Letter to the editor

Personal reflections on the *New Frontiers* issue of *Intervention*

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Everything I wanted to write about psychosocial interventions in areas of armed conflicts and low income is exposed in the *Intervention* publication *New Frontiers* (December 2014, (12) Supplement S). It is written in an academic way, with correct quotations that I would have neither the patience nor the energy to do. So thank you, on behalf of myself and if I dare to say, on behalf of all suffering people that we have often provided inappropriate or useless psychosocial assistance.

My concern is now more how to spread critical views and new professional concepts among mental health experts for psychosocial assistance in areas affected by armed conflict. Everything is already written in books and scientific journals. It is about practice, about field work. I recently spent a month in the Middle East and a week in Turkey at the Syrian/Turkish border working with refugees from Syria. I had the impression that not so much, or not enough, has changed in psychosocial assistance to people affected by armed conflict in comparison to when I started to work with children affected by armed conflict in the former Yugoslavia during the nineties.

I remember in the first year of war, the easiest way to get money for psychosocial programmes for Bosnian refugee children in Slovenia was to declare them as trauma therapy programmes. The first question from most donors was: how many children with posttraumatic stress disorder (PTSD) are there? How many children with PTSD will be included in the programme? PTSD was the entrance ticket for fund raising. We did not dare to speak about sad children, scared children or suffering children, to briefly to use human language for suffering and losses.

In countries affected by armed conflict, local mental health professionals were not familiar, or not sufficiently familiar, with community and public health approaches reaching a huge number of persons and activating natural social resources in communities. The local mental health establishment has not adapted its aims, strategies and activities to a new situation related to arm conflict, nor to the presence of a mass of people in need of psychosocial support. Neither had foreign experts, educating students within academic settings, nor local professionals working in institutions and services, adapted. In the academic sphere, and in the mental health establishment, there were astonishingly few intentions or efforts to develop and implement strategies from which a huge number of people (for instance school children or women) and the whole community could benefit. Psychosocial activities of nongovernmental organisations (NGOs) and international nongovernmental organisations (INGOs), in most cases, had little connection to regular mental health services.

I also remember the obsession of identifying needs for psychosocial assistance. During the war in Iraq, colleagues told me that the most important donor for a psychosocial programme, advised by experts, requested that before the programme started, to make an assessment of the number of traumatised people. Time, money and energy were invested in assessments of needs, most of which were only scarcely covered by psychosocial programmes. The idea of assessing local resources to empower people, although articulated in papers, had not yet spread in the field.

In spite of some critical writers who warned about us our misconceptions, the

omnipotent vision of professional psychological interventions for traumatised people prevailed.

Of course, everything was not as bad as described. Psychosocial programmes brought many good things and benefits to people. In fact, a lot was written about the good things we did with our psychosocial humanitarian activities, and much less about our errors or misconceptions. When we have spoken about them, we have, and still, do it mostly on a theoretical level, without showing their implications on the reality of mental health assistance to people affected by armed conflicts and poverty.

In the Middle East I had difficulties preventing my colleagues from lecturing in courses for teachers about DSM V and to explain the variants and diagnostic criteria of Attention Deficit Hyperactivity Disorder (ADHD). I had to stop a young psychologist who had intended to speak about Freudian concepts to teachers of classes with 70, 100, or 120 refugee children in them. A very energetic, well educated young colleague, dedicated to his work with children, expressed his gratitude to me because within the frame of training for the first time, he had the opportunity to cooperate with school workers. In my opinion, one of the most important achievements of the training was that school workers recognised the role of the school and teachers in protecting child mental health (*'We know now that we can help children with difficulties...'*) and that some medical mental health workers started to cooperate with schools. I consider that such changes in thinking, perception and attitudes are more important then learning *'techniques'*. In order to implement the *New Frontiers* and to sustain the raised energies and changes in attitudes, the programmes need to contain monitoring, refreshment and re-energising workshops, possibilities for a follow-up exchange of experiences and mutual encouraging and empowering of field workers.

My key question is how to implement the *New Frontiers* ideas into the reality of field activities? What could be done to translate more extensively these new ideas into practice? To transform them into a *'critical mass'* of mental health protection activities in regions affected by armed conflict and terrorism?

I see a possibility through establishing a mobile academy of field work in areas affected by armed conflict, an experiential school for designers of programmes, managers of projects and trainers in psychosocial programmes. It could be created in cooperation with United Nations Agencies. Courses could be run in different countries/regions in need of psychosocial programmes. The course could use the locality as a *'case study'*, and produce programmes for psychosocial protection. The implementation of some psychosocial programmes could be a part of the course (learning by doing). Combining the courses with practical work, preparing psychosocial projects, collaborating with local mental health professionals and services, running trainings for local helpers (teachers, volunteers, etc) would also economise expenses. In a way, the *'academy'* should be linked to or integrated in psychosocial projects run in the country.

The main goals of such a field work academy should be the development of:

- philosophy and skills of participants for community based, human resources activating and social networks based approach;
- sensitivity and skills for application of the cultural and contextual dimension and social responsibility;
- skills for establishing collaboration with local mental health services and relevant institutional structure (schools, etc).

Teachers at the academy should be *'new frontiers'* experts, field workers presenting models of good practice and local people

contributing the input of the cultural and contextual dimension, wisdom and locally acceptable strategies.

In order to *'contaminate'* the mental health establishment with *'new frontiers'* philosophy, an important group of participants should be local mental health professionals working in regular services and mental health settings. They, and not western nor northern experts, should be the main players in their own territories in developing psychosocial assistance to people affected by armed violence. This is sometimes the case, but the practice should be more prevalent. Usually, disconnected parallel systems of mental health protection coexist: the *'normal'* establishment (services, institutions) and the INGOs' or NGOs' psychosocial activities. As well as capacity building and developing a sustainable public health and community approach in the frame of local establishments, the transfer of responsibility for the programme to local professionals would have an economic benefit. Instead of pouring considerable sums of donated money for psychosocial programmes back into western countries (NGO or the institution responsible for the programme) much more money will be used locally for implementation.

Another reflection on *'New Frontiers'* I am not sure that psychosocial activities aimed to help people affected by armed conflicts and other mass disasters in poor countries should be as strictly separated from mental health protection in rich countries, as we used to present it. Rich countries have an enormous social underground of poor, excluded, marginalised populations for which existing mental health services with their professional basis and practices are not of considerable benefit. We are all familiar with the low percentage of users of mental health services. Usual figures are 20–30 % of those in need of assistance actually benefit from mental health services. Should the principles of *'New Frontiers'* not be introduced into the formation of mental health workers in *'normal'* life circumstances and implemented in regular mental health settings of developed countries?

My final reflection might sound old fashioned and not very scientific. After 25 years of work with children affected by war, terrorism and poverty and in the 80th year of my life, I dare to say that in order to make our efforts more valuable, we need more common sense and more humanity. I am more and more embarrassed to use the word *'training'* for my work. What I try to do is to contribute to empowering people (teachers, primary care workers, volunteers, NGO workers), to encourage them to use their wisdom and experience to help children in distress. I try to show concern and respect for suffering and the ability to cope of people I work with, and to express humanity and solidarity. Of course, I spread information from my profession which could help them in providing assistance to themselves and to others, and I transfer my experiences. However, these experiences are not any more important than the experiences of the people I cooperate with in the programme. To be clear, I keep in mind participants of the *'training'*. I try to build, together with them, the bulk of energy, experience and knowledge needed to help children in distress within the frame of everyday settings. We constantly repeat that the most powerful ingredient of psychotherapeutic intervention is the relation between two humans – the therapist and the client. When speaking about psychosocial activities for persons affected by armed conflicts, we are embarrassed to speak about human relationships. Maybe because it is not a scientific category, or not *'evidence based'*? I agree with astronomers that *'lack of evidence is not lack of existence'*.

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