PSYCHOSOCIAL INTERVENTIONS AND THE DEMORALIZATION OF HUMANITARIANISM

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Summary. This paper critically analyses from a political sociology standpoint the international conceptualization of war-affected populations as traumatized and in need of therapeutic interventions. It argues for the importance of looking beyond the epidemiological literature to understand trauma responses globally. The paper explores how the imperative for international psychosocial programmes lies in developments within donor countries and debates in their humanitarian sectors over the efficacy of traditional aid responses. The aim of the paper is threefold. First, it discusses the emotional norms of donor states, highlighting the psychologizing of social issues and the cultural expectations of individual vulnerability. Second it examines the demoralization of humanitarianism in the 1990s and how this facilitated the rise of international psychosocial work and the psychologizing of war. Third, it draws attention to the limitations of a mental health model in Croatia, a country which has been receptive to international psychosocial programmes. Finally it concludes that the prevalent trauma approaches may inhibit recovery and argues for the need to re-moralize resilience.

Introduction

War-affected populations have been conceptualized under international policy of the last decade as traumatized en masse and in need of therapeutic interventions (de Jong et al., 2000; Mollica, 2000). This paper critically analyses the evidence from a political sociology standpoint and affirms the importance of looking beyond the epidemiological literature to understand trauma responses globally (Bracken, 2002). Humanitarian action is not apolitical (de Waal, 1997; Macrae, 2001), nor is international psychosocial work as a branch of humanitarianism. The nature of humanitarian aid proffered to recipient populations is bound up with the relationship of international non-governmental organizations, predominantly Western, to their own societies and governments. The imperative for international psychosocial programmes lies in developments within donor countries and debates in their humanitarian sectors over the efficacy of traditional aid responses. The decade of the
1990s witnessed the politicization and militarization of aid as instruments of conflict management. The Balkans region in particular became subject to the new aid strategies and is therefore interesting to discuss in relation to the impact of the new approaches. The aim of this paper is threefold. First, the paper discusses the emotional norms of donor states, highlighting the psychologizing of social issues and the cultural expectations of individual vulnerability. Second, it examines the demoralization of humanitarianism in the 1990s and how this facilitated the rise of international psychosocial work and the psychologizing of war. Third, it draws attention to the limitations of a mental health model in Croatia, a country which has been receptive to international psychosocial programmes. Finally, it concludes that the prevalent trauma approaches may inhibit recovery and argues for the need to re-moralize resilience.

**Western emotional norms**

The explosion of international interest in the psychological impact of war on populations may be traced back to developments within Western donor countries and their new cultural sensibilities. The individual and his or her personal feelings have become the main reference point in contemporary Western societies, which lack strong shared ideological, moral or religious convictions and collective consciousness (Nolan, 1998). Social issues in Western donor countries are increasingly understood in emotional terms. At the same time social norms have shifted in the West from emotional reticence to emotional display. However, the erosion of previous political or communal affiliations has not resulted in a vigorous individualism, but anxious, insecure individuals (Lasch, 1984; Furedi, 2003). ‘Modern society plunges us into a condition of uncertainty in which we often lose track of what we feel and slip into states of depression and helplessness,’ argues an advocate of mass therapeutic programmes for the public (Samuels, 2001, p. 3). Contemporary Western societies’ lack of a clear moral or ideological framework weakens the individual’s sense of selfhood and communal links, which foster psychological security. This phenomenon of emotional vulnerability in post-traditional societies is anticipated by the psychoanalyst Erik Erikson in his identification theory (Erikson, 1968, 1980).

Firm convictions, whether religious, moral or political, promote resilience of character. However, bereft of convictions and disposed to introspection, the personality type of contemporary Western culture is characterized by emotional vulnerability (Lasch, 1984; Sennett, 1976, 1998; Furedi, 2003). This sense of vulnerability is exemplified in the dramatic rise of post-traumatic stress disorder (PTSD) in the West. The PTSD classification has been persuasively analysed as the archetypal syndrome of the emotionally vulnerable individual of post-traditional societies (Young, 1995; Bracken, 2002). Individuals today already have a fragile sense of purpose and community in their lives and are vulnerable to anything that disturbs the precarious sense of purpose and identity they have achieved. The characteristic intrusive-avoidance symptoms of PTSD are related to the shattering of meaning and attempts to integrate distressful experiences and regain a sense of coherence (ibid.). In other words, PTSD as ‘a disorder in which the victim experiences a profound sense of meaninglessness and dislocation’ is an exaggerated form of the pervasive cultural
anxiety over meaningfulness and personal identity (Bracken, 2002, p. 187). Indeed people appear to seek meaning in the diagnosis of PTSD as a disorder that encapsulates the contemporary human condition (Nolan, 1998, pp. 9–17; Furedi, 2003). Feelings of anxiety and vulnerability have led to an explosion of psychological complaints and demands for professional diagnosis and support. A substantial proportion of visits to the doctor in Britain now relate to issues concerning emotional well-being (Shaw & Middleton, 2001; Shaw & Woodward, 2003). One study found that psychological or social distress constituted approximately 30% of all GP initial consultations and approximately 50% of consecutive meetings at a GP surgery (Kessler et al., 1999). Therapy resonates with the psychologically inclined populations of contemporary Western societies, fostering enormous growth in the numbers of counselling professionals. The creation of a huge counselling industry has been further promoted by state policy, which is developing therapeutic approaches to address social issues from crime, educational achievement, family breakdown and poverty to social exclusion (Nolan, 1998; Furedi, 2003). Social advancement is increasingly envisaged as being created through enhancing personal growth and interpersonal communication skills rather than the huge New Deal-type projects of the past.

Over the last decade policymakers have found a new source of legitimization affirming individuals' self-esteem and managing people's emotions (Nolan, 1998; Furedi, 2003). These therapeutic interventions are given momentum with the advocacy of emotional self-understanding and well-being as fostering good citizens and good employees (Giddens, 1994; Samuels, 2001). Official concern with what is called 'emotional literacy' also parallels new Western management techniques which emphasize transferable 'soft' skills to facilitate communication and team co-operation to enhance responses in rapidly changing markets (Sennett, 1998). Such instrumentalization of the emotions has been condemned as the 'McDonaldization of the emotions', in which emotional responses risk becoming mechanized: 'petrified, routinized, and otherwise made artificial' (Mestrovic, 1997, p. 146). There are potentially alienating and coercive aspects to government intervention in people's personal emotional lives when social problems are re-interpreted in terms of emotional functionalism/dysfunctionalism. Preoccupation with emotional functionality problematizes individuals' emotional responses and their ability to cope with life events. So even where individuals do not specifically seek support, professionals are encouraged to intervene proactively with therapeutic programmes.

The provision of counselling has become a routine feature of contemporary culture and may be experienced as an education into vulnerability. After every disaster, teams of trauma counsellors descend on the area in question, offering PTSD counselling, not just to bereaved relations, but to the whole community. Policy is premised on the assumption of vulnerability. Indeed there are few trauma studies that take a 'salutogenic' approach, that is, focus on those who are resilient (Waysman et al., 2001), and it is neglected in emergency responses (see Almedom, 2004, this volume). This is not surprising given our cultural disposition to look for vulnerability. The present expectation of vulnerability may be compared with the Aberfan disaster of 1966 in which 116 children and 28 adults were killed as a result of a landslide onto a school in Wales. No counselling was offered to the bereaved relations, while the surviving children were quickly returned to schooling after a fortnight so that they
would not dwell on the tragedy (Furedi, 2003, p. 19). The villagers were praised by the *Times* newspaper as having done ‘admirably in rehabilitating themselves with very little help’ (*Times* quoted in ibid.).

Today, in sharp contrast, expectations of those at risk of emotional trauma include anybody who witnesses distressful events on television. Thus it has been claimed that individuals can develop ‘varying degrees of PTSD from graphic displays of carnage’ (Coward, 2001). Following this view, proposals were made or discussed to offer counselling over the Iraq War to students from Arizona State University in the United States to Stirling University in Scotland. Whether such proposals were dismissed or not, the very suggestion that students whose only exposure to the war was likely to be through the media might be in need of counselling illustrates cultural expectations of vulnerability and how the categories of those who are deemed at risk of incapacity are expanding.

The very report of a community having experienced conflict is sufficient for international humanitarian agencies to deem the group as having PTSD and requiring specific psychosocial support. The automatic provision of mass trauma counselling in the wake of any disaster exemplifies the cultural projection of individuals as universally vulnerable and in need of emotional processing to mediate psychosocial dysfunctionality. Essentially the international psychosocial model may be represented as below:

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Experience of distressful event → Trauma responses → Psychosocial dysfunctionality
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The model assumes that people globally understand their suffering through the prism of psychology and that their suffering may be addressed through therapeutic programmes (Young, 1995; Summerfield, 2001; Bracken, 2002). However, if PTSD is understood as a disorder of meaning (Bracken, 2002), this suggests both the culturally specific appeal of PTSD counselling and its limitations in addressing a wider social crisis of meaning.

The model overlooks how distress is mediated by political or religious convictions, cultural beliefs, social circumstances and previous experience of adversity, and not simply by the distressing events themselves (Shepherd, 2000). Irrespective of whether populations appear resilient, they are deemed to be suffering from ‘hidden scars’, ‘invisible wounds’ or ‘undiagnosed trauma’ and requiring preventive treatment to break cycles of emotional dysfunctionalism (Mollica, 2000). Their resilience is effectively pathologized as a failure to process emotions, for the model conflates the experience of distress with emotional dysfunctionality requiring therapeutic management (de Jong *et al*., 2000). Consequently, while cultural differences are acknowledged, it is only insofar as entailing the adaptation of therapeutic methods. The overall prescription of people as vulnerable and needing to process their emotions remains in international responses.

What is at issue is not simply the relevance of the PTSD model globally and what sort of emotional management is or is not culturally appropriate, but its problematizing of communal responses and communal resilience. There is growing realization that current therapeutic approaches may inhibit community recovery, firstly by denying resilience and validating vulnerability, and secondly by interfering with communities’ own resources. In particular there are growing doubts over the efficacy
of psychological debriefing programmes (Rose et al., 2003a, b). The professionalization of emotional responses may unintentionally weaken communal responses, by encouraging identification with and dependence on (international) professionals. However, even where community cohesion is regarded as weak prior to the particular disaster, the very experience of disaster may pull a community together (Rogers, 1993). Nevertheless, the therapeutic norms of donor countries continue to be projected onto disaster-affected populations globally and influence international humanitarian responses.

The pervasiveness of therapeutic responses has led social commentators to characterize contemporary Western society as a ‘post-traumatic culture’ (Farrell, 1998). Tellingly, therapeutic forms rather than religious ceremonies are becoming the predominant cultural rites that accompany public and private events. The counselling profession has been described as ‘a new priestly class’ displacing religious leaders as the guardians of society (Nolan, 1998). The idea of the therapeutic ethos as a new religious creed captures well how cultural expectations of emotional vulnerability have become prescriptive. It seems individuals have to reveal emotional vulnerability to authenticate the suffering they have witnessed and their compassion for the victims. The demise of the traditional British stiff upper lip was evidenced in the displays of mass grief following Princess Diana’s death. Nobody, it seems, is exempt from the dictates of contemporary therapeutic norms, including the British Royal Family, who was widely accused of being unfeeling for not being demonstrative over Diana’s death. In the same vein, the former BBC journalist Kate Adie was attacked for her emotionally restrained reporting of the Dunblane school massacre in 1996 (Mayes, 2000). Under the therapeutic ethos, not to be traumatized in the face of tragic events is tantamount to being callous and indifferent to human suffering. This helps to explain the phenomenon of ‘survivors’ guilt’ and the relatively high instance of secondary trauma among emergency workers or other staff involved in the care of victims. Indeed secondary stress disorder has been explained by the Dart Center for Journalism and Trauma as an ‘empathic response that affects people such as therapists and journalists when they become overwhelmed by others’ traumatic experiences’ (http://www.dartcenter.org/selfstudy/index.html). Through displaying emotional vulnerability and requiring therapy, carers demonstrate their empathy. Failing to acknowledge emotional vulnerability and seek therapy is almost becoming regarded as socially irresponsible. To suggest that the stiff upper lip is more useful than counselling and that counselling is unhelpful or even that time heals is to invite a tirade of outraged responses, as the Oxford-based Cochrane Centre (Joseph et al., 2003) or the British agony aunt Virginia Ironside have found.

De-moralization of humanitarianism

Alongside the cultural developments within donor countries, which encouraged the rise of international therapeutic interventions, there were important developments within the aid sector, which facilitated the adoption of psychosocial programmes. Tony Vaux (2001), former Oxfam representative, describes humanitarian work as being underpinned by emotion and the emotional relationship between aid worker and aid recipient. Emotion has not been absent from aid work. An empathetic
relationship is assumed within the symbolism of the humanitarian act itself as well as the personal interactions between aid worker and recipient.

The altruistic ideals of humanitarianism accord with the contemporary therapeutic ethos of donor countries. Empathy has come to the fore as the foundation of ethical behaviour in Western societies, because of their lack of cohering values with the demise of traditional value systems and ideologically based politics. Humanitarian organizations have become important voices in public discourse following the end of the Cold War. However, the decline of shared ideological, moral or religious convictions in donor states as ‘post-traditional’ societies has impacted on the convictions of the humanitarian sector. As Vaux vividly testifies in his account of relief work, ‘Altruism is a difficult feeling to maintain and a shaky concept in a postmodern world, without given beliefs and morality’ (Vaux, 2001, p. 1).

Humanitarian organizations went through much soul-searching over their mission and their motives in the 1990s, despite the huge expansion in their work and public profile. Indeed the very sponsorship of humanitarian activities by donor governments became a source of anxiety for humanitarian organizations over the way that aid and their role as humanitarians were being politicized. Humanitarians could no longer assume that their role was ethical and benefited recipients: both the nature and the work of humanitarian organizations were fundamentally questioned. Numerous books on humanitarianism have been published over the last decade whose very titles demonstrate how vehemently aid work has been attacked. Michael Maren’s The Road to Hell (1997), Timothy Morris’ The Despairing Developer (1991), David Rieff’s A Bed for the Night: Humanitarianism in Crisis (2002), David Sogge’s Compassion and Calculation (1996) and Alex de Waal’s Famine Crimes (1997) are a just few of the damning critiques that came out in the last decade. Newspapers and magazines too carried negative articles on aid work such as The Economist’s ‘Sins of the Secular Missionaries’ (2000). Even popular culture, normally very positive about humanitarian organizations, portrayed negative images. The cartoon South Park, for example, satirized humanitarian intervention in its ‘Stavin’ Marvin’ sketch which depicts humanitarianism as a bloated and parasitic industry disrupting the lives of its supposed beneficiaries.

Humanitarian organizations were encouraged to adopt psychosocial work by the sector’s crisis of legitimacy. There were three areas of contention: humanitarian principles, the technologies of aid and the efficacy of material aid. The technologies of aid left many aid workers concerned about the bureaucratization of aid work as its role expanded. Instead of representing an act of empathy between people, there was disquiet that the humanitarian sector was becoming a self-serving industry (Maren, 1997). The sense of humanitarianism becoming alienating rather than humanizing was heightened by doubts over the efficacy of humanitarian aid work. Soul-searching led to a questioning of the aid worker and recipient relationship too. Empathy for the person in need appeared no longer to be sufficient to guide interventions, and the motives of aid workers themselves came under scrutiny.

New codes of practice proliferated in the 1990s, but their very elaboration suggested the depth of the crisis in humanitarianism. Definitive principles to guide action remained elusive. The detailed codes multiplied, revealing profound doubts over the ethics of aid work and the integrity of aid workers. Humanitarianism was not only attacked as short-termist and ineffective in providing for people’s needs.
Humanitarianism was attacked for actually harming people’s welfare. Critiques such as Mary Anderson’s *Do No Harm* (1999), Joanna Macrae’s *Aiding Recovery?* (2001) or Alex de Waal’s *Famine Crimes* (1997) set out how humanitarian aid could exacerbate crises and undermine local economies. The giving of humanitarian aid was problematized for ‘feeding the killers’ and fuelling conflicts. In war economies it was found that ‘Any kind of external assistance ... could be converted into guns; it therefore became impossible to separate humanitarian aid from the war itself’ (Vaux, 2001, p. 82). In future, aid was to be judged by how it contributed to resolution of crises and promoted developmental and human rights goals. However, the elusiveness of these goals in the face of recurring disasters and protracted conflicts, and the profound doubts over the principles and consequences of aid work, all contributed to a demoralized humanitarianism and a demoralized humanitarian aid worker.

One of the attractions of psychosocial work for aid workers has been to bring back the human in the face of the bureaucratization of aid, foregrounding how people and communities personally experience disaster or conflict. Western aid workers are simultaneously projecting their personal sense of vulnerability and loss of meaning onto disaster or war-affected populations. A sense of purpose mediates distressful situations and encourages difficulties to be interpreted as worthwhile sacrifices (Frankl, 1964; Cherniss, 1995; Bracken, 2002). One study that has looked at the reasons for positive outcomes highlights how:

> Those who view themselves as in charge of their fate (control), who are committed to meaningful goals and activities (commitment), and who view stress as a surmountable challenge are more likely in the long run to integrate the trauma into their lives and to enjoy a satisfactory level of adjustment. (Waysman, 2001, p. 545)

These findings help to explain how aid workers have previously appeared remarkably resilient rather than vulnerable. In the 1970s and 1980s’ era of the individual in humanitarianism, aid workers had great autonomy over their activities and great confidence in the rightness of what they were doing. However, for many aid workers, the commitment that comes from meaningful work and which fosters resilience has been undermined by the fundamental doubts over their mission and motives. In addition, the thrill of danger and the adrenaline of action in relief work are becoming taboo under the therapeutic ethos alluded to in the previous section. Aid workers are culturally encouraged to be emotionally vulnerable as a sign of caring. Whereas previous generations of aid workers could be buoyed up by their mission, aid workers over the last decade have found themselves exposed not just to distress and danger, but to severe censure and profound misgivings over their relief and developmental activities.

As a disorder of meaning (Bracken, 2002, p. 187), the rise of PTSD among humanitarian staff may be regarded as an exaggerated form of the wider crisis of purpose in humanitarianism. The significance of meaning has been neglected in the literature on PTSD in international relief and development personnel. The literature tends to focus on the severity of exposure to stress and organizational training and support systems for aid workers (Smith *et al*., 1996; McCall & Salama, 1999; Eriksson *et al*., 2001). It has been argued that ‘Relief workers today are faced with situations which generate more stress than straightforward natural disasters’ (Salama, 1999,
p. 12), as if the disasters of the past were straightforward. More straightforward previously, however, was how humanitarians regarded their mission and what ethical dilemmas they set themselves. The humanitarian emergencies of the past were potentially as complex as today, but the Cold War solidarist framework simplified humanitarian responses. In essence, this framework assumed the legitimacy of host governments and aid agencies in humanitarian emergencies, and did not challenge official representations of the crisis, leaving questions of political responsibility and the political role of aid unexplored. The Ethiopian famine of 1984, for example, was never a straightforward famine, but aid agencies responded as if it were (Vaux, 2001). The image of a simple natural disaster contrasts with the way that crises are approached today as ‘complex political emergencies’, such as the current food shortages in Zimbabwe. The idea of the complexity of emergencies and how aid may prolong crises has raised new difficult dilemmas for humanitarian organizations.

The problematizing of the humanitarian role in crises, rather than the suffering on the ground per se, has arguably contributed more to rising mental health problems among aid staff. Mental breakdown among relief workers has strikingly been when they have been most demoralized by their mission. The Somalia mission of 1992 sharply exposed this crisis of morale. Oxfam staff, for example, experienced significant stress problems arising from the mission, which did not simply relate to the suffering and dangers they encountered, but the organization’s ill-prepared responses. An internal evaluation written two years after the mission found that:

> The majority of people spoken to who worked in Somaliland and Somalia were still experiencing distress and trauma as a result of their experience. The feelings varied from nightmares, a loss of confidence, a feeling of failure and dissatisfaction with the work achieved, and feelings of personal inadequacy to anger and disillusion with aid work. (Quoted in Vaux, 2001, p. 154)

Rapid growth in trauma counselling for international aid workers, peacekeepers, journalists and human rights workers has accompanied the rise of international trauma counselling. Counselling, however culturally popular, is no solution to a wider crisis of meaning.

Furthermore, psychosocial intervention may be extending alienating technologies through its instrumentalization of the emotions. The significance of international psychosocial work goes beyond the alleviation of distress. Psychosocial work is being given prominence because of how social problems are being reinterpreted in Western societies as issues of emotional functionalism/dysfunctionalism. Distressful experiences are regarded as triggering traumatic symptoms causing dysfunctionalism leading to cycles of trauma and violence. Acting upon the emotions and promoting a sense of emotional well-being are regarded as addressing both the consequences and the causes of crisis by breaking cycles of psychosocial dysfunctionalism. As one international NGO worker involved in trauma counselling in Burundi explains:

> When we look at the cycle of violence, we can see that unless there is healing, mourning and unless you go through the four or five stages of the healing process, you can’t reach that area of acceptance. Then the cycle of violence continues. (IRIN, 2002)

Thus trauma is regarded as significant for not only impairing the development and mental well-being of the individual, but the future development and well-being of the society as a whole. Consequently, the emotions of crisis-affected populations have
become a legitimate sphere of external activity, and therapeutic interventions are being burdened with broad social tasks. The next section explores the pathologizing of war and why psychosocial programmes have become so popular among donors.

Understanding war through a therapeutic model

The new international humanitarian framework treats violent conflict as a manifestation of psychosocial dysfunctionalism. This pathologizing of war relates to the outlook of contemporary Western society. Lacking strong convictions themselves, donor countries find it difficult to imagine people believing in causes they consider worth fighting for and project populations at war as dysfunctional. War is almost invariably discussed as having a negative impact on a population's mental health. Current understanding assumes universal vulnerability, whereas earlier models assumed the general resilience of people. International reports typically speak of war causing a 'vicious circle' of 'psychosocial dysfunction, new instability, new vulnerabilities, and new hazards' (WHO, 2002, p. 6). Thus international psychosocial programmes seek to address 'unresolved communal psychological wounds' as 'one of the most - if not the most - powerful fuels of future war and violent conflicts' (Common Bond Institute, 2003) and as shaping 'future political/ideological development and/or decision-making' (Volkan, 2001).

There are now thousands of international projects providing trauma therapy for war victims. However, projections of mass trauma are not borne out in practice. The lack of spontaneous identification with trauma in non-Western societies has been striking. A practical 'problem focused coping style' is common to non-Western societies as compared with the 'emotion focused coping style' of contemporary Western therapeutic cultures (Summerfield, 2001). Problems are not automatically conceptualized in therapeutic terms even where survivors experience distressing reactions such as nightmares (ibid.). Aid agencies have acknowledged encountering few individuals who would classify themselves as suffering from a psychological disorder (Wiles et al., 2000). International aid workers, predominantly Westerners, are actually far more likely to identify themselves as having PTSD than the war-affected population itself because of changed cultural norms. However, the precautionary principle of contemporary risk consciousness decrees that policy should be formulated on the basis of the potential for a disorder developing. Yet the effectiveness of trauma counselling is contested (Rose et al., 2003a; Sensky, 2003). The current advice of the Cochrane Review is that 'There is no current evidence that psychological debriefing is a useful treatment for the prevention of post-traumatic stress disorder after traumatic incidents,' (Rose et al., 2003b). Indeed many refugees experience the provision of trauma counselling as stigmatizing (Wiles et al., 2000). Greatly appreciated in emergency situations, instead, are the message and tracing services along with the practical assistance and any personal instances of friendliness, kindness or consideration by individual aid workers that recognize them as fellow human beings. But ultimately psychological recovery comes from the overall circumstances and meaning of people's lives and not simply from what is inside people's heads as the international therapeutic model implies, and as Summerfield discusses in this volume and elsewhere (2002).
The situation of the post-Yugoslav states is interesting, for some of the social developments that have encouraged the therapeutic turn in the United States and Western Europe apply to Central and East European states. Moreover, there is a readiness to follow Western perspectives, including Western therapeutic sensibilities, with the desire for incorporation into the European Union. Thus critiques on the inappropriateness of Western therapeutic approaches for non-Western societies are resisted as implicitly undermining their claims to a Western identity and inclusion in Western intergovernmental organizations. The attractiveness of PTSD is very apparent in Croatia with thousands of veterans queuing up for the diagnosis and war pensions based on their psychological state. With 80% of war pension claims on the basis of PTSD, Croatia illustrates the dangers of the current therapeutic model and the validation of vulnerability. The government’s responses have perversely given incentives to individuals to adopt a sick role rather than promote recovery: war pensions have actually been set at higher levels than key public sector salaries. Unsurprisingly, instead of the numbers of veterans diagnosed with PTSD declining since the end of the war eight years ago, the numbers continue to escalate. Ten thousand are now registered and the Minister for Croatian Veterans is predicting that it may rise to as many as 80,000 (Hauswitschka, 2003). Yet tellingly there is an absence of PTSD diagnosis among veterans registered as 100% disabled: they are presumably already entitled to a war pension without requiring the diagnosis. The government is now faced with a looming financial crisis arising from its readiness to recognize PTSD among its war veterans: war pensions represent a significant drain on the government’s budget.

In highlighting the dangers of validating vulnerability, this is not to deny issues of emotional ill-being: the suicide rate in Croatia is reportedly higher than after the Second World War and is comparable to the numbers killed in the war (Dujic, 2002). Nevertheless, emotional ill-being in the country cannot simply be treated as a mental health issue, but is bound up with the disappointments of the peace, which has not yet brought economic prosperity and integration into the European Union. The therapeutic model is inadequate to address a generalized lack of purposefulness in society. Moreover, the call for therapeutic interventions as ‘preventive medicine’ (Volkan, 2001), even where populations appear resilient, may perpetuate emotional problems by denying populations’ own coping strategies and creating unaccountable relations of dependency. As the salutogenic study cited above highlights, those who view themselves as in charge of their fate are more likely to have positive outcomes (Waysman et al., 2001). Yet against this finding, the new post-conflict strategies imply extensive loss of local control under comprehensive external governance, as has been the case in Bosnia (Pupavac, 2004). The humiliation of dependency on the international community has been identified as affecting the population’s emotional well-being (de Jong et al., 1999). Longitudinal studies of trauma in war-affected populations under de facto international protectorates need to take into account such suspension of self-determination in analysing mental health. The trauma label is rightly experienced by many societies as stigmatizing for it is being invoked to deny their capacity more generally, with implications for their rights and freedoms.
The present casual reference to war-affected populations as traumatized is unhelpful in formulating appropriate responses. The predominant international trauma approach validates vulnerability and casts doubt on resilience. The demoralizing of resilience under contemporary culture has been neglected until recently. The importance of fostering resilience was brought home to policymakers following the terrorist attack on the World Trade Center. An anxious ethos cultivating emotional vulnerability is distinctly ill-equipped to manage terrorist threats whose very tactic is to promote fear. Policy needs to tackle how people are inhibited from being resilient because of the prevailing cultural norms. Researchers at the International Policy Institute of the War Studies Group at King's College London have suggested 'the need for an approach that clarifies people’s values rather than emphasizing their vulnerabilities' (Durodie & Wesselly, 2002). This recommendation is useful in identifying how a generalized lack of meaning in society contributes to emotional vulnerability.

An age of relativism does not generate strong belief systems that promoted people of character in the past. The clarification of values may remain elusive for the foreseeable future in the humanitarian sector as more generally in Western societies. However, this crisis of meaning and its manifestation in emotional vulnerability is not universal. There is a danger that international psychosocial programmes become a global education into vulnerability. Therapeutic approaches, focused on feelings rather than activities, may encourage adoption of sick roles, fostering social disengagement and isolation as in Croatia. A starting point for national and international policy should be the re-moralization of resilience. Individuals or communities who demonstrate hardiness and do not seek counselling should not be pathologized as being ‘in denial’ of their ‘hidden scars’. It should be remembered that adverse experiences may promote resilience and galvanize dormant communal responsiveness (Joseph et al., 1993). There is new interest in findings of resilience (Rogers, 2003). A study of the reconstitution of New York City's Emergency Operations Centre, for example, found elements of resilience and that this resilience was extremely important for the efficacy of the emergency services' responses (Kendra & Wachtendorf, 2003). In this spirit, a New York community reconstruction project has named itself 'NYC Recovers' (see Fullilove et al., 2004, this volume). Even where value systems are weak, resilience may be supported by affirming people’s professional values: their skills, activities and courage as firefighters or water engineers and so on.

The lessons of resilience are vital for addressing the reconstruction of disaster and war-affected communities internationally, as well as the domestic management of the new security threats faced by Western societies. The casual projection of populations as traumatized and dysfunctional under international psychosocial programmes is experienced as stigmatizing. Humanitarian organizations need to rethink how they approach the issue of the emotional well-being of war-affected populations and their own staff. A sense of meaningfulness is crucial to emotional well-being. The demoralization of the humanitarian mission underlies the rise of PTSD among humanitarian workers and the pathologization of populations. A mental health model is inadequate and may be inappropriate to address the emotional well-being of both
war-affected populations and humanitarian organizations. Moreover, the tendency of the international psychosocial approach to conflate traumatization with brutalization is dehumanizing and unethical. At the heart of the humanitarian mission and modern ethics has been the belief in fellow human beings. Affirmation of this core principle of humanity is vital to the morale and morality of humanitarianism and the wider search for meaning.

References

Anderson, M. (1999) Do No Harm: How Aid Can Support Peace – or War. Lynne Rienner, Boulder, CO.
Bracken, P. (2002) Trauma: Cultural Meaning and Philosophy. Whurr Publishers, London.
Cherniss, C. (1995) Beyond Burnout: Helping Teachers, Nurses, Therapists, and Lawyers Recovery from Stress and Disillusionment. Routledge, New York and London.
Common Bond Institute (2003) 11th Annual International Conference on Conflict Resolution: http://www.aphweb.org, accessed 24 March 2003.
Coward, R. (2001) Seeing is reliving. Observer, 4th March.
Dart Center for Journalism and Trauma (2003) http://www.dartcenter.org, accessed 24th March.
de Jong, K., Ford, N. & Rolf, K. (1999) Mental health care for refugees from Kosovo: the experience of Medecins Sans Frontieres. Lancet 353, 8th May, 1616–1617.
de Waal, A. (1997) Famine Crimes: Politics and the Disaster Relief Industry in Africa. James Currey, Oxford.
Durodie, B. & Wessely, S. (2002) Resilience or panic? The public and terrorist attack. Lancet 360, 14th December.
Dujic, G. (2002) Je li patnja hrvatskih branitelja imala smisla? [Did the suffering of Croatian veterans serve any purpose?] Hrvatsko Slovo, 26th April: http://www.hkz.hr/hrvatsko_slovo/2002/366/t112.htm.
Economist (2000) Sins of the Secular Missionaries. Economist, 29th January, 25–28.
Erikson, E. (1968) Identity: Youth and Crisis. Faber, London
Erikson, E. (1980) Identity and the Life Cycle. W. W. Norton, New York and London.
Eriksson, C., Kemp, H., Gorsuch, R., Hoke S. & Foy D. (2001) Trauma exposure and PTSD symptoms in international relief and development personnel. Journal of Traumatic Stress 14(1), 205–212.
Farrell, K. (1998) Post-Traumatic Culture: Injury and Interpretation in the Nineties. John Hopkins University Press, Baltimore and London.
Frankl, V. E. (1964) Man’s Search for Meaning: An Introduction to Logotherapy. Hodder and Stoughton, London.
Fulfillove, M. T., Hernandez-Cordero, L., M addow, J. S. & Fulfillove III, R. E. (2004) Promoting collective recovery through organizational mobilization: the post-9/11 disaster relief work of ‘NYC Recovers’. Journal of Biosocial Science 36, 000–000.
Furedi, F. (2003) Therapy Culture: Cultivating Vulnerability in an Age of Uncertainty. Routledge, London and New York.
Giddens, A. (1994) Beyond Left and Right: The Future of Radical Politics. Polity Press, Cambridge.
Hauswitschka, A. (2003) Pancic: Od PTSP-a je napravljen bauk. Vjesnik, 16th April: http://www.vjesnik.hr/html, accessed 20 April 2003.
IRIN (2002) Burundi: Focus on Trauma Healing. 10th September: http://www/irinnews.org.
Joseph, S., Williams, R. & Yule, W. (1993) Changes in outlook following disaster: the preliminary development of a measure to assess positive and negative responses. Journal of Traumatic Stress 6, 271–279.

Kendra, J. & Wachtendorf, T. (2003) Elements of resilience after the World Trade Center disaster: reconstituting New York City’s Emergency Operations Centre. Disasters 27(1), 37–53.

Kessler, D., Lloyd, K., Lewis, G. & Pereira Gray, D. (1999) Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. British Medical Journal 318, 436–439.

Lasch, C. (1984) The Minimal Self: Psychic Survival in Troubled Times. W. W. Norton, New York.

McCall, M. & Salama, P. (1999) Selection, training, and support of relief workers: an occupational health issue. British Medical Journal 318, 113–116.

Macrae, J. (2001) Aiding Recovery? The Crisis of Aid in Chronic Political Emergencies. Zed Books, London.

Maren, M. (1997) Road to Hell: The Ravaging Effects of Foreign Aid and International Charity. Free Press, New York.

Mays, T. (2000) Submerging in therapy news. British Journalism Review 11(4), 30–36.

Mestrovic, S. (1997) Postemotional Society. Sage, London.

Molliva, R. (2000) A society at war from invisible wounds. Scientific American, June, 54–57.

Morris, T. (1991) The Despairing Developer: Diary of an Aid Worker. I. B. Taurus, London.

Nolan, J. (1998) The Therapeutic State: New York: Justifying Government at Century's End. New York University Press, New York.

Pupavac, V. (2004) The emotionology of the New International Security Paradigm. European Journal of Social Theory 7(4), 149–170.

Rieff, D. (2002) A Bed for the Night: Humanitarianism in Crisis. Vintage, London.

Rogers, L. (2003) How tragedy changed lives for the better. Sunday Times, 16th March, 14.

Rose S., Bisson J. & Wessely, S. (2003a) A systematic review of single-session psychological interventions ('debriefing') following trauma. Psychotherapy and Psychosomatics 72(4), 176–184.

Rose, S., Bisson, J. & Wessely, S. (2003b) Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Cochrane Review). In The Cochrane Library, Issue 2. Update Software, Oxford.

Salama, P. (1999) The psychological health of relief workers: some practical suggestions. Relief and Rehabilitation Network 15, 12–14.

Samuels, A. (2001) Politics on the Couch: Citizenship and the Internal Life. Profile Books, London.

Sennett, R. (1998) The Corrosion of Character: The Personal Consequences of Work in the New Capitalism. W. W. Norton, New York.

Sensky, T. (2003) The utility of systematic reviews: the case of psychological debriefing after trauma. Psychotherapy and Psychosomatics 72(4), 171–175.

Shaw, I. & Middleton, H. (2001) Recognising depression in primary care. Journal of Primary Care Mental Health 5(2), 24–27.

Shaw, I. & Woodward L (2003) The medicalisation of unhappiness? The management of mental distress in primary care. In Shaw I. I. & Kauinnen, K. (eds) Constructions of Health and Illness: European Perspectives. Ashgate Press, Aldershot, pp. 125–138.

Shepherd, B. (2000) War of Nerves: Soldiers and Psychiatrists 1914–1994. Jonathan Cape, London.

Smith, B., Ager, I., Danieli, Y. & Weisaeth, L. (1996) Health activities across traumatized populations: emotional responses of international humanitarian aid workers. In Danieli, Y.,
Rodley, N. & Weisaeth, L. (eds) International Responses to Traumatic Stress. Baywood Publishing, Amityville, NY, pp. 397-423.

Sogge, D. (ed) (1996) Compassion and Calculation: The Business of Private Foreign Aid. Pluto, London.

Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. British Medical Journal 322, 95-98.

Summerfield, D. (2002) The effects of war: moral knowledge, revenge, reconciliation and ‘recovery’. British Medical Journal 325, 1105-1107.

Vaux, T. (2001) The Selfish Altrusist: Relief Work in Famine and War. Earthscan, London.

Volkan, V. (2001) Traumatized societies and psychological care: expanding the concept of preventive medicine. Mind and Human Interaction 11(3), 177-194: http://www.healthsystem.virginia.edu/internet/csmhi/volkan.cfm, accessed 20 April 2003.

Waysman, M., Schwarzwald, J. & Solomon, Z. (2001) Hardiness: an examination of its relationship with positive and negative long term changes following trauma. Journal of Traumatic Stress 14(3), 531-548.

WHO (2002) Breaking the vicious circle. Health in Emergencies 12, 6.

Wiles, P. et al. (2000) Independent Evaluation of Expenditure of DEC Kosovo Appeal Funds. Phases I and II, April 1999-January 2000, Vol. II. ODI with Valid International. ODI, London.

Young, A. (1995) The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder. Princeton University Press, Princeton.