Richman, 1998; Loughry et al. 2003). Studies in the Balkans and in Rwanda made large use of the scale to estimate the number of traumatic events that civilians (and especially children) had been exposed to; the data was then used to inform the general public, donors, and humanitarian agencies of the harmful consequences of the war. This approach has raised ethical questions (Summerfield 1999; Bracken and Petty 1998) and arguments that, in doing so, agencies enact heavy victimization of war-affected communities in order to ask for funding and justify their programmes. James (2011) has introduced the concept of "trauma portfolio", a list of an individual's life events that an agency will regard as relevant, suggesting that this implies a very simplistic view of the person, as nothing more than the "trauma" that they carry.

Moreover, the checklist approach reveals a strong "dose-effect" assumption – the higher the number of traumatic events, the stronger the "trauma". Summerfield (1997) has argued that such a perspective regards the victims as merely passive receptacles of negative psychological events. He further argues that assessment scales like the Harvard Trauma Questionnaire (and other popular ones such as the Impact of Event Scale (IES) and the Post-traumatic Stress Diagnostic Scale (PDS) and the UCLA-PTSD Reaction Index) do not acknowledge that the impact of events on an individual is dictated by their own interpretations and choices. Much like the "traumatized child soldier", now a well-known character in the popular imagination, the victims to whom such questionnaires are applied are assumed to have no agency, active choice, or power to construct their own frames of meaning (Gilligan 2009; Armstrong 2008). This is hardly the case. Assessment tools that present lists of elements that may not be culturally relevant or familiar, do not tell us anything about the relevance of the events or symptoms they investigate. Their application consists in the above-mentioned "category fallacy" (Kleinman 1977). In this regard, it has been argued that for most people who are diagnosed with PTSD it is a "pseudo-condition" that does not explain their day-to-day functioning (Summerfield 1999).

Richman (1998) has pointed out yet another difficulty embedded in the use of checklist assessment scales. The author notes that scales present items and questions whose cultural familiarity can be called into question whereas what is most relevant



remains unasked. Culture strongly influences elements such as health-seeking behaviour and manifestations of suffering. The application of assessment tools that refer to Western standards may risk leaving relevant signs of distress unnoticed and produce large overestimates of people in need of treatment (Summerfield 1999). Recent developments in this regard are anything but encouraging; a study by Schaal et al. (2015) of ex-combatants in the DRC compared rates of PTSD and used criteria from the fourth and the fifth versions (the most recent one, issued in 2013) of the Diagnostic and Statistical Manual of Mental Disorders. The study concluded that more people are diagnosed with PTSD when using the DSM-V, suggesting that the risk of over-diagnosis remains very high.

### **Assumptions embedded in PSS**

The core question when it comes to psychosocial support for war-affected populations appears to be ‘What has a bigger impact on the well-being of people affected by a crisis, past “trauma” or contextual, social and economical factors?’ From this, two main approaches can then be identified. On one side, are the trauma-focused interventions with a curative approach that frame distress primarily within medical, psychiatric and psychological models of PTSD, depression, anxiety, and other disorders, and tend to target individuals. On the other, is a more comprehensive *psychosocial approach* that adopts a developmental perspective and targets communities by using a number of different therapeutic and psychosocial models. Such approaches claim to focus not so much on the reduction of clinical symptoms but on the presence of protective factors and on the development of resilience (Pedersen et al. 2015; Kalsma-Van Lith 2007).

However, the reality is much less dichotomous (Jordans et al. 2009) since the interventions implemented are unlikely to perfectly mirror either of the two approaches. Trauma focused programmes still make up a large part of psychosocial aid initiatives; the rhetoric of trauma and PTSD is the first to be mobilized by NGOs and aid agencies in the immediate aftermath of crisis.

In light of what this review has discussed thus far, it is worth following Summerfield’s (1997; 1999) reasoning in enumerating several assumptions embedded in the very concept of psychosocial support as listed below. Summerfield specifically refers to trauma models and his observations concern interventions that claim to adopt a community-focused, allegedly non-clinical or medicalizing approach. Although the article dates back almost twenty years ago, from the time of this writing, it is still relevant:

1. *Experiences of war and atrocity are so extreme that they don’t just cause suffering, they cause ‘traumatisation’.*

The complex dimension of suffering is thus reduced, objectified and turned into a technical tool, the ‘traumatisation’, to which technical and short-term solutions can be applied (e.g. counselling).

2. *There is a universal human response to highly stressful events, and it is captured by Western frameworks.*

Such is the assumption underlying the wide use of not only of assessment scales, as highlighted above, but also psycho-education. Psycho-education is one of the most widely implemented PSS interventions implemented following traumatic events (Jordans et al. 2009; Tol et al. 2011; Pedersen et al. 2015)

and is an attempt to normalise common reactions to stress through educational sessions. Although it is usually viewed as a standard, even neutral procedure, the Foucauldian notion of knowledge as always being laden with values cannot be forgotten. Psycho-education informs its beneficiaries of notions rooted in a biomedical theory that views the mind as created by the brain, and likens the latter to a machine whose malfunctioning can be fixed with universal methods (Bracken 2002). Non-Western taxonomies often range across more than one realm, namely, the moral and physical, rarely the supernatural. The knowledge behind psycho-education is therefore a knowledge that belongs to the agency from where it emanates, and does not take into account the perspectives and priorities of the people it claims to benefit.

3. *Large numbers of victims traumatized by war need professional help.*

The role of the expert is introduced and legitimized, therefore the war-affected individual to the role of victim and passive receiver of the intervention. This step results in a further process of victimization of the affected population (Armstrong, 2008), facilitated by the stamp of authority implicit in the relationship of expert-non-expert / provider-consumer. Aid agencies have shown behaviour similar to that of the military in terms of their rigid structure and mode of service provision (Fassin and Pandolfi 2010; Dolan 2013; Kienzler and Pedersen 2012). Even though the IASC guidelines (2007), widely regarded as the main referral point in the field of PSS today, clearly state the importance of beneficiaries playing an active part in the organization and prioritization of any intervention, their voices are mostly silenced. This concerns both the needs assessment phase and the post-intervention, evaluation one.

4. *Victims (on a worldwide level, and not only as far as the West is concerned) do better if they emotionally vent and talk through their experiences.*

The idea that talking functions as a cathartic experience and is capable of alleviating suffering and distress lies at the core of various practices in war-affected countries, even in the field of transitional justice where scholars argue that truth commissions are based on the same principle of emotional venting (Summerfield 2002).

As far as the psychosocial sphere is concerned, this assumption underpins widely implemented, trauma-focused approaches like Narrative Exposure Therapy (NET) and Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT). In both cases, the role of “exposure” to trauma, where talking at length about the event and eliciting emotions, is paramount. However, it’s worth highlighting that a study by O’Callaghan et al. (2015) on war-affected youth in DRC found no difference between TF-CBT and a non trauma-focused intervention in the reduction of post-traumatic symptoms. This suggests that the role of exposure might have been overestimated.

Furthermore, the idea of emotional venting puts a strong emphasis on the causes of suffering as situated within the individual. Conversely, scholars argue that war is rather a collective experience, and the devastating impact that comes from the destruction of people’s social worlds, identity, and history cannot be ignored (Summerfield 1997; 1999; Bracken et al. 1995). It has been noted that the alternative to PTSD is not an “epistemological murk” (Breslau

2004). Attempts have been made by scholars and practitioners to grasp the collective dimension of the experience of war. James (2011) has talked of “ruptures in the collective sense of identity” in regard to political violence in Haiti; Eisenbruch (1991) has introduced the term “cultural bereavement” for survivors of Pol Pot’s regime in Cambodia; Kleinman et al. (1997) have coined the expression “social suffering”. Such efforts seem to have been largely ignored by trauma-focused approaches (Summerfield 1999; Barenbaum 2004).

5. *There are vulnerable groups and individuals who need to be specifically targeted for psychological help.*

The literature consulted for this review shows that most PSS interventions do have specific population targets. It has been argued, though, that such an approach risks disconnecting such groups from the rest of the community, and from the social dynamics of healing that need to be encouraged and strengthened. Wessels makes the same point in regard to programmes aimed at former child soldiers, noting that often “well-intentioned programmes exacerbate stigma by focusing benefits exclusively on formerly recruited children, triggering jealousies and social division at a moment when communities need to unite” (Henderson and Wessels 2009:588).

6. *Wars represent a mental health emergency. Rapid intervention can prevent the development of serious mental problems, as well as subsequent violence and wars.*

No evidence exists supporting the claim that rapid interventions are more effective in reducing the impact of a crisis on mental health. Nevertheless, the rise of rapidity and emotional venting in the field plays a fundamental part in a particularly popular intervention – “psychological debriefing” – in which the discussion about the event needs to happen immediately after its occurrence. However, when the effectiveness of psychological debriefing was finally evaluated, it was found to be at best ineffective and in some cases even harmful (Barenbaum 2004; Betancourt et al., 2013; Pupavac 2005). Despite this, the prompt timing of intervention seems to have become a dimension that has been taken for granted. A UNDP report on perceptions of justice in South Sudan states that “Humanitarian agencies, NGOs and donors cannot afford to wait for the conflict to end before addressing the problem” (Deng et al. 2015).

After negative evidence was found to disprove the effectiveness of “psychological debriefing”, the general enthusiasm appears to have shifted towards Psychological First Aid (PFA), whose use is recommended by all the recent guidelines. Similarly to “psychological debriefing”, the use of PFA is recommended in the immediate aftermath of a traumatic event, but it does not involve re-exposure to the event through emotional venting. Although its core principles, which revolve around showing sympathetic support to a fellow human being in distress (e.g. through active listening), make it seem unlikely that it could cause harm, it should be noted that no direct evidence has been produced yet that proves the effectiveness of Psychological First Aid (Dieljtens 2014; Bisson 2012; Shultz and Forbes 2014).

7. *Local workers are overwhelmed and may themselves be traumatized.*

Local staff’s reactions to a stressful job and demanding tasks are

immediately understood as post-traumatic reactions. Abramowitz and Kleinman (2008) have made the same point in regard to the IASC guidelines (2007). They further argued that local staff group in the psychosocial support field tends to be viewed as a lens through which expatriate practitioners can interpret the culture and find their way through the local context. This reveals an objectification of culture, which does not acknowledge its processual, social and dynamic nature. In its approach to local staff, the objectification of suffering (through a PTSD diagnosis) and the objectification of culture meet.

## **Guidelines**

It is important to highlight that the term “psychosocial” has been pointed out as problematic (World Bank, 2004; Clancy and Hamber, 2008; Baingana and Bannan, 2004). There is in fact little agreement on what exactly it entails, and such confusion has allowed a variety of programmes to be implemented.

What kind of interventions are usually defined as “psychosocial”? Looking closer at what they have consisted of reveals that the common label of “psychosocial” is not at all explanatory of their content or frame of reference. A case study report on northern Uganda by AVSI (2005), states that the same organization has used the term “psychosocial” to refer to “both a specific programme developed over the past eight years and an approach that informs its many activities (including health, agriculture, water and sanitation, education and emergency aid)”. Clancy and Hamber (2008) has have highlighted that, although such a term refers to the close relationship between social conditions on and mental health, and to the influence that they have on one another, many projects labeled labelled as “psychosocial” in reality describe interventions and activities consisting mainly or solely of either mental health interventions or community service projects. Programmes as different as community sports sessions (Staempfli and Matter 2013, South Sudan) and Eye Movement Desensitization and Reprocessing trials (UNICEF 2001 Indonesia) both share the same label of “psychosocial interventions”. It has been argued that such lack of clarity can confuse research methodologies and that the absence of both a concrete definition and of essential components are a huge obstacle for interventions (Baingana et al. 2003). Moreover, it has been pointed out that the same confusion has not only allowed not only for the implementation of a range of very different programmes, but that it has done so with a lack of clear ethical standards to be achieved, making the history of PSS in some cases “morally ambiguous” (Abramowitz and Kleinman 2008).

In response to such issues, a number of guidelines for psychosocial interventions have been developed over the years. They share the aim of representing both a frame of reference to help humanitarian aid practitioners set-up, monitor, and evaluate services on the ground, as well as employ a clear set of minimum standards to protect populations from malpractice in this field. However, since the establishment of rules is never apolitical nor devoid of implications, it is worth analyzing analysing them in further detail. This section aims to give a brief overview covering of the composition of different guidelines. Four of them will be discussed: the Sphere Standards (Sphere Project 2000; 2004; 2011), the IASC guidelines (IASC, 2007), the mhGAP Humanitarian Intervention Guide (mhGAP-HIG, WHO 2015) and the Building Back Better report (WHO 2013).

### *The Sphere Standards*

The Sphere Standards were issued by the Sphere Project (a group of NGOs and the Red Cross and Red Crescent Movement) in three different editions, dated 2000, 2004 and 2011. They are particularly interesting in that through the different versions it is possible to analyse the changes that psychosocial support has undergone in the last few decades. In the first official 2000 edition, Mental Health is not mentioned as a relevant part of humanitarian aid in the aftermath of a crisis. The only forms of psychosocial support hinted at are limited to brief mentions to unspecified “psychosocial counselling” for victims of sexual and gender based violence (SGBV). In the 2004 edition, changes can be noted where Mental Health is given a brief sub-paragraph in the section dedicated to “Non-Communicable Diseases”. Interventions listed are limited to unspecified “social interventions” and psychiatric assistance to people with pre-existing conditions (e.g. people in institutions, and individuals whose psychological suffering is not considered to be caused by the emergency). Psychological First Aid (PFA) appears to be the only suggested intervention for people with forms of crisis-induced acute distress.

In the most recent edition in 2011, however, the Mental Health section has been expanded, and is now a separate paragraph in the chapter dedicated to Health. What is particularly noteworthy is that the introduction to the paragraph states: *“Mental health and psychosocial problems occur in all humanitarian settings”* (Sphere Standards, 2011:333). In a ten-year time span, the notion that war generates mental health epidemics has thus become a given. Furthermore, in the Core Standards section relative to Mental Health, it is stated that: *“People have the right to complain to an agency and seek a corresponding response. [...] Formal mechanisms of complaint are an essential component of an agency’s accountability to people and help populations to re-establish control over their lives”* (Sphere Standards, p. 57). Such a statement is worthy of attention, not only because it hints at the risk of interventions being imposed on war-affected populations; but more importantly, because it limits the power of the locals to commenting on what agencies do, rather than being able to establish clear priorities for their programmes. This again echoes observations made in the literature concerning similarities between humanitarian and military interventions (Fassin and Pandolfi 2013; Keinzler and Pedersen 2012; Branch 2011; Dolan 2013).

Moreover, the Sphere Standards states: *“Culturally appropriate practices, such as burials and religious ceremonies and practices, are often an essential element of people’s identity, dignity and capacity to recover from disaster. Some culturally acceptable practices violate people’s human rights (e.g. denial of education to girls and female genital mutilation) and should not be supported”* (Sphere Standards, 57-58). Such statements make it clear that the attention to local culture, frequently highlighted by these guidelines, is anything but neutral and holistic, but rather deeply selective. It is possible to glimpse a medical-imperialistic vision (Summerfield 2013), that tends to impose definitions of illness, healing and well-being, as well as a moral perspective that goes as far as delimiting good cultural practices, that are permitted, and *bad* ones that should be suspended.

It is important to note that morality is but another culturally-bound aspect. To introduce a foreign aspect, regardless of the good that the principles intends to project, the expression of what sounds universal to a Western ear, is an extremely political action and in many ways a deeply questionable exhibition and (ab)use of power.

### **The IASC guidelines**

The Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC 2007) are considered today as a fundamental referral point in the PSS field. They have been praised for various reasons, namely their expansive understanding of the nature of suffering, their rejection of a “victim model” and their attempt at creating a common framework for implementation and evaluation. The IASC Task Force on Mental Health and Psychosocial support in Emergency settings has developed a widely- implemented multi-layered approach for PSS, commonly known as the Intervention Pyramid (Figure 1), which emphasizes that only a very limited number of people need specialised mental health care in the aftermath of an emergency. They also insist on using caution when it comes to the application of diagnostic labels and emphasize the importance of community self-help.

Despite representing an important step forward, the IASC Guidelines have been developed in the context of various reforms implemented by the UN which risk affecting the independence of the humanitarian sector from the political and military sectors (de Jong et al. 2008). Furthermore, scholars argue that these guidelines tend to portray culture as a static and immutable entity – training local staff for accessing, interpreting and readily translating it for Western practitioners (Abramowitz and Kleinman 2008).

The strong and pervasive focus of the IASC on “Emergency Preparedness” and minimum responses implemented in such cases are in line with the view that pinpoints war and other crises as capable of eliciting “mental health epidemics”. Furthermore, they manifest the same tendency to distinguish good and bad cultural practices discussed above in relation to the Sphere Standards.

The IASC guidelines are an undeniable step forward in the field of PSS, and their importance cannot be underestimated; however, it can be argued that they also represent the final step towards making the field of “MHPSS” relevant in every aspect of humanitarian aid, thus stabilising the conception of “complex emergencies” as “psychological emergencies”.

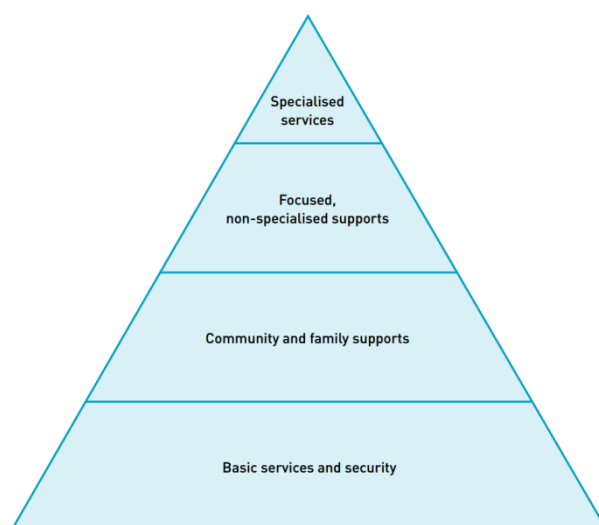


Figure 1. IASC Intervention Pyramid (2007)

### **The mhGAP Humanitarian Intervention Guide (mhGAP-HIG)**

These guidelines were developed by the World Health Organization (WHO) in 2015 with the aim of supporting general health facilities in assessing and managing the conditions of mental, neurological and substance use in areas affected by humanitarian emergencies. The guidelines were adopted from the WHO's mhGAP Intervention Guide (2010), a widely-used evidence-based manual that advises on the management of these conditions in non-specialized health settings, and is tailored for use in humanitarian emergencies.

It is worth highlighting that Post-Traumatic Stress Disorder is included in the “humanitarian” version of this manual, further strengthening the idea that wars and disasters are seen as psychological emergencies and PTSD as a specific tool for understanding suffering in such emergencies.

The application of the mhGAP-HIG poses a heavy risk of medicalizing war-affected populations (Ventevogel 2014). This tendency can be attributed to three characteristics presented in this particular toolkit. First, the classification system used is based on the International Classification of Diseases of the World Health Organization (ICD-10), that clusters severe disorders with a credible bio-genetic base (e.g. psychosis, dementia, bipolar disorder) together with more common problems such as depression and anxiety. Such clustering often renders distinguishing pathological from non-pathological life difficult. Furthermore, WHO's mhGAP-HIG approach is based on a strong individualistic outlook and assumption that mental disorders are universal, both of which have been largely questioned. There is also a noted preference for interventions that involve pharmacological substances in the mhGAP-HIG, revealing the tendency for the implementation of “quick fix” interventions that have little relevance with the social and collective dimensions of suffering and healing.

### **The Building Back Better report**

Although the Building Back Better report (WHO 2013) cannot technically be described as a set of guidelines like the ones discussed above, it may have relevance due to its core principle that highlights an important shift occurring in the field of psychosocial support in the last decade.

The 2004 World Bank toolkit “Integrating Mental Health and Psychosocial Interventions into World Bank Lending for Conflict-Affected Populations” states that: *“there has been a tendency to implicitly assume that the impact of trauma caused by mass violence (i) may be transitory and non-disabling, and (ii) that interventions in the emergency phase are sufficient”* (Baingana and Bannon 2004:1), and that such assumptions were to be questioned. This statement indicates a shift towards a view of trauma that is permanently impairing, and in need of long-term intervention. The IASC guidelines (2007) follow the same thread, advocating for the integration of mental health into the primary health care systems of war-affected countries. The Building Back Better report falls perfectly in line with such a statement, emphasizing that humanitarian aid needs to think of emergencies as opportunities that improve the existing services and that describe how this goal was pursued in ten emergency-affected areas. While it has been argued that a shift away from the short-term focus of PSS programmes is desirable, a few questions need to be raised.

Too often, governments of war-affected countries with humanitarian agencies operate with a lack of resources or the willpower to take charge of the (re)construction

of public services; they thus entrust have their management entrusted to NGOs. As noted above, aid agencies in war-affected countries tend to introduce definitions of illness and healing that may not be strictly relevant to the specific context. This extended presence of NGOs indicates a further risk – the employment of an increased number of medical staff expressly trained by Western mental health workers. The World Bank 2004 toolkit acknowledges that this entails a risk of over-diagnosis (31). It is therefore likely that an extended involvement of NGOs in war-affected areas will have a pathologizing effect on the population – not only during the emergency itself, but also and more importantly in the long run.

Furthermore, the issue of dependency needs to be taken into account. This problem is twofold. On the one hand, it has been argued that the long-lasting presence of NGOs in war-affected countries might lead to the population becoming increasingly dependent on them, especially in cases where their voices are not acknowledged as relevant in defining the priorities for intervention, regardless of their kind. This has been known to have a victimizing effect and to be harmful to processes of peacebuilding and post-conflict reconstruction (Dolan 2013; Fassin and Pandolfi 2010; Armstrong 2008).

On the other hand, it could be argued that dependency is not unilateral and instead also works the other way around. NGOs looking to take charge of public health systems do have an interest in demonstrating that their presence on the ground is needed – for example by proving that high rates of mental disorders are found in the population of interest – in order to obtain funding from international donors. The aforementioned practice of carrying out assessment surveys using questionnaires that tend to over-diagnose mental disorders goes precisely in this direction. Importantly, the population that such scales target is a non-clinical one and largely did not ask for psychological help (IASC 2007; Summerfield 1999; Kienzler and Pedersen 2012). There is very little evidence that war-affected individuals in non-Western countries have regarded their mental health as an issue or looked for specific treatment for it *en masse* (Almedom and Summerfield, 2004). Thus, in order to justify NGO presence in war-affected areas, they are dependent on the population's willingness to undergo assessments and treatments.

### **Common limitations of implemented PSS interventions**

The literature consulted for this review also provides interesting insights into some of the main challenges and limitations that involve psychosocial interventions in war-afflicted countries. They can be listed as follows:

*Lack of evidence base.* Despite most interventions that report positive outcomes, their evaluations (if present) often lack thoroughness (e.g. relying on anecdotal information), leading to a generally weak evidence base for demonstrating the effectiveness of mental health and psychosocial programmes (Jordans et al. 2009). Such an absence of thoroughness is often attributed to weak research design (e.g. lack of control group, no randomization applied).

While a good evidence base exists for interventions such as Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) and Narrative Exposure Therapy (NET), it should be noted that such programmes appear to be the most trauma-focused and individually-based interventions available. Their suitability for non-Western contexts is therefore questionable. By contrast, close to no evidence exists for more community-based, culturally relevant interventions.



The lack of a good evidence base has most frequently been reported as being a huge obstacle in this field, and the need for standardized procedures for evaluation of interventions has been repeatedly highlighted as a recommendation for future research (Lopes Cardozo 2008; Betancourt et al. 2013; De Jong et al. 2014; Jordans et al. 2016; IASC 2016).

Evidence is also lacking on fundamental matters such as who should and should not receive specialized treatment. Also, despite the popularity of first-aid measures such as PFA, there is a lack of research on the fundamental question of how much time should pass between a “complex emergency” and the implementation of a psychosocial intervention.

*Lack of cultural adaptation.* Another frequently mentioned limitation of PSS programmes is the lack of cultural adaptation applied during actual service delivery. Out of all the interventions examined, only a few reported to have adapted the actual project to the local context. As a matter of fact, although most interventions only claim to have been culturally adapted, they often do not elaborate on such processes (Jordans et al. 2009; Pedersen et al. 2015). Thus, the use of assessment tools that are not locally validated still occurs too frequently and the risks entailed in the use of such instruments have been detailed above.

*Lack of research on treatment mechanisms.* The literature examined highlights a significant lack of research on treatment mechanisms, constituting another huge obstacle when aiming to implement effective interventions. The only two retrieved studies that examined this issue (Jordans et al. 2012; 2013) concerning mechanisms of counselling in Burundi and South Sudan respectively, are multiple n=1 studies and caution should be used when interpreting the results.

*Lack of longitudinal studies.* Another issue that has been frequently pointed out in the research on psychosocial interventions is the fact that most studies are of cross-sectional in nature, meaning that follow-ups are very rarely found. This represents a major limit: the lack of longitudinal studies makes it impossible to evaluate the long-term effectiveness of PSS programmes (Jordans et al. 2009; Tol et al. 2011; Betancourt et al. 2013)

*Outcomes measuring.* The assessment of outcomes poses problems too; results are found to be mostly measured using PTSD (e.g. reduction of symptoms), even when interventions claim to measure other variables, such as social functioning or psychosocial well-being (O’Sullivan et al., 2016). Research on outcomes is therefore needed in order for intervention results to be significant in non-medicalizing ways.

*Reintegration practices.* In studies concerning the mental health and the reintegration of former child soldiers and ex-combatants, most of the commonly used reintegration practices (e.g. reception centres) have hardly ever been examined. Given that attention has recently been drawn to effective reintegration of former combatants being a part of peacebuilding and post-conflict reconstruction processes, in-depth research on effective reintegration practices needs to be implemented (Russell 2006; Wessels, 2008; Hendersen and Wessels 2009; Blattman and Annan 2010; Betancourt et al, 2010, 2013; Samarasinghe 2015).

## **Psychosocial support in Uganda, Democratic Republic of Congo (DRC), South Sudan, Central African Republic (CAR)**

A closer look at interventions implemented in Central African Republic (CAR), Democratic Republic of Congo (DRC), South Sudan and Uganda provides further confirmation of the points discussed in this literature review.

### *Central African Republic*

In CAR, the “trauma discourse” appears to be deeply embedded in the humanitarian field. A CORDAID project report states: “*Everyone is traumatized*” (CORDAID 2015). The intervention proposed consists of the establishment of a number of listening centres targeting conflict victims and traumatized populations, with the aim of addressing mental health problems and facilitating reconciliation processes. Again, underlying the logic of this project is a missed identification between the individual and the social level.

A report carried out by Save the Children in 2015 evaluated the psychological needs of children and found a post-traumatic stress disorder rate of 64%, and of 87.4% in cases where only one symptom was missing to meet PTSD criteria; such a high rate points to a possible medicalization of what are normal reactions to painful and stressful events and life conditions.

Action Contre la Faim (ACF) carried out a project in 2014 and 2015 aimed at exploring the transmission of trauma from mothers to their children, therefore conceptualizing trauma as a physical disease, situated deeply inside the individual. Although the results of this study are not yet available, such an approach is worrying as it is extremely medicalizing, therefore distancing itself from a perspective that takes into account the complex and culture-bound processes of meaning making. In another report, ACF further links “traumas” to feelings of revenge, therefore pathologizing the affected individuals’ negative emotional reactions to a disruptive events.

### *Democratic Republic of Congo (DRC)*

Psychosocial support programmes in DRC appear to be strongly focused on two main issues: conflict-related sexual and gender based violence (SGBV) and the reintegration of former combatants, specifically, of “child soldiers”. Counselling for rape survivors has been widely implemented; although post-conflict factors have sporadically been taken into account (Verelst et al. 2014), post-traumatic stress disorder is the usual frame of reference. The same is valid as far as former combatants are concerned, for whom the implementation of strongly trauma-focused therapies is widespread (Mels et al. 2009; Pham et al. 2010; Veling et al. 2012; McMullen et al. 2013). PTSD has also been linked to the concept of “appetitive aggression” (the perception of aggressive behaviour toward others as positive or fascinating), which reveals a tendency for practitioners to regard “trauma” as a potential initiator of “cycles of violence” (Hermenau, 2013). A project by the World Bank for the Reinsertion and Reintegration Project of former combatants, initiated in 2015, identifies psychosocial support as a key issue in the Disarmament, Demobilization and Reintegration (DDR) process. It is worth noticing, though, that such a project recommends interventions such as TF-CBT and NET therapy for former combatants; the limitations of such approaches have been discussed above. In this regard, a study carried out with former child soldiers found exposure to trauma

(the core principle of TF-CBT and NET) to be ineffective. The authors add a remark whose importance cannot be overlooked: *“When asked about their most pressing concern, the majority (of the participants) stated a lack of money to pay school fees, not past war experiences, as their greatest difficulty. [...] This study demonstrates the importance of including the voice of the participants in the design of research interventions, instead of deciding on behalf of participants what type of intervention is in their best interest”* (O’Callaghan et al. 2015: 41).

Furthermore, it should be highlighted that such a twofold focus of PSS in Democratic Republic of Congo of targeting very specific groups of individuals, risks excluding them from the rest of the community, enhancing stigmatization and further damaging the already fragile post-conflict social fabric and processes of social healing.

### *South Sudan*

PSS in South Sudan appears to have particularly focused on the issue of refugees and people displaced as a consequence of the conflict. A closer look at a number of studies (Neuner et al., 2004; Roberts et al., 2009; Ayazi et al., 2012) suggests that the dimension and objectification of “trauma” seems to be taken for granted. A study by the United Nations Development Program (UNDP) states: *“Trauma is a natural consequence of largescale conflict”,* and *“Survey data point to an alarming rate of PTSD and exposure to trauma in South Sudan”* (Deng et al. 2015:63). The same study warns policy makers of the possible effect of PTSD on people’s perception of solutions to conflict, highlighting yet again a tendency to medicalize post-conflict suffering. A psychological needs assessment carried out by the International Organization for Migration (IOM) in 2014 claims that the psychosocial support programmes that have been implemented usually consist of different forms of counselling (IOM 2014:12). Interestingly, however, the same report notes that dedicated guidance counselling services did not emerge as a necessity at the individual or family level, but rather at the community one, hinting that locally perceived priorities are not so much focused on the individual sphere and past traumatic experiences as they are on the social one, where most of the post-conflict healing processes take place. In very recent years, the integration of mental health services into primary health care seems to have become a topic of interest also in South Sudan. However, a 2015 report by the Peter Alderman Foundation points out that such an objective might be unrealistic in such an extremely resource poor context, therefore highlighting another aspect of recent guidelines like IASC and mhGAP-HIG that has been deemed questionable.

### *Uganda*

In Uganda, during and after the civil war between the government and the Lord’s Resistance Army (LRA), “child soldiers” have been of paramount importance in the discourse and focus around which psychosocial support programmes have been implemented. The wide majority of the projects have been targeting this category of individuals, although confusion around the term “psychosocial” is widespread: *“The term ‘psychosocial’ has become a catchphrase amongst agencies working in northern Uganda (not just the reception centers) for just about anything to do with assistance that is additional to giving FAPs (formerly abducted people) food.”* (Allen and Schomerus 2006, p. 50). The “trauma” discourse appears to have been largely prevalent, with a number of studies reporting various PTSD rates, sometimes as high as 97% (Derluyn et al., 2004). Commonly implemented trauma-focused interventions are NET therapy (Ertl et al. 2011; 2014; Winkler et al. 2015; Pfeiffer and Elbert 2011)

and Cognitive-Behavioural Therapy (Sonderegger 2011).

A further commonly implemented intervention consists in various forms of counselling, often offered by organizations such as AVSI and HealthNetTPO, whose many activities included the training of Community Volunteer Counselors (CVC). Counselling was also one of the main and more appreciated services offered at “reception centres”, whose aim was to facilitate the reintegration of demobilized “child soldiers”. Although such structures have hardly ever been researched, it has been pointed out that counselling offered in such centres had very little to do with any form of therapy; it often consisted mostly of advice-giving, and the “counsellors” who administered it frequently had no clinical training or experience (Allen and Schomerus 2006). Furthermore, follow-ups were found to be virtually non-existent, constituting a huge limitation.

Moreover, despite most studies linking mental health and the process of reintegration, the connection is usually established between PTSD symptoms and feelings of revenge affecting such process. There is a paucity of research on post-conflict factors (e.g. stigmatization towards former combatants) and their long-term effects on mental health, which may be relevant to look into. Despite some studies arguing that social rejection in northern Uganda is very weak and that relationships within the community are generally positive, other findings suggest that social exclusion is instead a widespread problem, and that many former combatants - both men and women - still live in very vulnerable conditions (Corbin 2008; Allen et al. forthcoming). If this proves to be the case, the lack of non-trauma focused psychosocial interventions targeting such post-conflict issues would be all the more worrying.

### **Conclusions and recommendations for further research**

The literature examined for this review allows for a number of conclusions, listed as follows:

First, despite the lively debate that has developed in academia around the cross-cultural use and validity of the category of post-traumatic stress disorder, the diagnosis of PTSD is still widely applied in non-Western countries. The ease with which NGOs and INGOs discuss “traumatized” populations is frankly appalling. There is a need to use less medicalizing and more culturally relevant categories in the field of psychosocial support in order for interventions to address the complex and social dimensions of suffering that follow a disruptive event, and to work on the resilience of affected populations rather than focus merely on aggregations of individual symptoms.

Second, it is possible to identify a shift in the focus of PSS, from short-term interventions in the aftermath of a crisis to the integration of mental health services in the primary health care system of affected countries. It is important to remember that this may not always be possible because of the lack of resources in the countries of interest. However, when such a goal can be achieved, it is of paramount importance to tailor the services to the actual needs of the communities. The risk of proposed interventions and services not reflecting local needs and having limited contextual relevance (and therefore being a form of “imposition”) needs to be constantly taken into account.

Third, in recent years the field of mental health has become more and more linked to post-conflict reconstruction and peacebuilding. Interventions aimed at successful reintegration of former combatants and facilitating processes of social healing need to distance themselves from a narrow focus on war-related traumatic

experiences. Instead, they should adopt a much broader community-based focus. Programmes targeting “vulnerable groups” need to shift their attention towards a wider social dimension where everyday dynamics of healing and reconstruction play a major role.

Fourth, a vast majority of the literature consulted consisted of cross-sectional studies. There is a strong need for longitudinal studies that can account for medium and long-term effects of psychosocial programmes; such a need is all the more pressing in light of the rise in attention to PSS and peacebuilding processes.

Fifth, while evidence for the effectiveness of trauma-focused interventions exists, those evidence supporting community-based ones seems to be extremely weak. Such interventions therefore need to be attentively monitored and evaluated in order to create a steady body of knowledge and evidence concerning community-focused programs.

Sixth, the voices of the people that PSS interventions claim to benefit appear to be rarely acknowledged or given the priority they deserve. The need to tailor, carefully, to the needs and priorities identified by affected populations cannot be emphasized enough. The field of psychosocial support in war-affected areas needs to be steadily based on local perceptions and perspectives in order to serve the actual needs of the communities and to not risk imposing false ones that are deeply bound to, and dictated by, Western rhetoric.

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