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J Health Psychol 2007; 12; 485
DOI: 10.1177/1359105307076235

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Emergency Conflict-related Psychosocial Interventions in Sierra Leone and Uganda

Lessons from Médecins Sans Frontières

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COMPETING INTERESTS: None declared.

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Journal of Health Psychology
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Los Angeles, London, New Delhi and
Singapore, www.sagepublications.com
Vol 12(3) 485–497
DOI: 10.1177/1359105307076235

Abstract

Médecins Sans Frontières has been involved in emergency mental health or psychosocial programmes since 1990. In this article the intervention model developed for emergency settings is shared. Psychosocial programmes distinguish two elements. The 'psycho'-component facilitates the reconnection of the affected individual to his environment. The 'socio'-element aims to create an environment that facilitates the individual to re-integrate. The nature of mental health and psychosocial programmes requires a multi-disciplinary approach. Emotional support can also be provided by regular medical staff and does not always require a specialist. The years ahead of us are important for the development of psychosocial interventions. Fundamental issues such as programme evaluation need systematic research.

Keywords

- *mental health*
- *psychosocial*
- *trauma*
- *war*

Introduction

MÉDECINS Sans Frontières (MSF) is an independent, humanitarian organization working with international and national staff in 87 countries worldwide. In its 29 years of existence MSF has developed specialist knowledge in providing health support to populations in emergency and crisis settings.

MSF has been involved in mental health interventions since 1990. The decision to intervene in the early stage of an emergency is largely based on operational observations and compassion of field workers. The usefulness of intervening in the early stages of a crisis has been documented in a number of settings (Brom & Kleber, 1989). This article aims to add to the knowledge base that informs provision of early psychosocial intervention programmes in emergencies involving refugees and war-affected populations with particular reference to Africa more specifically Sierra Leone and Uganda.

We outline a general framework and activities incorporated in MSF psychosocial programmes for refugees and displaced people after man-made disasters. We discuss the impact of these programmes on our work in Sierra Leone and Uganda. The article concludes with lessons learned to date.

Violence in Africa: some examples

WHO's *World report on violence and health* (Krug, Dahlberg, Mercy, & Lozano, 2002) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

When using this definition of violence the number of conflicts in Africa is high. According to the IDMC (2006) report, there is war and/or conflict in 20 African countries. Daily violence is the reality for many Africans now or has been in the past. To give an impression of what people actually experience some findings of two MSF surveys conducted in Africa follow.

Sierra Leone suffered from a brutal internal war from 1991 until 2001. The internal strife was instigated by outside powers that had an eye on the country's rich mineral resources and led to a decade of savagery, barbarism and horror for most of its inhabitants. In addition to killings many people were displaced or became refugees in neighbouring countries. Currently, Sierra Leone is stable and peaceful. Figure 1 shows the exposure to violence of civilian

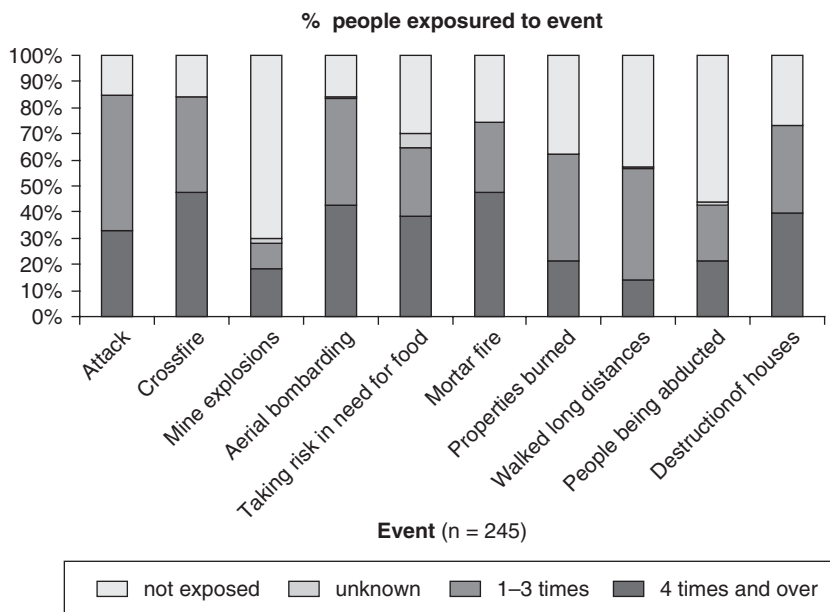


Figure 1. Exposure to violence in Sierra Leone from 1991-1999.

Source: De Jong et al. (2000)

respondents ($N = 245$) in a Sierra Leonean survey conducted by MSF (de Jong, Mulhern, Ford, van der Kam, & Kleber, 2000). Incidents include direct warfare: attacks on village (84%), exposed to cross-fire (84%), explosion of mines (28%), aerial bombing (83%), mortar fire (65%), burning of properties (62%) and destruction of houses (73%). In addition to the direct threats caused by the hostilities, the lack of food and other commodities forced people to take extra risks (74%). Some people (57%) had to walk long distances to find a safer place. The risk of abduction was clearly present since 43 per cent of the respondents reported to have been abducted. Generally, half of the respondents indicated that the event had taken place more than three times in the past 10 years.

A different study into the violence in Sierra Leone particularly focused on sexual violence (Amowitz et al., 2002). This survey showed some 9 per cent of the respondents and 8 per cent of female household members experienced war-related sexual assaults. Comparison to other conflict areas such as Sri Lanka (2%) and Chechnya (0%) shows this to be a rather high rate (de Jong et al., 2002, 2004).

It is equally dreadful to see that Amowitz et al. (2002) found non-war-related sexual assaults in the same context as being equally high (9%). In other areas in Africa such as South Africa, women reported even higher numbers of incidents of sexual violence: three out of 10 women surveyed in the Southern Metropolitan region of Johannesburg reported that they had been victims of sexual violence in the previous year (Martin, 1998).

Figures and differences on rates of sexual violence should be interpreted carefully, however. The topic is taboo and that may result in underreporting in some settings. Furthermore, we experience often that definitions of sexual violence held by those affected differ substantially.

In contrast to the Sierra Leonean conflict that was characterized by full-blown war, Uganda suffers from a low-intensity, chronic and geographically confined conflict. The Lord Resistance Army (LRA) of Joseph Kono has been in conflict with the Government of Uganda for the last 30 years. The rebel group started as a resistance group and has emerged as a brutal guerrilla group with 80 per cent of fighters consisting of abducted children. They terrorize among others their own ethnic group (Acholis) by unpredictable tactics of ambushes, killings, lootings and abductions. Despite the different type of conflict exposure, violence is not very different (Fig. 2). Nearly one-third

reported in an MSF study (2004) to have lost a family member (death or disappearance), others experienced violence (17%), or destruction of property (11%).

Some consequences of violence

The material consequences of violence are well known and often visible. Human loss is expressed in anonymous and depersonalized numbers. To give a human dimension to loss, we constructed in our Sierra Leonean survey (de Jong et al., 2000) an inventory of what human loss people suffered. The loss in the nuclear family (partner (5%), father (5%), mother (7%), child(ren) (9%) and siblings (16%)) was reported less than the loss of more 'distant' family members (aunt, uncles (14%)). The percentages reported on death of neighbours (53%) and friends (50%), was clearly higher as there are more of them. These data indicate that at least 50 per cent of the respondents lost someone they knew very closely. Many respondents witnessed the death of a close person: 30 per cent witnessed the death of a friend; 41 per cent the death of a neighbour. An additional 7 per cent witnessed the death of their own child.

The physical consequences of violence often receive wide coverage and attention; the mental health effects of violence less so. In our Uganda survey it was found that both men and women reported ongoing symptoms of traumatic stress (see Fig. 3). When asked to think of 'the most frightening event that has happened since 2002', women reported feeling the following symptoms 'a lot' of the time within seven days before the survey: irritability/anger (59.2%), experiencing reminders of the traumatic event (47.4%), waves of strong feeling (35.5%), dreaming about the event (34.2) and physical reactions, like shaking/sweating (32.9%). Men reported feeling the following symptoms 'a lot' of the time within seven days of the survey: reminders of the traumatic event (56.3%), irritability/anger (53.1%). The following symptoms were reported 'moderately': trouble concentrating (38.5%), trouble falling asleep (38.5%), intrusive thoughts (37.5%) and recurring mental images (32.3%).

Interventions

The guiding framework for MSF's intervention

Psychological health rests on a continuum of psychological well-being. Partly depending on the cultural

Most significant traumatic event experienced by respondents

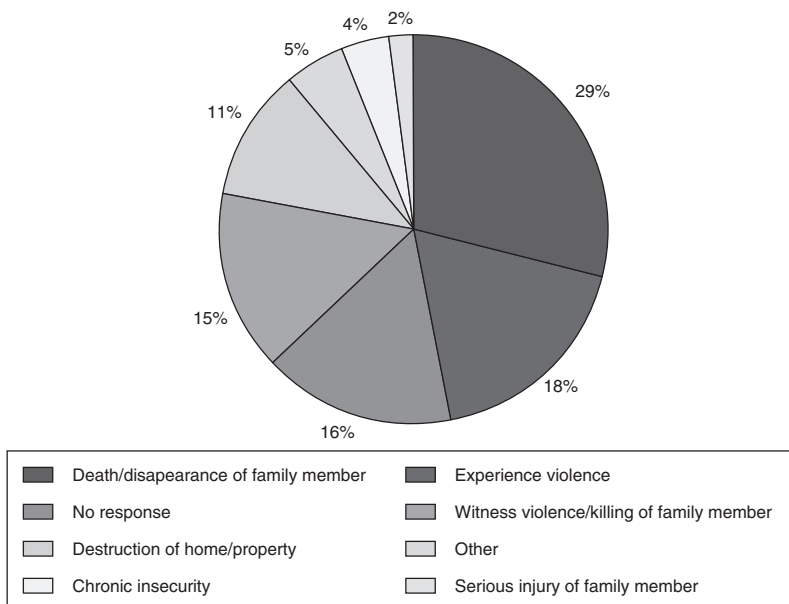


Figure 2. Exposure to violence in Lira, Kitgum Pader areas of Northern Uganda.
Source: MSF (2004)

ideas of a community, an individual’s psychological state can be defined as normal and healthy, or as abnormal and mentally ill. Between these two ‘extremes’ is a large middle category of psychosocial problems (see Fig. 4).

The answer to the question: ‘What focus is appropriate for a mental health or psychosocial intervention?’ depends on the type of emergency situation at hand. All medical interventions need to have psychological and social components. However, in *acute emergencies* such as Sierra Leone health projects focus on those mental disturbances that cause immediate danger to physical survival. Meanwhile, in *chronic crises* such as Uganda, they generally focus less on mental disturbances and more on psychosocial problems that hamper people’s process of coping with the extreme stress. The interdependency between the individual and his environment is an important element of the coping process. Programmes that address the psychological consequences of violence have to pay attention to this specific relationship. In psychosocial projects a joint approach of both individual care and community support is vital. The ‘psycho’ and ‘social’ elements should be complementary in order to ensure that

individual and environmental healing capacities are mobilized (de Jong, 2005; de Jong & Prosser, 2003).

The process of coping and adaptation starts at the onset of an emergency. Therefore, mental health disturbances and psychosocial problems need to be addressed from the beginning of an emergency. Provided they are implemented in an appropriate way, research increasingly confirms the importance of early intervention (Shalev, 2003; Shalev et al., 1998; Ursano et al., 2004; Yehuda, McFarlane, & Shalev, 1998).

Objectives of MSF’s intervention projects

Mental health or psychosocial projects?

Depending on the definition of mental health one can distinguish between mental health or psychosocial projects. If mental health is regarded as a continuum that includes psychiatric disorders, psychosocial and psychological problems as well as people considered to be non-symptomatic a differentiation between mental health and psychosocial projects is not necessary (see Fig. 4). If mental health is defined as only dealing with the top of the public

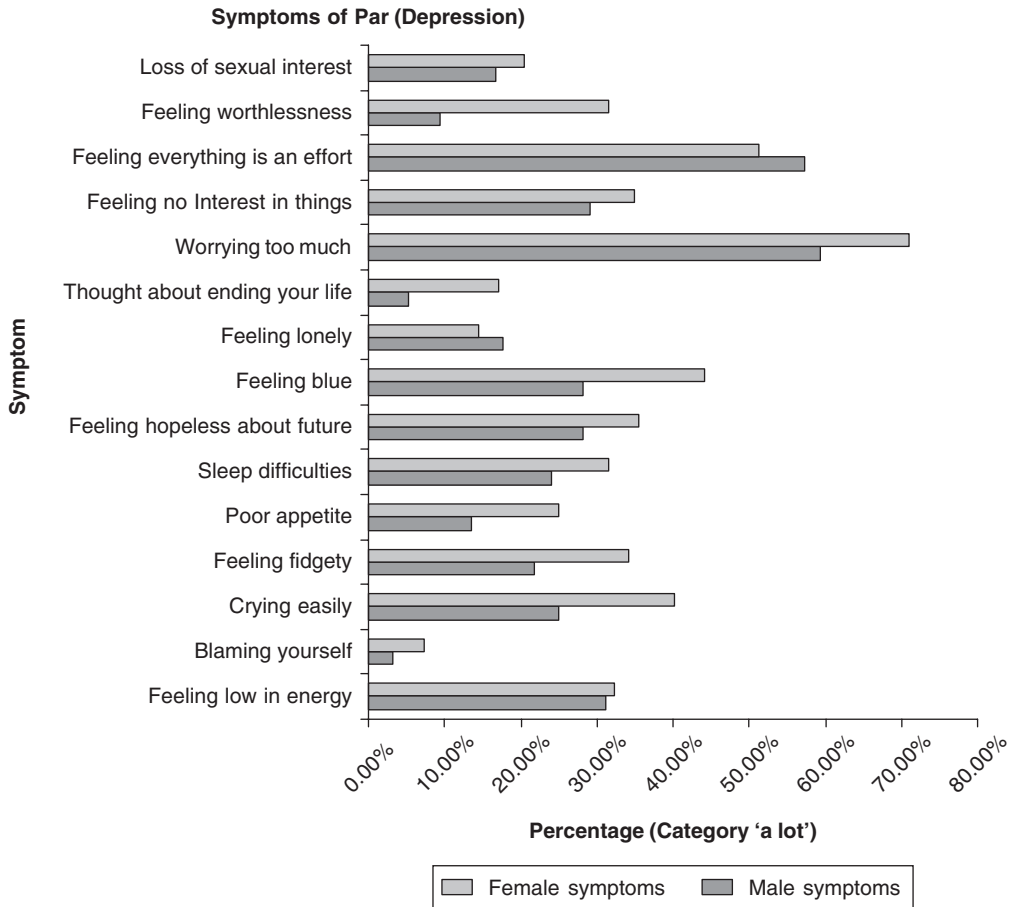


Figure 3. Intervention model for psychological projects to address the psychological consequences of violence through individual community interventions.
 Source: De Jong (2005)

health pyramid then it makes sense to define mental health and psychosocial projects differently.

Mental health projects Mental health interventions are aimed at reducing suffering caused by mental disturbances. Especially in the first stage of an emergency, drug therapy and (secondary) psychosocial support are combined.

Psychosocial projects Psychosocial projects interventions aim to reduce the psychological consequences of mass violence. To achieve this, two elements are distinguished. The ‘psycho’-component provides support on the individual level. It facilitates the reconnection of the affected individual to his environment, his community and his culture

(Herman, 1992). The ‘socio’-element aims to create an environment that facilitates the individual, or rather groups of affected individuals, to re-integrate.

Both elements need to be addressed in any psychosocial project. The importance of and the balance between both elements (the ‘psycho’ and ‘socio’) in the project implementation depends on cultural, environmental circumstances, phase of emergency, etc. (de Jong & Prosser, 2003).

Package of psychosocial activities

Psycho’logical package

The psychological element of the project is delivered as a package (see Fig. 5). All components of this ‘psycho’logical package must be in place, either

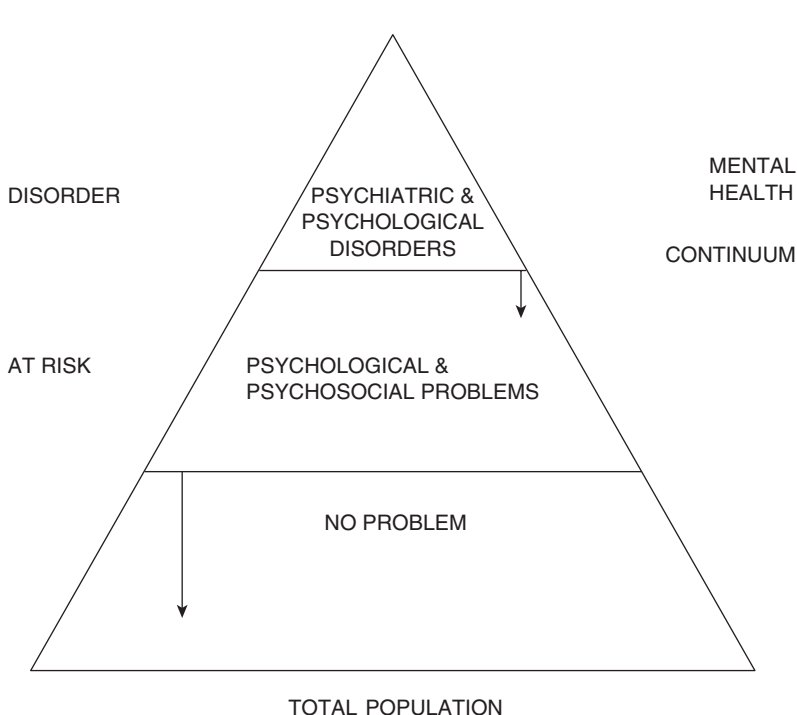


Figure 4. Mental health continuum (Arrows indicate changes caused by mass violence).

in the form of direct services or of a referral, to ensure a comprehensive programme. The ‘psycho’-logical package includes the following components.

Psychiatric support In acute emergencies expatriate and national specialists give (temporary) psychiatric support to beneficiaries. To avoid dependency on external specialists in chronic crises, psychiatric support is usually provided through referral of the clients to existing medical or psychiatric services.

In Sierra Leone even the most basic psychiatric services were absent (see Asare & Jones, 2005). With one psychiatrist in the country and one institution that was hardly staffed MSF doctors provided basic psychiatric treatment in the MSF-run primary health care settings in addition to the basic technical support that was given to the institution. The integration of mental health support in the MSF primary health care clinics increased accessibility of the psychosocial support in the places where we worked. The doctors referred patients and clients that increased the credibility of the psychosocial services. The efficacy of our primary

health care services as a whole increased because medical staff could focus their activities on the physically and mentally ill. Similarly, the quality augmented because psychosocial cases or people suffering from somatization could be referred to counselling services. The integration of both physical and mental health messages in the communities led to a better understanding of health and the relationship between physical and mental aspects in the community.

Supportive counselling Counselling is offered as systematic support to individuals and small groups. The counselling interventions are based on cognitive behaviour techniques and brief therapy principles that are translated to the existing cultural environment. The counselling does not aim primarily to heal or to cure people of their psychosocial problems. In situations of acute or ongoing humanitarian crisis and exposure to traumatic events, healing or curing is not realistic. The role of the counsellor is to support and improve the coping mechanisms of beneficiaries. Supportive counselling provides people

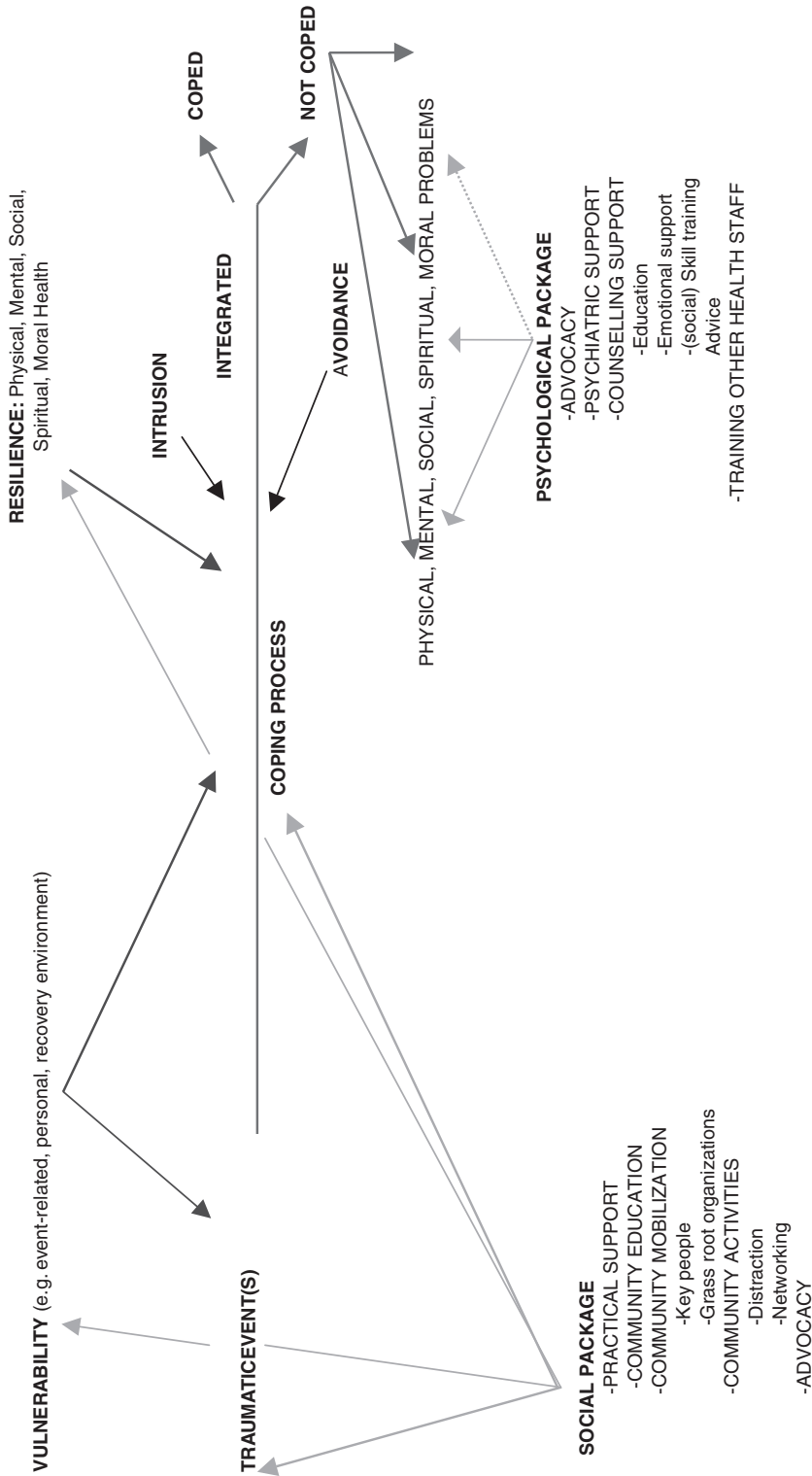


Figure 5. Intervention model for psychosocial consequences of violence through individual and community interventions. Source: De Jong (2005)

with some emotional support, and practical advice. In both our Uganda and Sierra Leone programmes people often turned to the counsellors because of lack of food or other necessities. Though referral to social services or other NGOs was done clients were also counselled on their problem-solving skills. Counselling should not only be limited to complaint reduction it should also help people to increase their self-control through education, social skill improvement and to boost their resilience through mobilization of self-support factors (physical, mental or social). Approaches focusing only on the psychological, physical or social dimension of the client's experiences have limited value. A separation between these entities assumes, incorrectly, a separation of body and mind, or the human from the environment. This separation is part of western medical-philosophical tradition and does not necessarily hold for non-western worldviews.

The process of coping with traumatic experiences includes the capacity to give meaning to the experience. In many non-western societies meaning is given through the spiritual world. The areas of moral and spiritual health are difficult for western NGOs and psychosocial counsellors to address. In Sierra Leone MSF included creditable spiritual leaders as advisors and as referral options in its programmes. They executed cleansing rituals and ceremonies to support clients. In Uganda MSF was unable to include them in the activities as their herbal and exorcism-based practices differed too much from our own ethical principles and quality standards.

Training Training of national staff is necessary to increase or to introduce skills and knowledge. However, the objective of the training is not to make counsellors become 'clinical psychologists' applying western techniques and therapies. The objective is to foster an attitude of non-judgemental listening. Training counsellors on how to connect to their clients requires trainers that can facilitate this process. This process starts with the exploration of what caring capacity is known and accepted locally. To experience that and how counselling works trainee-counsellors use each other. Through this mutual counselling process a local counselling toolset is created. It is important that trainers reinforce the counselling attitude and model a listening attitude themselves from the start of the training. In the Sierra Leone programme initial training was technical and western skilled oriented. This led to confusion among counsellors. Being afraid to do

things wrong counsellors became either paralysed or very technical. Because this was difficult to change MSF decided to develop a 'standard' training for national counsellors (van der Veer, 2003).

Advocacy Proximity to beneficiaries is essential for showing empathy, solidarity and compassion. The changing environment requires ongoing monitoring of needs. Human rights violations necessitate speaking out or advocating for those who cannot speak. Counsellors in MSF psychosocial programmes work in the clinic as well as in the community. The proximity of the counsellors helped MSF to identify cases of sexual violence that would otherwise have passed by unattended because of the taboo on it. MSF staff presented the matter also to local authorities who took measures based on the information.

'Social' package

The social component of a project addresses psychosocial problems at a group level. A package of activities is proposed to stimulate the re-integration of traumatized people and to facilitate the coping of large groups of people. All components of the 'social' package should be delivered, otherwise resilience or protective factors can only be partly mobilized. The 'social' package includes the following components.

Practical support Traumatized people and populations need considerable practical, physical support to enhance their recovery environment. Medical services, water and sanitation assistance or food support are just some examples. The prevalence of needs is often overwhelming. Therefore, to ensure appropriate referrals of those in need for practical support, expatriates, national counsellors and community workers need to know what is available in the community (social map). To provide adequate support and to foster self-help mechanisms the national staff's understanding of socially and culturally appropriate methods is vital. Since not all the support can be expected from the community, close co-operation among NGOs needs to be stimulated.

Community education Large-scale education about prevailing psychosocial problems in the community is necessary to increase self-control and self-help. Education also assists to diminish taboos about mental health and psychosocial problems. Furthermore, it increases awareness about counselling services.

Community mobilization The social fabric of communities is often affected by mass violence. This results in a reduction of people's protective mechanisms. After mass violence the regeneration and revitalization of new or former community structures often requires facilitation from outside. Cultural leaders such as chiefs, religious leaders or the elderly must be stimulated to re-assume their roles. Grass root initiatives need assistance and stimulation. They often prove to be important mechanisms for the provision of practical support. Local cultural groups like theatre, or folk play companies are often instrumental in creating a better atmosphere.

In the camps in Northern Uganda people were without employment. The communities were shattered and the care capacity reduced. To mobilize the community MSF facilitated the establishment of a community shelter. The people built the facility themselves. The process of organizing and building led to a boost in community life. The shelter was later used for community gathering, an 'indoor' market and a variety of psychosocial and other activities.

Community activities The atmosphere in refugee and internally displaced camps is often far from uplifting. Community activities can be used to improve the general atmosphere, to stimulate community action on general issues like hygiene promotion or to re-start community cultural customs like dancing or story telling. Despite the serious emergency conditions MSF organized in its Sierra Leone programme football competitions to improve the community cohesion and to create a better atmosphere. These activities improved the sense of belonging. The community started to organize their distraction activities such as child dance groups and handy craft. This required extensive networking with both significant people in the community and (folk) artists to start it. After the initial push the community activities took on their own life as the community owned them.

Speaking out Human rights are universal and must be respected. Counsellors and expatriates have the right to speak out (advocacy) against human rights abuses and to raise awareness about human rights abuses. To raise attention for the suffering in Sierra Leone and Uganda MSF published reports and articles in scientific journals (see de Jong et al., 2000; MSF, 2004). Though the efficacy of these reports is difficult to establish the wide

media attention they attracted ensured that the suffering was acknowledged.

Monitoring

It is difficult to measure and monitor the effectiveness of psychosocial programmes (Burkle, 1999; Mooren, de Jong, Kleber, Kulenovic, & Ruvic, 2003) in emergencies due to several factors. Conventional monitoring and evaluation criteria are not applicable or valid in changing, unpredictable and unstable contexts. Field reality challenges conventional evaluation criteria such as determinants of effectiveness. Furthermore, documentation and systematic measurement of outputs are often not possible in emergencies. Epidemiological evaluation models advocated by western psychiatry are insufficient to prove the effectiveness of humanitarian actions (Robertson, Bedell, Lavery, & Upshur, 2002). For example, evidence-based psychology and medicine use effectiveness or impact as justification for psychosocial interventions, but epidemiological data do not tell us anything about the fundamental motives for humanitarianism: compassion, empathy and a sense of justice. In addition to this most evidence is based on western situations and for higher technological interventions. The cultural differences in the perception of trauma, expression of suffering and the mechanisms for coping make it difficult to generalize from one context to the other (Hollifield et al., 2002). Culture-specific models and instruments to evaluate that programme outputs improve resilience require extensive time and resources (i.e. a long-term investment on behalf of MSF).

In Uganda we looked into the beneficiary perspective on the effectiveness of our services (Schley, 2005). Thirty former clients of the programme were interviewed on their self-reported change in the following domains: general complaints; health; daily functioning; skills; practical problems; mood; symptoms; and coping. Clients were measured on these indicators using 'increase, decrease, stay the same'-ratings.

A majority of respondents (55%) reported a complaint reduction due to counselling, 41 per cent claimed their daily functioning to have improved, 62 per cent claimed their mood improved and 65 per cent stated their coping skills increased. The general trend of all indicators showed 65 per cent of clients reporting improvement in most of the domains from the time of the counselling intervention to the

period of evaluation. Approximately 20 per cent of respondents claimed to have worsened in the domains of health, daily functioning and practical problems. Neuner, Schauer, Klaschik, Karunakara and Elbert (2003) found similar improvement rates (71%) after a psychological intervention among Sudanese refugees living in Uganda.

MSF is not a scientific organization and needs to focus its attention on the provision of medical emergency support to people in need. However, it can profit from the efforts of others such as Bolton (2001; Bolton & Tang, 2002) who developed new methods of psychological and psychiatric assessment in non-western settings. The body of knowledge regarding psychological interventions in African settings is growing. For Uganda both Bolton et al. (2003) and Neuner et al. (2003) established promising results on psychological treatment in refugee settings. Within this context MSF can contribute to the development of creditable evidence regarding psychosocial intervention in the future.

Integration in health programmes

The nature of mental health and psychosocial care requires a multi-disciplinary approach. The evident *relationship* between *traumatic exposure* and *poor health* suggests intensifying the collaboration between primary and specialty medical care (Schnurr & Jankowski, 1999).

Medical professionals like community health workers, nurses and medical doctors come into regular intimate contact with the emotional and psychological worlds of their clients. The curative and palliative role of the practitioners cannot simply end with the provision of technical support. Providing emotional support is critical to a comprehensive treatment process that takes into consideration people's psychological, social, spiritual and moral functioning. It involves being compassionate about people's feelings, applying basic communication skills and sharing knowledge on, for instance, techniques for recovery from the psychological consequences of violence. Providing emotional support to a patient directly benefits the healing process and does not require a specialist.

Psychosocial care components are integrated in a variety of ways in basic health care services (see Fig. 6). When the provision of emotional support given by the medical staff is insufficient to meet the psychosocial needs of a patient, referral to other

existing psychosocial service may be necessary. Patients should only be referred to non-MSF services that have been quality-checked by the medical team. In the absence of local psychosocial support services a trained local counsellor or expatriate mental health specialist can take the case referrals.

When the psychosocial needs overwhelm the existing local or expatriate services, a *community-based* psychosocial component is implemented. The component has to be integrated into existing Ministry of Health or medical services provided by an international NGO.

Psychosocial activities should also be linked to other types of medical activities like nutritional, HIV/AIDS, health education, sexual violence, reproductive health, safe motherhood and tuberculosis programme activities.

To emphasize the intense collaboration between mental and physical health in humanitarian medical interventions all project proposals have to contain physical and mental health activities. This is only realized if staff hold on to an attitude of comprehensive medical thinking (patient instead of disease oriented) and an integrated management style.

The way forward

Mental health and psychosocial problems have until recently been largely neglected in international humanitarian assistance. It is therefore regrettable that the boom in provision of such programmes has often resulted in exaggerated expectations on the part of the beneficiaries, overoptimistic claims made about their likely impact and subsequent criticisms of poorly formulated or ill-advised service delivery (Summerfield, 1999).

The years ahead are therefore going to be particularly important for the development of programmes of early psychosocial intervention. Acquired knowledge and accumulated experience needs to be expanded and shared. There are also fundamental issues that need to be addressed through systematic research. In particular these include cross-cultural assessments of psychosocial problems and needs, cross-cultural validation of Post-traumatic Stress Disorder (PTSD) and other stress-related concepts, cross-cultural assessments of the relevance of assistance to be offered, appropriate early intervention programmes and programme evaluation (Kleber, Figley, & Gersons, 1995). Operational issues such as the basic principles that should inform planning and delivery of early intervention, setting programme

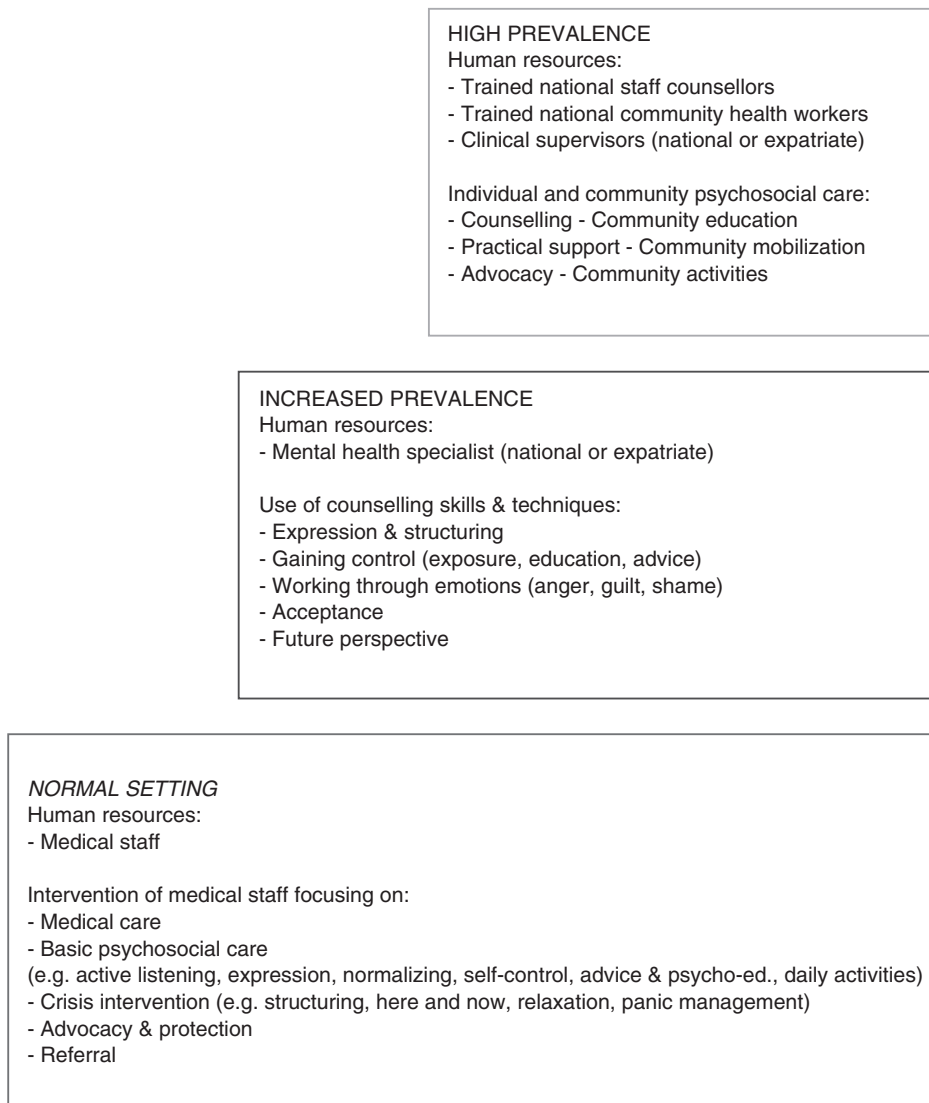


Figure 6. Various levels of psychosocial integration in primary health care settings.

objectives and deciding on what constitutes appropriate programme activities warrant more detailed discussion. In this respect a promising initiative is the formulation of draft guidelines for psychosocial programmes (Aarts, de Graaf, de Jong, Kleber, & van der Put, 2001; IASC, 2007).

The chief lessons learned over the past 10 years are that fine-tuning interventions to the cultural settings and specific community contexts in which they are to be provided is vital for their acceptance and

uptake of services. Knowledge about processes and practicalities of bridging cross-cultural differences and how to adapt services to local needs are limited and rarely applied with due consideration. To overcome this problem it is strongly recommended that both NGOs and expatriates adopt a more listening attitude and a more modest disposition in which helping takes precedence over healing. MSF has found that over time the content and methodology of our training and support has undergone marked

changes. Our initial interventions in non-western settings such as Lebanon, Sierra Leone, Indonesia, Colombia and Tajikistan taught us to balance our western MSF perspectives with the explanatory models and language used by beneficiaries. It is our experience that national staff are well able to act as cross-cultural translators and negotiators when given the opportunity to do so.

Furthermore, MSF has found that training of national staff cannot be achieved through single 'one-off' training programmes. Regular and systematized coaching on the job and case supervision should complement formal training. These are regarded as essential to ensuring that learning becomes a continuous process for all involved. It also goes some way towards guaranteeing the quality of services provided. This support should be available and accessible every day. The implementation of early intervention programmes for refugees and populations affected by war usually requires a longer-term commitment to local involvement, and consistency in provision.

Another important finding relates to the balance between psychological and social aspects of assistance. Too much emphasis on clinical services may result in stigmatization and in underused services. If local populations are not informed of what services are setting out to do in their communities their expectations may be unrealistic. Conversely, an exaggerated emphasis on the social and awareness components of psychosocial programmes can result in ever-increasing demands for more in-depth support, counselling and therapy that are not available. It is our experience that the balance between the 'psycho' and 'social' needs and provision is subject to cultural variations and fluctuates according to contextual factors.

In spite of the dearth of information regarding psychosocial programmes the experience of MSF strongly supports the notion that early psychosocial programmes are important. During emergencies the shattered emotional worlds, the broken trust and the eroded belief in the benevolence of human beings need to be addressed. Early support of coping and adaptation processes plus the prompt provision of practical help and the immediate facilitation and restoration of a sense of community carries the implicit and crucial message that someone cares.

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