

Working with survivors of war in non-western cultures: the role of the clinical psychologist

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In this paper the possibilities are explored for integrating Western individualistic models of assessment and intervention in clinical psychology and psychotherapy into work in areas of armed conflict where the culture is predominantly collectivistic. Sri Lanka is used as a case study to provide examples and illustrate how such integration might take place. Directions for training in assessment, intervention, programme evaluation, research, teaching, and supervision are discussed.

Keywords: Clinical psychology, Western models, collectivistic cultures, Sri Lanka

Clinical psychology in non-western areas of armed conflict

In many non-Western countries around the world, the number of fully trained clinical psychologists is very few, and doctoral programmes in clinical psychology are often unavailable. Students wishing to obtain their doctoral degrees in clinical psychology often do so in countries such as France, Australia, and the United States of America. In Sri Lanka, for example, to the author's knowledge, there are fewer than three clinical psychologists with such training. Several other psychologists with Masters degrees and some with bachelor degrees practice as therapists and/or engage in instruction and training. Given the paucity

of professionals in the field, it is understandable why a clinical psychological perspective does not play an important role among professionals offering psychosocial services for survivors of war in non-Western developing countries such as Sri Lanka.

If more clinical psychologists were available, however, the question arises as to what resources and skills the clinical psychologist might have to offer to a multi-disciplinary psychosocial intervention team. Does a clinical psychologist offer services that are distinct from, yet complement those offered by a psychiatrist, social worker, counsellor, or social psychologist? In many cultures there is still stigma in seeking and receiving mental health services, and clinical psychologists may be avoided by all but the most severely mentally ill. Further, in order to be effective, mental health services in areas of armed conflict should be adapted to the socio-cultural context of the victims/survivors, which often includes multiple socioeconomic needs. Attempting to conduct psychotherapy in a situation where the client's primary need is for food, shelter, and employment would be a fruitless undertaking.

Nonetheless a clinical psychologist may still provide valuable services to survivors of

war in collectivistic cultures. In order to do so, it is the contention of this paper that the field clinical psychology as conceptualized in North American and European countries will need to include collectivistic as well as individual and intra-psychic perspectives.

The clinical psychologist as assessor and diagnostician

In many Western cultures one of the main roles of a clinical psychologist is to conduct psychological assessment with a view to diagnosis, which is used to inform treatment.

However, assessing a client's resources and coping styles, including aspects of social support, is as important as assessing the client's psychological distress. Such an approach is also likely to be viewed more positively by the client, as s/he relates and keeps in mind the aspects of his/her functioning which are optimistic in nature. A more comprehensive assessment such as this would also be more suitable to the psychosocial context of collectivistic cultures¹. Professionals working in war-torn areas such as Sri Lanka are often struck by the resiliency of victims and survivors, who often maintain a sense of optimism, dignity, and work ethic despite constant and unremitting blows to their physical and psychological well being. Thus the client's religious beliefs and faith, professional skills, emotional and social support from family and neighbours, and willingness to overcome difficulties should be assessed comprehensively, so that such resources can be utilized to aid recovery from the traumas caused by war.

In countries such as Sri Lanka, diagnosis of mental health problems is most often conducted by psychiatrists. Patients who arrive at psychiatric clinics often have chronic and severe symptoms of mental health disorders

such as schizophrenia, severe depression, and obsessive-compulsive disorder. In Sri Lanka the treatment model for the vast majority of these disorders is medication and sometimes, electroconvulsive therapy (Gnanajoti, personal communication).

However many people who have been severely affected by the armed conflict are more likely to present themselves at humanitarian aid agencies or general health clinics rather than at psychiatric clinics (e.g. Somasundaram, 2001); their symptoms often are not so florid as to require medication and/or hospitalization. Many of them suffer from mild to moderate symptoms of posttraumatic stress disorder (PTSD). PTSD is most effectively treated through some form of psychotherapy such as exposure and cognitive-behaviour strategies, with medication considered as adjunctive treatment (Expert Consensus Panels for PTSD, 1999; Foy, 1992). Clinical psychologists could therefore serve a useful function in assessing the psychological needs and resources of survivors of war who do not require hospitalization and/or psychotropic medication; while fully recognizing that such assessment is only one component of care for the client. In some situations, assessment may be carried out in tandem with therapy. If assessment is conducted with the basic clinical skills of empathy, mirroring, and positive regard, clients are less likely to perceive this phase as an 'examination' and more as a phase of 'getting to know me.' Further, as in the West, assessment would not be a static, one-time event, but would be a continuous, dynamic process.

It is also well recognized that experiences of severe trauma can lead to a host of other clinical syndromes that do not conform to the classic diagnosis of posttraumatic stress. Past research has revealed that exposure to

traumatic events greatly increases a person's risk for developing depression, obsessive compulsive disorder and other anxiety disorders, substance abuse disorders, and sub-clinical syndromes including antisocial and violent behaviours (Pynoos, Steinberg, & Piacentini, 1999). Moreover, these symptoms experienced by the individual are likely to affect interpersonal functioning, particularly relating to family, community (neighbourhood) and employment. In predominantly collectivistic cultures such as Sri Lanka, poor interpersonal functioning is likely to cause more suffering to the individual with clinical symptoms than the symptoms themselves. Hence a clinical psychologist's careful assessment of the current psychological and interpersonal functioning of the client would greatly contribute to planning effective psychosocial interventions.

Over the last four decades, psychological assessment in the United States and other North American and Western countries developed rapidly in terms of both sensitivity and specificity for mental health disorders such as depression, anxiety, and post-traumatic stress. Although such assessments may be useful points of departure for assessing people in traditional non-Western cultures, clinicians must use great caution in using them. First, people in these cultures may not be as familiar with questionnaires and surveys as North Americans are, and response biases may exist which may not have been observed among the North American samples. Second, the normative samples used in the United States and other countries are likely to have demographics and cultural values very different from those of non-Western cultures, and great caution must be used in translating raw scores into standard scores based on completely different normative groups. Finally,

even if norms are developed, there is a question as to whether the measures are assessing the same construct in both cultures. For example somatic complaints are much more likely to form part of the clinical profile of depression and anxiety in Sri Lanka, and recent research has revealed such links (Somasundaram, 2001). Nonetheless, assessment of the client's mental health is important, as interventions could then target the client's mental health needs. A clinical psychologist might therefore perform a useful function by developing culturally relevant assessment instruments to be used with victims and survivors of armed conflict in collectivistic cultures.

A useful point of departure may be surveys for assessing posttraumatic stress, a syndrome which has demonstrated cross-cultural validity (Sack, Him, & Dickason, 1997; Marsella, Friedman, Gerrity, & Scurfield, 1996; Thabet & Vostanis, 2000; Van Ommeren, 2000; Van Ommeren, B. Sharma, G. Sharma, Komproe, Cardena, & de Jong, 2002). However concepts such as depression and anxiety may need to be re-evaluated in non-Western cultures. A robust finding in clinical research is that Asians in general tend to express psychological distress through somatic symptoms (Chun, Enomoto, & Sue, 1996), a finding that can also be applied to Sri Lankans (e.g. Somasunderam, 2001). Thus culture-specific assessments for depression and anxiety in non-Western areas of armed conflict countries such as Sri Lanka should also include questions relating to physical functioning. Conversely, clinical psychologists can train general practitioners in health clinics to assess patients for anxiety, depression, and PTSD who present with multiple somatic complaints.

The goal of careful and thorough assess-

ment is to arrive at a diagnosis of the client which will inform treatment. As mentioned before, such diagnosis would not be static, resulting in a label, but a dynamic process with room for monitoring and change as the client and therapist begin working together. Here the diagnostic system used in countries such as the United States, the Diagnostic and Statistical Manual (American Psychiatric Association, 2000) would be of limited utility. Rather, broad categories of mental health distress such as depression, anxiety, obsessive-compulsive disorder and posttraumatic stress may serve as useful points of departure for informing psychotherapeutic interventions. In addition, the clinical psychologist working in non-Western areas of armed conflict must be trained not only in diagnosis of the individual. She or he must be well aware of larger systems which may be operating on the individual and causing distress. In such situations, the psychologist would be best advised by a social worker who may be better trained to evaluate the psychosocial environment of the individual.

The diagnosis of the client may be used as a useful “short cut”, so that mental health professionals and their clients have a common language they can use. The mental health professional can inform the client of what to expect with such symptoms, and the client can use the framework of diagnosis to inform the professional of how the general description is experienced ‘inside the skin’ of the client. Diagnosis can also inform what kinds of interventions may best suit a given individual or group and which interventions may be particularly unsuitable. For example, a person with moderate symptoms of posttraumatic stress is not likely to be helped by watching a cathartic enactment of the traumatic event (such as afforded by theatre groups)

because such enactment would only cause greater dysregulation of the person’s system due to increased anxiety. Similarly, a person with obsessive compulsive disorder is unlikely to be helped by ‘pure’ psychosocial interventions aimed at ameliorating poor economic and social conditions. In such situations, consultation with a clinical psychologist can greatly aid in effective delivery of psychosocial interventions.

The clinical psychologist as therapist and alleviator of symptoms

While the goal of assessment is to arrive at a diagnosis, the goal of diagnosis is to guide treatment priorities. As already alluded to above, diagnosis can be useful in conceptualizing cases and helping to inform interventions that are effective for people based on their resources and coping skills, clinical symptoms, their personality traits, their personal history and their current material and interpersonal context, including psychosocial stressors and supports. This may be particularly pertinent for those suffering from war trauma, as the variants of traumatic stress require careful assessment of both the individual and the environment in which the individual operates. Missing some of these perspectives can end up further harming some of the clients who present themselves at the clinics operating to help victims and survivors of war.

Undertaking individual interventions in collectivistic cultures without paying heed to the system in which the individual functions may result in greater harm to the client and his/her social ecology (Strang & Ager, 2003). Even in individualistic cultures such as the United States many clinical psychologists argue out that behaviours considered ‘abnormal’ at a given time and place are in fact healthy adaptations to unhealthy and untenable systems (e.g. Combs, Penn,

& Fenigstein, 2002; Newhill, 1990). For example for many Sri Lankan Tamils who have experienced not only prejudice and discrimination but also systematic destruction of their culture, reactions such as learned helplessness and anger may indeed be healthy reactions to untenable situations. By attempting to 'cure' the individual of such symptoms so s/he can return to the system that led to the symptoms in the first place, the psychologist may be enabling the perpetuation of dysfunctional social and cultural systems.

On the other hand prior research has made available several therapeutic techniques which might be of use in collectivistic non-Western cultures. For example, in Sri Lanka sacred Buddhist texts discuss ways in which one can overcome disappointments, and Hindu philosophy includes similar discussions of the will, both perspectives which are highly compatible with and similar to cognitive-behavioural techniques, which are effective for a variety of psychological disorders (Stein, Jaycox, Kataoka, Wong, Tu, Elliott, & Fink, 2003).

Similarly, relaxation training as an anxiety-reducing technique is compatible with both the Hindu and Buddhist practices of transcendental meditation, and has been used with great efficacy for a variety of presenting problems including chronic pain due to torture (Fernando, 2003). In addition, recent outcome research indicates that *interoceptive exposure*, a technique which can be integrated with meditation exercises, may be successful with survivors of war who present with fear of trauma cues² (Taylor, 2003). Other types of therapy include narrative therapy (Merscham, 2000), which this author has used successfully with Sri Lankans of all ethnicities who have experienced severe traumas and are at a loss for making meaning in their lives; and Rational

Emotive therapy (Ellis, 1998) for those clients who would be helped by a more challenging type of therapy. In this context it would also be important that clinicians study traditional and indigenous healing methods, use language and concepts already available in the culture (e.g. chanting and meditation), and carefully assess the efficacy of these methods (see Galappatti, 2003, for a more extensive discussion on this issue).

Group therapy may be another efficacious means of alleviating symptoms for some mental health disorders (Yalom, 1985). For example, grief therapy and bereavement groups have been found to be helpful for widows and widowers of war; this author used group therapy effectively for groups of Sri Lankan women affected by suicide bombers whose primary symptoms were fear and avoidance (rather than the full clinical syndrome of posttraumatic stress disorder). Group therapy can be behaviour-focused, topic-focused, and/or process-focused. The latter is more often used with groups with higher levels of education and milder symptoms. It is less likely to be useful for the vast majority of clients in non-Western developing countries such as Sri Lanka. In addition, group therapy would not be indicated for torture survivors who have not dealt with their primary symptoms. Such people are naturally likely to be reluctant to disclose information which they believe may be used later against them in acts of betrayal. Nonetheless clinical psychologists with training in group processes and managing group dynamics can be very effective conveyers of healing for several types of groups, including people dealing with bereavement, loss, and even physical disability.

A clinical child-psychologist also has much to contribute to the field. As Pynoos and

colleagues (1999) point out in their thorough review of the consequences of trauma, children are particularly vulnerable to both the proximal and distal variables relating to a traumatic event. Children are doubly vulnerable in situations such as war, as their physical and psychological well-being depends not only on their own resources, but that of the elders (typically, parents and grandparents) around them (Dybdahl, 2001; McIntyre & Ventura, 2003; Pynoos et al., 1999). Children who are born into a climate of war, repression, and discrimination may develop a world-view that differs significantly from that of children growing up in a climate of peace and justice (Garbarino, 1999; Shuter, 2002). A clinical psychologist working in collectivistic non-Western cultures must commit to innovative therapeutic interventions that target not only the clinical symptoms of the child, but also garner the support of the child's nuclear as well as extended family (cf. Somasundaram & Jamunanantha, 2002). To be successful in such an endeavour the psychologist must be familiar not only with models of family and group therapy, but also of how cultural values (such as adherence to traditional roles and the importance of religious rituals) impinge upon a family in general and upon children in particular.

The clinical psychologist as evaluator, researcher, and educator

Psychosocial interventions which target the mental health of war survivors in Sri Lanka are often conducted with no evaluative component with which one could assess which types of interventions would be most efficacious, and under what circumstances they would be so. There is much work to be conducted on evaluating the efficacy of different treatment regimens for different types of psychological distress for different

socioeconomic groups or even for different religious groups. Systematic research and replication, which builds upon findings, is needed in order to be able to verify the efficacy of certain types of therapy. While case studies may be used to supplement and tailor interventions to suit individual clients, larger-scale studies would help to set expectations and accountability for psychotherapists working with these groups.

Clinical psychologists can also play an important role in conducting empirical research (both qualitative and quantitative) on the phenomenology of a variety of mental and behavioural disorders. Clinical research in Sri Lanka should begin with narratives, interviews, and qualitative data, if the findings are to be valid and useful in the culture. Similar work has been undertaken successfully in countries where value systems are likely to differ from those of European and North American systems (e.g. Elsass, 2001, Sveaass & Castillo, 2000; Van Ommeren et al., 2002). The qualitative data can provide a basis for more quantitative studies which would lead to the development of norms and guide prognoses for survivors of war.

The clinical psychologist can also be an important liaison between the clinical community and the academic world, by disseminating information obtained through research and assessment in classrooms and publications and at professional meetings. Such information would include findings on culturally specific ways in which people in non-Western collectivistic cultures express and cope with psychological distress resulting from exposure to war, and culturally unique and effective treatments for mental and behavioural disorders. By publicizing such findings, clinical psychologists can keep the field of psychology in both the West and the East informed about

alternative ways of approaching mental health issues.

The clinical psychologist as supervisor/trainer

Finally, there is a role for the clinical psychologist as supervisor and trainer. Typically, clinical psychologists have a doctoral degree (Ph.D. or Psy.D.), and receive extensive training in their academic and clinical programmes. Being trained in the research-practitioner model, a clinical psychologist is in an excellent position to supervise and train both research assistants and clinical trainees. Indeed this is one capacity in which clinical psychologists can be particularly useful in war-torn countries such as Sri Lanka. There is an overwhelming need to train and supervise students in these countries who wish to obtain their doctoral degree in clinical psychology. In addition, laws are needed to regulate the field so that only those with the proper training and education can practice as licensed mental health professionals³. Monitoring systems would lessen the potential psychological harm caused to clients by practitioners lacking the necessary training, and hold therapists accountable to their sponsors and their clients.

As with assessment, diagnosis, treatment, and evaluation, clinical training should be conducted in a manner that is most beneficial to the local community. Thus rather than individual, and purely pathology-focused training, a clinical-community paradigm may be best suited for clinical psychologists practicing in non-Western collectivistic cultures where armed conflict has destroyed the psychosocial infrastructure of the people. Supervision of clinical trainees would entail not only a focus on different methods of assessment, diagnosis, and treatment, but would also focus on clinical

process issues such as counter-transference, power differentials, sexual attraction towards clients, and recognizing and dealing with vicarious trauma and burn-out. The latter would be of particular significance for professionals working in war-torn areas, as they are exposed daily to story upon story of human suffering, grief, loss and desperation. In addition, clinical psychologists can be helpful resources for counsellors in areas of armed conflict. Counsellors need training not only to work competently within their areas of expertise, but also to recognize when they are working outside their areas of expertise and need to refer their clients to other professionals such as psychologists and psychiatrists.

In summing up, there are several key functions that a clinical psychologist can perform among people in non-Western collectivistic cultures experiencing armed conflict. However, clinical psychologists must see themselves as part of a team, rather than as individual 'experts' in the field of mental health. A clinical psychologist is in a unique position to take what is best from the worlds of medicine, mental health, sociology, and anthropology to form a unique perspective that is beneficial to the culture in which s/he works. In doing so, the psychologist should exercise caution in using Western assessment tools and diagnostic categories in non-Western cultures. Clinical psychologists should also be receptive to using treatment regimens that emerge from within the culture. They should be open to being taught by others knowledgeable in behaviours specific to that culture, including priests, local healers, and the clients themselves. By so doing, clinical psychologists can be invaluable resources to multidisciplinary and interdisciplinary intervention teams in countries torn apart by the violence of war, and be effective healers

among those who have experienced its horrors.

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¹ Indeed clinicians in the United States are now being urged to conduct such assessments of more adaptive behavior; the recent move towards what is being known as 'positive psychology' is propelling clinical psychologists to assess what is right (e.g. gratitude, kindness, accountability) with an individual at the same time as they are assessing what is wrong with her/him. Curiously, it appears that this move towards positive psychology is occurring at the same time as the push towards higher cultural competence and greater awareness of ethno-cultural and cross-cultural issues in psychology.

² Interoceptive exposure is a type of desensitization process based on the observation that some clients with panic attacks and PTSD have a 'fear of fear,' often catastro-

phizing even normal physiological sensations such as heart rate. The therapist uses interoceptive exercises to help clients elicit a variety of somatic responses (e.g. racing heart, chills, choking). Each client identifies one or more of these symptoms as most closely resembling the experience of having a panic attack. The exercises demonstrate that clients have control over such symptoms and that the symptoms are not necessarily life-threatening. In cultures where meditation is a common practice, initial breathing exercises may be used to elicit responses similar to 'hyperventilation', and deeper meditation exercises can be used to resume control over the hyperventilation.

³ With regard to this issue, there is a practice in the university system in Sri Lanka which is likely to be detrimental to further development of the field. That is the privilege granted to senior faculty in a university from one department or discipline to

obtain a 'Ph.D.' in another discipline by writing a dissertation relating to that discipline. This author has read two such dissertations for Ph.D.s in Clinical Psychology. The candidates clearly lacked knowledge and training in the field, yet it was likely that these degrees would be granted, as the candidates were senior faculty at the university.

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