

It Takes a Village: Psychological Recovery in Complex Emergencies

Elena Cherepanov

Boston MA

Abstract While qualitative and anecdotal field evidences provide compelling illustrations of the value of Mental Health (MH) relief work, the professional community has yet to arrive at a conceptual framework and evidenced-based practices. Additionally, the controversies surrounding understanding MH needs in complex emergencies, scarce resources and limited engagement time of relief organizations, offset the recognition of accomplishments. One solution to this could be a Community-Based Psychological Recovery (CBPR) paradigm where the MH specialists partner with the community to create self-sustaining support systems. It based on the recovery-oriented paradigm, where the success of individual psychological recovery determined by quality of community support providing secure sense of self, supportive relationships, empowerment, social inclusion, and meaning (SAMSHA, 2004). Trauma, famine, violence and marginalization challenge these supports. It CBPR facilitates recovery by mobilizing and strengthening recovery resources, and sensitizing community to the needs of vulnerable groups. In this way, it aims to prevent post-trauma communal violence and radicalization. CBPR model based on the premise that. With training and support, the local trauma specialists in the disasters, wars and ethnic conflicts zones can become powerful agents of change in restoring and strengthening the community's capacity for self-reliance and healing. CBPR models piloted in Chechnya, Chernobyl, Kosovo, Liberia, and E. Ukraine.

Keywords Complex emergency, Post-trauma violence, Disaster behavioral health, Community trauma, Psychological recovery, Sustainability, Community recovery potential, Functional community

1. A Brief History of the Mental Health Disaster Relief Work

In recent years, complex emergencies, such as disasters, famines or armed conflicts have increasingly become the priority of international disaster response and the relief work. However, the NGOs (Non-Governmental Organizations) have been incorporating mental health (MH) elements into relief work in complex emergencies since the early 1980's, when the professional relief community embraced the importance of attending to both physical and MH needs. Tremendous programmatic development followed. In 1998, Medcines sans Frontiers (MSF) formally recognized the need to implement mental health and psychosocial interventions as part of the emergency work, though they had been using mental health professionals much earlier. Already by 2012, MSF staff held 191,300 individual and group counseling sessions in the Russian Federation, Sudan (Darfur), Iraq, Congo, Kashmir, and other countries. Kaz de Jong, the MSF mental health advisor questioned, "What do you do if there is enough food, but no one wants to eat?"

"Sometimes people are unable to eat because they no longer want to live. They may have witnessed the killing of their family," adds De Jong (2005) describing the MH needs during Bosnian refugee crisis.

The late 1980's-early 1990's was a pivotal time in the field of trauma psychology. The inclusion of the PTSD diagnosis in DSM-IV was a major and inspiring victory for victims and their advocates. Trauma psychology rapidly made major advances, mostly in PTSD epidemiology. The fascination with collecting and cataloging PTSD symptoms in various populations soon raised questions about the validity of the syndrome in widely different cultures. International relief work brought to the table first-hand experience of dealing with trauma in diverse cultures. Their work also raised specific concerns about the applicability of standard PTSD assessment and treatment tools in different cultural and social contexts, and about the reduction of normal human responses, and the complex reality of trauma to the conventional set of pathological PTSD symptoms. Yehuda and McFarlane (2009), in their passionate response to growing critique of cultural validity of the PTSD diagnosis, argued that because PTSD has become the whipping post for the challenges that emerging knowledge brings to the classification of mental disorders suggests that the PTSD diagnosis has a strong cultural resonance. To strengthen their appeal, Yehuda and McFarlane begin their

* Corresponding author:

elena.cherepanov@yahoo.com (Elena Cherepanov)

Published online at <http://journal.sapub.org/ijpbs>

Copyright © 2015 Scientific & Academic Publishing. All Rights Reserved

article with the plea not to throw the baby out with the bathwater and conclude with the appeal not to shoot the messenger. Along similar lines, Hinton & Lewis-Fernandez (2011) cautiously acknowledged the legitimacy of concerns that even though there is some evidence of the cross-cultural validity of PTSD, the evidence of cross-cultural variability in certain areas suggests the need for further research. These authors recommend criteria modification and textual clarifications to improve its cross-cultural applicability. This debate is a reflection of emerging and ongoing controversies surrounding use of PTSD criterion in the cross-cultural work.

While deployed MH modules in complex emergencies clearly showed qualitative and anecdotal benefits, enthusiastic research was soon confronted by the boring but unavoidable questions about standards of care, empirical research, measurable outcomes and quality control.

An example of the current state of affairs is the array of competing views on the outcome indicators. The opinions range from advocating for the use of formalized but highly controversial GAF (Global Assessment of Functioning), as suggested by Van Ommeren, & Wietse (2011), and, on the other extreme, to statements that standardized evidenced-based practices are inapplicable in complex emergencies by definition. These apologists argue that every situation is unique, and that there is no general tool to measure individual suffering, and any assistance makes victims feel supported and thus has humanitarian value just by virtue of doing something. Other widely used efficacy criteria based on self-reported satisfaction, symptom reduction, or simply the number of sessions provided and persons served. The limited progress and lack of consistency in demonstrating the programs' effectiveness to the professional communities, organizations, and donors continued to force the question of the overall impact and value of this work.

The second wind for MH in complex emergencies research came in 2000 when the UN declared mental health a priority, but the real political push for global MH came later, in 2001, with the World Health Organization (WHO) Report on Mental Health, which highlighted the fact that mental health has been neglected for far too long and is crucial to the overall well-being of individuals, societies, and countries. The report advocated for global policies changes that are urgently needed to ensure that stigma and discrimination are broken down, and that effective prevention and treatment are put into place.

In 2008, WHO once again took the lead in organizing the recommendations in the Mental Health Global Action Programme (mhGAP). There, the mental health was defined *as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community* (2008). MhGAP further outlined strategies aimed at improving the mental health of diverse populations. Since then, WHO has undertaken different projects and activities, such as the

Global Campaign Against Epilepsy, or the Global Campaign for Suicide Prevention. The essence of mhGAP is building partnerships for collective action and reinforcing the commitment of governments, international organizations, and other stakeholders. In addition, WHO proposed the guidelines for MH interventions in emergencies and a set of activities that include support to countries in monitoring their mental health systems, formulating policies, improving legislation and reorganizing the services. WHO guidelines also offered a definition of complex emergencies and outlined the general framework for MH policy development in situations where complex emergencies presented unique challenges due to their systemic impact. As a result, in September of 2011, the UN General Assembly adopted the political declaration on the international agenda on MH in the context of disease prevention and control. There MH issues were recognized as an important cause of morbidity and a contributor to the global burden of non-communicable diseases. The followed Guide for Field Workers, developed by War Trauma Foundation in 2011, operationalized the mhGAP guidelines for the mental health work and recommended psychological first aid (PFA) as intervention of choice in complex emergency over psychological debriefing. While hardly anyone argues that PFA is universal and useful set of skills to assist individuals in the immediate aftermath of disaster or acute crisis, the debriefing has a different scope of applicability and is most effective to aid relief workers after the exposure to critical incident. These two methods are not validly comparable, and the claim that PFA is an evidence-informed practice has yet to be substantiated.

2. Is the Disaster Mental Health Module in Crisis?

The semi-chaotic diversification of MH programmatic models, along with paucity of evidenced-based practices, put pressure on MH to demonstrate its usefulness in complex emergencies. To the layman, the element of mystery often surrounding the MH domain and psychological work traditionally deferred inquiries about the rationale for programmatic choices with regard to particular models and interventions. This created a paradoxical situation when, while the relief organizations embraced the importance of MH work and are mostly willing to move forward the programs, the added value largely remains unclear. This lack of clarity cast doubts on the general ability of MH programs to fulfill their mission ("And what is this mission anyway?").

After a full-throttle start, the MH disaster relief module suddenly found itself in the middle of heated debates about its strategic goals, its role in multidisciplinary relief efforts, and about the most effective MH models and approaches. In the absence of conceptual clarity, the MH field programs do not always include long-term strategic planning or considerations for sustainability. The programmatic decisions often made on an emergency basis and depend on the organizational culture, and available resources (logistics,

finances, and cadres) rather than understanding of needs and quality of the work. Even the needs assessment, the beginning of all beginnings, remains highly arbitrary and depends on the organizational ideology. The methodology of the needs assessment greatly depends on the adopted theoretical framework and school of thoughts: every approach has a different understanding of problematic areas, interventions and indicators of effectiveness. A psychoanalyst's view of the needs, ideas about effective interventions and treatment will differ from a cognitive-behavioral therapist or a crisis counselor. As per this writer's observation, the representation of multiple approaches in the field may result in conflicting interventions and contradictory recommendations to the survivors, bringing even more confusion into an already chaotic situation. While trial and error has its place in relief work-based trialing, it is vital that MH specialists receive some kind of *prior* standardized training, adopt universal counseling skills such as motivational interviewing, and use the evidence-based practices. A complex emergency is not the right place to experiment with fad interventions or to settle theoretical differences. This is a reason to why the organizations with field experience have definite advantages in developing empirically sound MH programs in the environment of theoretical eclecticism and assessment fiefdoms.

The types of MH programs that are employed in the international relief work can be grouped dependently on the response phase (prevention, immediate response, long-term and chronic issues) and the target need:

- Programs that provide immediate disaster response, trauma treatment in the aftermath or war, famines and during disease outbreaks: MSF (Kosovo, Bosnia, Sierra Leone, Liberia), SOS Armenia (Armenia); The Haitian Mental Health (HMH) Network;
- Programs that gear toward behavioral health aspects of chronic disease or health conditions management, HIV, TB, epilepsy, psychosomatic complaints, ambiguous medical diagnoses, complex needs, stress and depression exacerbating the health issues and compromising the access to care;
- Maternal and reproductive health, mother and child care and integrated primary care: MSF (Russia, Tajikistan, Sudan); The Last Mile (Liberia); MDM (Liberia, Syria)
- Programs for victims of violence and gender-based violence: MSF (DRC, Papua New Guinea and others);
- Programs for special groups: persons with mental health disabilities, children, adults, orphans and other: World Vision, MDM (Liberia), SOS Children's Villages International, Seven Hills International;
- Participation in community development, prevention, education, policies development training the cadres: Carter Center (Liberia), MDM (Long-term development program in the Philippines), Partners in

Health (Haiti).

The most effective psychological approach in complex emergencies is yet to be determined, and the declaration of the superiority of some approaches over others goes beyond the scope of this article, however, there are some models that seem to have more acceptances from the multidisciplinary practitioners. As Souza, Yasuda & Cristofani (2009) described the MSF project at Habilla, Darfur, the integration of MH into the *primary care system* worked well and corresponded with the advances in community health care, such as Integrated Care and Trauma-Informed care frameworks (pp.1-8). The main benefits of Integrated MH models are:

- Many trauma survivors have concurrent medical conditions;
- Primary care providers identify and make referrals for those with ambiguous or additional mental health needs; psychosomatic complaints are often the initial reason to seek a treatment;
- MH services often carry a stigma. Participation in a stand-alone MH program may feel unsafe and stigmatizing for survivors and expose them just by virtue of seeking treatment; on the other hand, receiving medical services is considered to be a much more socially acceptable alternative;
- The integrated model identifies "non-medical" sufferers and brings focus to those with more severe impairment;
- It assures the continuity of care, smooth and seamless handoffs between the programs;

Despite all of the great things about this model, it has its limitations. To be sustainable, the provided supports and treatment need to be backed up by concurrent multidisciplinary systemic changes: helping a victim of domestic violence is as effective as the availability of legal, psychosocial and logistical (shelter, finances, employment) follow-up and support. Another example is the diagnosis of HIV which is just the beginning of the journey, where the treatment success depends on many interconnected factors where some are psychological (depression affects the treatment adherence), while other are medical, but also the quality of social supports and access to the medications and aftercare.

Mollica et al. (2004, pp. 2058-2067) noted that mental health is becoming a central issue for public health complex emergencies and underscored the need for standardized approaches to the assessment, monitoring the outcomes of which is crucial to evidence-driven quality improvement, and the dissemination of the results achieved. A thorough desk review of existing psychosocial assessments and evaluations done by the Mailman School of Public Health (2009), identified a number of widespread problems that led to questionable or inconclusive results including (p. 3). Those are:

- Lack of clear and appropriate project objectives;

- A number of common methodological weaknesses in evaluations;
- Lack of appropriate and standardized quantitative tools for assessing psychosocial wellbeing. The strengths and weaknesses of the available tools lays in the cultural validity of underlying concepts and disagreements about what can be considered a good outcome.

In the past several years, there has been significant interest in developing the assessment tools focusing on target issues such as depression, trauma or anxiety. Among them are Hopkins Symptom Checklist-25 (HSCL-25) (Parloff, Kelman and Frank, 1954) and the Harvard Trauma Questionnaire (Mollica et al., 1990). The methodologically novel and probably most promising tools these days come from the medical primary care setting. These are the World Health Organization Quality of Life (WHOQOL) (The WHOQOL Group, 1998) and the Wellbeing Check (WHO-5, 1998) (Bech, 2012). These assessment tools developed to measure the individual well-being in primary health care settings with both clinical and psychometric validity, and they have larger applicability in complex crisis situations where is difficult to single out one factor determining the systemic impact. These portable instruments validated in many languages and use positively phrased questions to avoid symptom-related pathologizing language.

3. Against the Odds: Progress and Accomplishments

In spite of all the surrounding controversy, the MH component in disaster relief work remains an undisputed priority in the strategic development of the relief agenda. The MH module is steadily gaining recognition and acceptance, and the number of MH programs has been increasing exponentially. Donors now express interest in prioritizing this area, and more relief organizations routinely incorporate an MH module into their work. The MH programs that started as support to the survivors of natural disasters, wars, and refugees, are quickly expanding into assistance for HIV and TB patients, victims of crimes, torture, and gender-based violence. The relevance of MH relief programs continues to expand into other areas of acute and chronic needs. Interest from the international professional community is reflected in the growing number of publications on this topic and specialized training for the relief of mental health workers. In the past, the autonomous data gathering, which was not always publically shared, and unilateral programmatic decisions has been a long-standing tradition for NGOs. Nowadays, there is a growing understanding of the importance of coordination of field MH services and data sharing, something that has been long accepted in medical care as a "must do." For example, this writer observed the efficacy of an international collaboration in Liberia in the summer of 2011. In the aftermath of the Côte d'Ivoire refugee crisis, the field organizations, such as UNHCR,

MDM (Medicine du Monde), MSF (Medicine sans Frontiers), TH (Tiyatien Health), Handicap International and others, have been sharing data and working closely together to develop the collaborative program to fill the gaps in access to MH services, to address the needs on multiple levels, and to establish continuity of care.

Throughout the years of implementing the MH module, organizations accumulated a great deal of experience; where the empirical findings pawed the road to the theoretical constructs. Unfortunately, opportunities for the international professional relief community to share their know-how on a regular basis are still scarce.

4. Mental Health Needs in Complex Emergencies

Wisner & Adams (2002), defined a Complex Emergency as situation of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large-scale movements of people, in which any emergency response has to be conducted in a difficult political and security environment (p. 9). Complex emergencies result in population displacement, the disruption of societal and community infrastructure, and infliction of individual and collective trauma. Cherepanov (2011) also argues that a complex emergency challenges the community's core capacity to support, protect and care. It destroys the social and psychological infrastructure and compounds existing inflicted individual and collective trauma. The complex emergency like any other severe trauma evokes sense of hopelessness and helplessness. It carries potential to demoralize, dis-empower the community, and overwhelm its capacity to support its members. This exponentially increases the members' vulnerability and contributes to further victimization, marginalization of victims, radicalization and the perpetuation of violence.

According to Summerfield (1999), while most trauma reactions are not pathological and are normally expected, the life of trauma survivor remains profoundly altered for years to come. De Young and Kleber (2001), De Jong, Komproe & Van Ommeren (2003); Jones et al, (2009) demonstrated that the severe traumatization (witnessing or being a victim of violence especially gender-based violence, experiencing sudden and violent loss of family members) consistently results in a multitude of chronic mental health issues. Among them, there are profound mood and behavioral changes, severe sleep problems, anxiety, depression, flashbacks, intrusive recollections, hypervigilance, and an increase in uncontrolled anger, along with the psychosomatic complaints that overwhelm regular primary care. In 2014, Cherepanov described how the experience of traumatization sabotages help-seeking behavior, brings negative changes in the family relationship and engenders hopelessness, helplessness, and self-neglect. These in turn contribute to substance abuse, violence, suicidal behavior, non-adherence to essential medical treatment, and, according to Schnurr,

Green and Bonnie (Eds) (2009), increases mortality and morbidity. On the other hand, effective coping with trauma can create personal growth and enhance the ability to relate to and support others, as Tedeshi & Calhoun described in their concept of Posttraumatic Growth (2004). According to Cherepanov (2011) and Pearson, Cherepanov (2012), a mature functional community that collectively survived and overcame traumatic event becomes more resilient, caring, and supportive to its members, and is better equipped to cope with future adversities.

Existing controversies in assisting with collective trauma predominantly revolve around the understanding of the psychological needs. If trauma reactions in the context of complex emergencies are expected and non-pathological responses to life hardship, this would indicate that any external psychological intervention has potential of doing more harm than good by imposing culture- incongruent expectations and interfering with the natural course of psychological recovery. Hans Stalk, MSF-Holland MH advisor, challenged even the use of the term Mental Health due to its inherently pathologizing connotation (Elena Cherepanov, personal communication, 2010). At the same time, the currently employed term Disaster Behavioral Health hardly sounds less stigmatizing due to the somewhat awkward assumption that there is such a thing as healthy behavior in disaster. Summerfield (1999) sharpened these concerns suggesting that any Western models of mental health problems, their assessment and treatment recommendations, and the concepts of depression and PTSD in particular, have no relevance, are intrusive and imposed on different cultures with little consideration to cultural appropriateness, and thus create more harm interfering with coping and creating iatrogenies. Summerfield (1999) went on arguing that the MH module is self-serving and benefits nobody else but the MH workers themselves. The quest to determine the MH needs in complex emergencies led De Jong & Kebler (2001) to introduce the psychosocial approach which since then became the golden standard for the MH relief work. This approach suggests that the psychological needs in disaster cannot be separated from the social needs, and both social and psychological supports are only effective when provided simultaneously. In 2011, De Jong developed the guidelines for this approach that consistently demonstrated its effectiveness in working with survivors of gender-based violence. In spite of the seeming contradictions, these schools of thoughts actually complement each other, proposing that there are different individual, cultural or community needs that require different approaches. These two lead experts in the global mental health, when coming from very different frameworks both found themselves concerned over the pathologizing the trauma reactions. The cultural relativism suggested by Summerfield, was nicely balanced by De Jong's emphasis on the universal value of basic needs such as need in food, shelter, safety and being free from the abuse and violence.

5. Community-Based Psychological Recovery

In 2004, Substance Abuse and Mental Health Services Administration (SAMHSA) in its National Consensus Statement on Mental Health Recovery defined mental health recovery as *the process of change through which individuals strive to improve their health and well-being, live a self-directed life, and strive to achieve their full potential*. The success of individual recovery is mitigated, to a great extent, by the community which provides the social infrastructure, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meanings. The latest advances in community mental health research and practice prioritize the community-based changes in support systems as one of the most important factors shaping the recovery of the individual trauma survivor. SAMHSA introduced the trauma-informed care paradigm, which emphasizes the importance of focusing on strengths and resiliencies instead of weaknesses and vulnerabilities in trauma survivors. The National Center for Trauma Informed Care (NCTIC, n.d.) views trauma-informed care and quality of supports as the hallmark of effective programs to promote recovery and healing through support from peers, survivors, ex-patients, and recovering persons. Goodman, et al., (1998) views the community as a powerful protective factor that can mitigate social ills and outlines the aspects that are key to this construct, including: participation and leadership skills, informational and logistic resources, social and inter-organizational networks, the sense of community, and an understanding of community history, community power, community values, and critical reflection (p. 840).

This author reasons that complex emergency destabilizes or destroys the community's social and psychological support systems and shatters the routine of daily life. It overwhelms community resilience, undermines coping capacities and heightens systemic vulnerabilities that have significant implications for the psychological recovery. The proposed Community-Based Psychological Recovery in Complex Emergencies model, or CBPR, prioritizes the restoration of community supports and sensitizes the community to the special needs of vulnerable groups, including persons with severe trauma or serious mental illness. It's thought that mobilization of the *community's recovery potential* can be achieved by concurrently addressing multiple layers of communal functioning, ranging from the mobilization of pre-existing, culture-bound traditional supports, psycho-education, to the restoration or development of new life routines along with improving access to professional mental health.

The author piloted the elements of this model in Chechnya, Chernobyl, Macedonia and Eastern Ukraine, and it was implemented as complete set of strategies in Liberia in the summer of 2011 as part of Tiya Health program (The

Last Mile). This project focused on developing community-based support groups to facilitate the community recovery in the aftermath of the Côte d'Ivoire refugee crisis. This model demonstrated high efficacy in achieving the sustainable positive changes on the community level. The support groups continued at least for three years, when the community members were coming together when felt the need for support, and only the Ebola health crisis interfered with the community gatherings and interaction. This success has been attributed to the choice of the target format, the support groups, which was built upon traditional Palava practices (*Palava* is the organized talk or discussion in the West Africa) when people come together during challenging times to discuss the solutions.

Community's Recovery Potential

Finding the contributing factors shaping community psychological recovery in the post-disaster period is analyzed through the lens of the *community's recovery potential*, which is defined here as set of psychological, social, and logistical resources, healing routines, and resilience. This includes past experience of survivorship, problem-solving protocols and decision-making scripts, and helping traditions: e.g., culturally-specific norms and expectations for helping, supporting those who experienced victimization or loss, funeral rituals, attitudes of key community players and role models. *A functional or supportive community has infrastructure in place to maintain the order, help and protect its members, and prevent victimization.* Along with official law enforcement, the council of elders, spiritual leaders, and traditional healers, neighborhood or village forums often serves to solve collective problems and improve the well-being of a community. Here are just some of the examples: in Western Africa, the mediation facilitated by "Palavers", elders or wise people with special conflict resolution skills. In many cultures (Chechnya, Armenia, Liberia and other), there are systems in place to protect the victims of domestic violence: a battered woman can seek protection from older men in the community and in the family. The community marginalization, such as forced migration, destroys these supports. Another example of community safeguards is found in the remote villages of East Liberia. A host family expected to introduce newcomers to the community at the village gathering and carries full moral and often financial responsibility for the delinquent behavior of this newcomer. *The functional community is not only helping- it also imposes and enforces behavioral and dictates moral norms.* In a village in Liberia, rape could result in expulsion from the village not only the rapist, but also the rapist's family (E. Cherepanov, personal communication, 2011). When the physical survival depends on the communal supports, this serves as harsh punishment for the whole family and a strong deterrent for others.

When the community marginalized because of complex emergency, it is no longer able to provide the adequate protection to its members, which only increases the

possibility for their victimization. The lack of safety triggers a heightened sense of vulnerability and the negative group dynamics such as scapegoating, revanchism, or vigilantism. This alters the social and psychological fabric of communal life, brings polarization and creates the breeding ground for perpetuation of violence, radicalism which can demoralize an already wounded and traumatized community. A complex emergency, such as a mass forced migration, weakens sense of social inclusion and connectedness and increases personal vulnerabilities, making members susceptible to both victimization and identification with the perpetrator. To reclaim the communal safety when unable to or culturally conditioned not to trust governmental law enforcement, the refugees in the camps or the resettled communities at times build alternative self-defense structures. A self-designated sub-group can assume responsibility for policing, judging and punishing. As this author observed in the refugee camps of Chechnya, Kosovo/Macedonia, and Liberia, while self-righteous vigilantism and scapegoatizm sometimes creates illusion of order, it easily becomes problematic, brings in more violence and, contrary to what was intended, and inadvertently results in further victimization.

6. Community-Based Psychological Recovery Model in Complex Emergencies

The model of Community-Based Psychological Recovery (CBPR) aims to achieve sustainable community-level impact by strengthening community supports and by sensitizing the community to special mental health needs of vulnerable groups. The ultimate goal of the CBPR model is to restore the community's self-reliance and capacity to provide protection and support to its members.

Effectiveness Indicators: What is Functional Community?

The effectiveness indicators for this CBPR model are yet to be standardized, and the major challenge lies in the question of how we define *functional or supportive community*. The intuitive answer suggests that this community probably is socially inclusive, capable of coping with adverse life events, has good conflict resolution capacities, and is kind and supportive to its members with special needs. Other parameters include the community's self-determination and self-reliance, functioning systems of communal support, conflict resolution and victim support protocol. The functional community discourages violence and enforces social norms; it offers supports for the routine life challenges such as illness, death, violence, and the loss of property. There is a respect of different cultures and subgroups: in North Caucasus, before the first Chechen war, there were over 65 ethnic groups sharing the same small piece of land. According to a teacher from a small village in the region, the community identity carried more importance than even ethnic identity, or was at least equal to it. Growing

up together in such a multi-cultural environment, the children had many holy days – both, Christmas and Navruz simply meant they would get treats (E. Cherepanov, personal communication, May 2013). Another positive indicator of the functional community is the increased competence and knowledge about compassionate care, mental health problems, resources sharing, random acts of kindness, and willingness to support those with serious mental illness or severe trauma. To summarize, a functional and supportive community is characterized by:

- Strong community identity inclusive to various subgroups
- Systems of community support
- Respect for different cultural values
- Protection by the community
- Compassion and inclusion of those with special needs
- Sharing social and logistical resources and information
- Conflict resolution protocols
- Valuing of self-reliance
- Volunteering and peer supports
- Community leaders who accept responsibility for the wellbeing of the community and promote the use of community support resources and systems

All this contributes to a well-functioning, supportive, resilient community that provides safety, security, social inclusion, and psychological comfort for its members. This is, of course, the ideal case scenario. There are some communities where the supports, routines and traditions ensure smooth daily functioning for the majority; but even then, persons with disabilities often remain excluded from communal life due to widespread stigma and prejudices. This remains a challenge for those outsiders who beg to differ and create a change in the communal attitudes.

Ground Assumptions

The mobilization of the community-based supports increases the community's capacity for self-reliance and sustainability of the recovery process determines the strategy of MH interventions. CBPR partners with the community to build upon community's strengths, resilience, and coping and recovery resources. Some ground assumptions of CBPR framework come from Disaster Behavioral Health, Psychological First Aid, Crisis Intervention and others from Mental Health Recovery paradigms; or based on the author's relief work experience:

- Most of the traumatic reactions during the complex emergency are normal, expected and do not need any treatment;
- Most of the traumatized individuals and communities possess enough strength, flexibility and resilience to recover *if they have support*;
- A community strives to achieve recovery, stabilization, and self-reliance;
- A community even during the most difficult times

possesses significant resources of strength that come from:

- past survival experience
- community, social and cultural history, values and traditions
- concern on the part of key community players for the well-being of the community
- traditions and customs of self-reliance, mutual support, resource sharing, and trust
- Special needs groups, such as the disabled, elderly, children, those with severe trauma reactions, or serious mental illnesses, may need additional supports;
- Any external humanitarian aid (logistics, services, food, or medications) is temporary and may discontinue at any time without much notice;
- Any external helping intervention carries the potential to impinge upon community self-reliance by creating dependency on external resources;
- Every community has both formal and informal leaders who, in an emergency, will step up, take charge of recovery and inspire and demonstrate values of kindness, compassion, sharing, caring and helping others;
- When fleeing, refugees bring with them the psychological prototype of their community. In a new place they try to replicate the routines, traditions, social and psychological connections which include the collective survivorship experience and mutual supports, but also myths and misconceptions about mental health issues;
- An effective community-wide intervention is a strategically chosen small change in the community system that may have a ripple impact and yield significant systemic results;

Operational Guidelines

Operational guidance puts into practice the assumptions and concepts, outlines the scope of services, defines and prioritizes tasks and suggests the best practices and standards. In order to achieve community-level systemic sustainable recovery-oriented changes, it is particularly important to have consistency in the approaches that aim at the restoration/re-building of the community's capacity to take care of itself by supporting its members. The step-by-step guidance creates the roadmap to this ambitious goal. Those steps are:

Community assessment: needs, intact infrastructure, leadership, community strength and resources

- To examine the community's pre-crisis functioning; past experiences of survivorship and resilience, historical and present traditional and unique sources of strength and coping, the hopes and the vision for the future;
- To identify key community players and formal and

informal leaders, and map their social interactions;

- To identify vulnerable groups and evaluate the available supports and community attitudes toward them;
- Find out about the community-wide activities, including recreational activities, which contribute to strengthening community's identity and the cohesion. In many communities sports serve this function;
- Un-assuming and realistic evaluation of existing healing practices from the harm-reduction point of view;
 - For the outsider, little is what it seems. Some indigent healing practices for mentally ill include torture. On the other hand, there may be some practices that are employed locally but are condemned as abusive by professional MH community. E.g., chaining the individuals with psychotic symptoms, in the absence of antipsychotic medications, in some instances is used for their own protection to physically prevent them from wandering away and ending up being raped or killed (Elena Cherepanov. Personal communication, 2012). In this case, the emphasis needs to be on assisting with development the viable and safe alternatives.

Implementation

- When possible and beneficial, building collaboration and partnership with established care systems including government and public health organizations, spiritual leaders, and traditional healers;
- Building on the intact infrastructure, available support systems, and traditional routines allows to rely on the available strength and resources;
- The active engaging the specialists, local cadres and the community leaders, strengthens the community's role in recovery and promotes its ownership, leadership and responsibility for the future and well-being of the members;
- Empowerment, encouragement and fostering compassion and mutual support;
 - Sometimes it is just a matter of giving permission or role modeling the expression of caring support, whatever strangely it may sound. In some cultures, where the public display of feelings is not expected, plainly letting people know that it is okay to show the compassion, can drastically increase the psychological comfort of sufferers, as this writer had the opportunity to observe on multiple occasions. When the community leaders role model helping behavior, this makes the particularly powerful impact;
- Concurrent multi-layer and multi-faceted education and skill building in providers, leaders (teachers, health care providers, spiritual leaders and traditional

healers) and community members to achieve consistency across the community systems.

- The education challenges the misconceptions, such as myths about perceived dangerousness and dehumanization of people with mental illnesses, contagiousness of epilepsy, blaming people or their families for mental health problems; it also offers the culturally appropriate coping skills that are identified during the community assessment, and teaches about the importance of mutual supports.

Care Coordination

- Increase in mental health competencies in the community by training of local cadres and health providers in compassionate care;
- Establishing the systems of intermediate care for those with greater mental health needs, such as individual counseling, integrated primary health care, special programs, aftercare and community outreach;
- Streamlining the referral system, availability and access to trauma-informed psychiatric care, medications and counseling for persons with severe mental health issues. Independently on the feasibility of psychiatric services, education on the nature and causes of mental illness, trained on how to support persons with serious mental illness and their overwhelmed families, including how to manage risks.

Sustainability

- Planning for a relief program must have incorporated an exit strategy and plan for ensuring the sustainability of the recovery process and reduction in dependence and reliance on external resources and supports;
- While there is an expectation of independent functioning of support groups, the ongoing support, supervision and re-trainings for the peer volunteers or champions of change is very important and allows maintaining the quality of care.

7. Conclusions

The sustainability of psychological recovery can be assured only by strengthening the role of the community itself. The community-based psychological recovery (CBPR) approach views the individual trauma recovery process as a part of sustainable changes within a community's support systems that enhances the community's capacity to cope with current and future challenges. Exclusive focus on assisting the individual trauma survivors without concurrent systemic and substantial changes in the community is ineffective and carries high potential for re-traumatization as the victims continue to de-humanized and stigmatized. The community cannot be forced to recovery. In CBPR model,

MH workers partner with the affected community, facilitating, assisting, strengthening and enhancing the natural recovery process by offering education, and empowerment, building upon the community's capacity for mutual supports, and supporting the recovery leadership. The capacity building, the sustainability and self-reliance achieved by engaging community in recovery efforts, sensitizing community to the needs of vulnerable groups and empowering the leaders to own and take responsibility for the recovery and the well-being of the community. It is crucial that strategic planning for MH program in complex emergency from the very beginning built on recognizing the community strength and resources, and includes steps to reduce dependence and reliance on external aid. A big role in this agenda plays the training of local trauma specialists in the disaster zones, ethnic conflicts and wars. With the supports, they can become powerful agents of change in the community. CBPR model was piloted in Chechnya, Chernobyl, Kosovo, Liberia, Russia and E. Ukraine, where hundreds of trained trauma specialists are now making tremendous difference contributing to post-trauma violence prevention and supporting the psychological recovery of trauma survivors, their families and the affected communities.

REFERENCES

- [1] Bech P. Measuring the dimensions of psychological general well-being by the WHO-5. QoL Newsletter 2004; 32: 15-16.
- [2] Chaskin R. J. (2001). Building Community Capacity: a Definitional Framework and Case Studies from a Comprehensive Community Initiative. *Urban Affairs Review* 2001;36:291-323.
- [3] Cherepanov, E., Ryan, M. (1996) Training of Auxiliary Mental Health Workers. In: *The Frontline Counselor*. Official Publications of the International Association of Trauma Counseling, p.3.
- [4] Cherepanov, E. A (1999) Summer in Kosovo. *Toronto Center for Psychodrama Newsletter*. V. 3, Issue 2, 1999.
- [5] Cherepanov, E. (April 13-15, 2008) Undocumented refugees with serious mental illnesses. *Center for Psychiatric Rehabilitation: From Innovation to Practice*.
- [6] Cherepanov, E. (November 2011) Psychological Impact of Radio-Nuclear Disasters. *Traumatic Stress Points*. Publication of ISTSS, pp. 3-4.
- [7] Cherepanov, E. (July, 2012) Community-based Psychological Recovery in Complex Emergencies. *ISTSS 28th Annual meeting: Beyond Boundaries: Innovations to expand services and tailor treatments*. Pre-meeting institute. Program of the conference, p.18.
- [8] Gebbie, K., Rosenstock, L. and Hernandez, L. (eds.) (2003). *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*. Washington, DC: National Academies Press.
- [9] Goodman, R., et al. (1998). Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement. *Health Education & Behavior*, Vol. 25(3):258-278.
- [10] Guide to the Evaluation of Psychosocial Programming in Emergencies (2009). UNICEF. Retrieved from: <http://mhps.net/wp-content/uploads/group-documents/67/1313407735-WHOMHPSSAssessmentToolkit2011-02-06draftforcomment.doc>.
- [11] Hinton, D.E., and Lewis-Fernandez, R. The cross-cultural validity of Post-traumatic Stress Disorder: Implications for DSM-5. (Sept. 28 (9), 2011) *Depression and Anxiety*. PubMed, 783-801.
- [12] Jong, K. de and Kleber, R.J. (2001). Early psychosocial interventions for war-affected populations. In Orner, R., & Schnyder, U. (Eds.), *Early interventions*. Oxford: Oxford University.
- [13] Jong, K. de (March 2011) Psychosocial and Mental Health Interventions in Areas of Mass Violence. A Community-Based Approach. MSF, Rozenberg Publishing Services, Amsterdam, 2nd Edition.
- [14] Jong, K. de, Komproe, I., Van Ommeren, M. (2003). *Common mental disorders in post-conflict settings*. *Lancet* 2003, 361:2128-2130.
- [15] Jones, L., Asare, J., Masri, El M., Mohanraj, A., Sherief, H., Van Ommeren M. (2009). Severe mental disorders in complex emergencies. *Lancet* 2009; 374: 654-61.
- [16] *MSF Mental Health Guidelines*. Psychosocial and Mental Health Interventions in Areas of Mass Violence (n.d.) (2005). MSF: Holland. Retrieved from http://www.msf.org/source/mentalhealth/guidelines/MSF_mentalhealthguidelines.pdf.
- [17] Mental Health Overview (2005). *Doctors without Borders Newsletter*, Retrieved from: <http://www.doctorswithoutborders.org/news/issue.cfm?id=2399&cat=issue-page&ref=tag-in dex>.
- [18] Mental Health (May 2, 2013). MSF On-line Newsletter. Retrieved from: <http://www.doctorswithoutborders.org/our-work/medical-issues/mental-health>.
- [19] Mollica, R., Cardozo, B., Osofsky, H., Raphael, B., Ager, A., & Salama, P. (2004) Mental Health in Complex Emergencies. *Lancet*, 364 (9450), 2058-2067.
- [20] Mollica, RF, Caspi-Yavin, Y, Bollini, P, Truong, T, Tor, S, Lavelle J. (Mar 1990). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Am Acad Child Adolesc Psychiatry*. 29(2):283-8.
- [21] Parloff MB, Kelman HC, Frank JD (1954). Comfort, effectiveness, and self-awareness as criteria for improvement in psychotherapy. *American Journal of Psychiatry*. 3:343-351.
- [22] Pearson, A., Cherepanov, E. (2012). Building a Disaster Behavioral Health Response to Radiological Nuclear Disaster". *Journal of Emergency Management*, v. 10 (6) p. 413-424.
- [23] NCTIC: The National Center for Trauma Informed Care (n.d). Retrieved from: <http://www.nasmhpd.org/TA/NCTIC.aspx>.

- [24] The World Health Organization Quality of Life (WHOQOL). Retrieved from: http://www.who.int/mental_health/publications/whoqol/en/.
- [25] The WHOQOL Group (1998). The World Health Organization Quality of Life assessment (WHOQOL): Development and general psychometric properties. *Soc Sci Med.*; 46:1569–1585.
- [26] SAMHSA (n.d.). *National Consensus Statement on Mental Health Recovery*, USA. Retrieved from <http://www.samhsa.gov/recovery>.
- [27] Schnurr, Paula P. (Ed); Green, Bonnie L. (Ed) (2004). Trauma and health: Physical health consequences of exposure to extreme stress. Washington, DC, US: American Psychological Association. xii 311 pp.
- [28] Souza A., Yasuda, S., and Cristofani S. (2009). Mental health treatment outcomes in a humanitarian emergency: a pilot model for the integration of mental health into primary care in Habilla, Darfur. *International Journal of Mental Health Systems*. 3:17.
- [29] Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programs in war-affected areas. *Social Science and Medicine*, 48, 1449–1462.
- [30] Tedeshi, R.G., & Calhoun, L.G. (2004). *Posttraumatic Growth: Conceptual Foundation and Empirical Evidence*. Philadelphia, PA: Lawrence Erlbaum Associates.
- [31] War Trauma Foundation and World Vision International (2011). *Psychological first aid: Guide for field workers*. *Psychological first aid: Guide for field workers*. WHO: Geneva.
- [32] WHO (2001) Mental Health: New Understanding, New Hope. *The World Health Report 2001*. WHO: Geneva.
- [33] WHO (October 9th, 2008). *Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders (mhGAP)*. WHO: Geneva (http://www.who.int/mental_health/mhGAP/en/).
- [34] WHO (2011). *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*. United Nations high-level meeting on noncommunicable disease prevention and control. Resolution adopted by the General Assembly UN 66/2.
- [35] Wisner, B., Adams, J. (Eds.) (2002). *Environmental health in emergencies and disasters: a practical guide*. WHO, Geneva. Retrieved from: (http://www.who.int/water_sanitation_health/hygiene/emergencies/em2002intro.pdf).
- [36] Van Ommeren, M., Tol, & Wietse. (Draft Version). (February 2011). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises*. WHO: Geneva. (<http://mhpps.net/wp-content/uploads/group-documents/67/1313407735-WHOMHPSSAssessmentToolkit2011-02-06draftforcomment.doc>).
- [37] UNICEF (2009). Guide to the Evaluation of Psychosocial Programming In Emergencies. Mailman School of Public Health. Accessed from www.cpcnetwork.org/admin/includes/doc_view.php?ID=446.
- [38] Yehuda, R., McFarlane A.C. (July 9, 2009). Is PTSD a Valid Diagnosis: Who Benefits From Challenging Its Existence? *Psychiatric Times*. Vol. 26, No. 7.