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Do No Harm: Toward Contextually Appropriate Psychosocial Support in International Emergencies

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In the aftermath of international emergencies caused by natural disasters or armed conflicts, strong needs exist for psychosocial support on a large scale. Psychologists have developed and applied frameworks and tools that have helped to alleviate suffering and promote well-being in emergency settings. Unfortunately, psychological tools and approaches are sometimes used in ways that cause unintended harm. In a spirit of prevention and wanting to support critical self-reflection, the author outlines key issues and widespread violations of the do no harm imperative in emergency contexts. Prominent issues include contextual insensitivity to issues such as security, humanitarian coordination, and the inappropriate use of various methods; the use of an individualistic orientation that does not fit the context and culture; an excessive focus on deficits and victimhood that can undermine empowerment and resilience; the use of unsustainable, short-term approaches that breed dependency, create poorly trained psychosocial workers, and lack appropriate emphasis on prevention; and the imposition of outsider approaches. These and related problems can be avoided by the use of critical self-reflection, greater specificity in ethical guidance, a stronger evidence base for intervention, and improved methods of preparing international humanitarian psychologists.

Keywords: psychosocial support, emergencies, unintended harm, resilience, cultural insensitivity

Large-scale emergencies such as tsunamis and armed conflicts create not only massive physical destruction but also an enormous toll of psychological and social suffering (Boothby, Strang, & Wessells, 2006; Cardozo, Talley, Burton, & Crawford, 2004; de Jong, 2002; Marsella, Bornemann, Ekblad, & Orley, 1994; Miller & Rasco, 2004; Mollica, Pole, Son, Murray, & Tor, 1997; Reyes & Jacobs, 2006; van der Kolk, McFarlane, & Weisaeth, 1996; Wilson & Drozdek, 2004) in the low- and middle-income countries where most disasters strike. Prominent sources of suffering include attack, losses of home and loved ones, displacement, family separation, gender-based violence, and exposure to myriad protection issues such as recruitment into armed groups and trafficking.

A decade ago, mental health and psychosocial supports in international emergencies were relegated to the humanitarian ghetto and seen as things to be done after the "real" humanitarian work of saving lives had been completed. This has changed as public awareness of the aftermath of emergencies has increased, and psychosocial supports have become familiar fixtures in the humanitarian response to disasters. More than any other single event, the 2004 Asian tsunami brought home to people worldwide the enormity of the psychosocial needs that emergencies create.

The expanded awareness of the importance of psychosocial intervention has brought an expansion of psychosocial interventions. Many practitioners, myself included, regard this as a positive development, because there is increasing evidence of the efficacy of psychosocial interventions in addressing issues of trauma (e.g., Barbanel & Sternberg, 2006; Carll, 2007; Green et al., 2003), depression (Bolton et al., 2007), family separation (Hepburn, 2006), recruitment (Betancourt et al., 2008), and related issues and in promoting resilience and positive coping by survivors and communities (e.g., Barber, 2009).

At the same time, practitioners increasingly recognize that there are risks involved with psychosocial interventions that may lead to unintentional harm (Anderson, 1999; Inter-Agency Standing Committee [IASC], 2007; Wessells, 2008). Here is a small sampling of do no harm violations I have seen in various countries.

Editor's Note
Michael G. Wessells received the International Humanitarian Award. Award winners are invited to deliver an award address at the APA's annual convention. A version of this award address was delivered at the 117th annual meeting, held August 6–9, 2009, in Toronto, Ontario, Canada. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners' reflections on their work and their views of the field.

In 1996 in Rwanda, orphans from the 1994 genocide were placed in small orphanages or centers, many of which were funded by Western groups, including churches, who wanted to provide care and protection for unaccompanied and separated children. An unfortunate and unanticipated consequence was that the centers contributed to family separation, as mothers desperate to support their babies abandoned the babies on the orphanages' doorsteps.

In 1999 in Tirana, Albania, where camps filled with Kossovar survivors of Serb attacks, an American psychologist had set up a tent for counseling women survivors of rape. For a woman to have entered the tent would have identified herself as a survivor of rape, which many families regard as a stain on family honor that must be rectified by killing the survivor.

In 2002 in rural Sierra Leone, international nongovernmental organizations (NGOs) worked after the war to support the reintegration of formerly recruited children. Unfortunately, most programs privileged former boy combatants, despite the fact that large numbers of girls had also been recruited (McKay & Mazurana, 2004; Wessells, 2006). This gender discrimination was itself a significant source of structural violence and psychosocial distress.

The longer one's engagement in humanitarian work, the greater one's appreciation of its complexity, the potential for harm, and the need to address a number of important issues. These include contextual insensitivity to the cultural, structural, and political aspects of emergency situations; excessive focus on deficits such as mental health problems without sufficient attention to resilience and coping; overreliance on individualistic approaches; power abuses such as the imposition of outsider approaches; and the provision of inadequate training and supervision for staff, among others.

It is an understatement to say that there is a shortage of easy answers to countless ethical questions. To obtain ethical guidance, practitioners often turn to professional codes such as the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 2002; hereafter referred to as the Code of Ethics). Although these codes do offer some useful guidance, they are typically written around general principles and seldom consider the specific, highly sensitive issues that arise in contexts of humanitarian emergencies. This lack of specificity makes it very difficult to define what constitutes ethical and appropriate practice in international emergencies.

There is also inadequate research and training. The paucity of research on which interventions work in large-scale international emergencies (Batniji, Van Ommeren, & Saraceno, 2006; Betancourt & Williams, 2008; Wessells & van Ommeren, 2008) has enabled an "anything goes" atmosphere. This is exacerbated by a lack of appropriate training. Many doctorate-level psychologists trained in North American and European universities lack the cultural, humanitarian, and other competencies needed to do responsible, contextually appropriate psychosocial work in large-scale emergencies. Because of these factors, it is not uncommon for psychosocial interventions in emergencies to violate the do no harm imperative that is a cornerstone of the principle of beneficence.

In this article, I identify some of the primary do no harm issues that have surfaced repeatedly in my global work responding to armed conflicts as well as natural disasters. I write not from a high moral ground of assuming "I would never cause harm!" but from a humbler, grounded perspective that recognizes that all interventions (and even one's presence) in emergencies have unintended consequences, including negative ones. Because emergencies are fluid, potentially volatile, and riddled with uncertainties and complexities, it is relatively easy even for seasoned practitioners to cause harm. Still, much harm can be avoided through awareness; appropriate preparation and ethical standards; and a critical, reflective stance. This article is written in the spirit of enabling the awareness and critical reflection needed to prevent harm. Admittedly, it does not provide exhaustive coverage of this essential topic.

An important caveat is that what counts as a harmful practice is in the eye of the beholder. Indeed, the identification of harmful practices and judgments about the balance of positive or negative effects of particular practices reflects one's values as well as technical considerations. The question Whose values matter most? is salient because the values of humanitarians often collide with those of the affected population. To manage this issue, I focus on frequently occurring practices that have been identified as problematic not only by Western psychologists but also by national psychosocial workers in diverse contexts. Although the emphasis here is on unintentional harm caused by U.S. psychologists, the key points apply to all psychologists and people who conduct psychosocial work in emergency settings. Because many of these people are not psychologists but psychiatrists, social workers, or trained paraprofessionals, I speak broadly of the unintended harm caused by psychosocial workers.

Insensitivity to Emergency Contexts and Systems

In emergency settings, one often encounters well-meaning U.S. psychologists who have no experience in international emergencies, little understanding of the local culture or context, and no relationships with the agencies or people in the affected areas. Although the psychologists are nobly motivated by the feeling that "I just had to come and help," this approach has been described as "disaster tourism" or "parachuting" rather than as professional humanitarian response.

Parachuting

Parachuting refers to the arrival of Western or outside "helpers" who have ongoing relations with neither relief efforts or agencies nor the affected population. Parachuting creates a number of problems. For example, it uses scarce resources such as food and water that might better go to affected people or to seasoned humanitarian responders. In addition, it is not uncommon for parachuters to violate cultural and social norms by, for example, flaunting alcohol in a society that regards such drinking as corrupt or dressing in ways that national people regard as immoral. Such culturally inappropriate behavior can dim local people's receptivity to the presence of outsiders when outsiders' help is needed.

Parachuters cause harm in myriad other ways, such as by using culturally inappropriate methods; by violating security precautions; by using aggressive methods that pick people open but then leave them vulnerable and without appropriate follow-up; by providing short-term support that raises expectations and leaves people feeling abandoned when the parachuters leave; and by failing to coordinate their work with related efforts. Parachuting is based on a misconception that outside psychologists should assume a role of providing direct services. Such a role is inadvisable, especially in light of their general lack of knowledge about the culture, sociohistoric context, and current situation. However, even experienced psychosocial workers may cause harm through the inappropriate management of contextual issues.

Personal and Collective Security

Many psychologists enter emergencies with little understanding of the security context or necessary precautions and with similarly low levels of awareness of the implications of their presence. Although security issues may be presented in terms of personal safety, their ethical implications extend far beyond individuals. For example, the presence of a U.S. citizen in a place such as Afghanistan is viewed by many people as a political act, and U.S. humanitarians have been targeted increasingly since 2001. Although a U.S. psychologist may decide to hazard personal injury, that decision does not address the wider risk that a U.S. citizen's injury or death will curtail humanitarian efforts, depriving local people of much-needed support. In addition, making clear-eyed decisions about security is hampered by the burnout, depression, substance abuse, and other problems that burden humanitarians on a significant scale (Ehrenreich, 2006).

Aid as a Weapon

A key feature of emergency contexts is the power dynamics among various groups in a local setting (Anderson, 1999; Wessells, 1999). Humanitarian aid can become a political tool when it is used to increase the power of some groups over others. For instance, in the refugee camps in Goma after the 1994 Rwandan genocide, particular groups seized power and controlled the humanitarian aid, using it as a means of advancing their own political agenda (Prendergast, 1996). Psychologists who are unaware of such dynamics may inadvertently have their presence and support politicized and used in ways that favor some groups of people over others.

Even in less dramatic cases, psychologists who do not understand local power dynamics may inadvertently support discrimination and other sources of harm. For example, psychosocial workers typically begin their work in a camp or village with a process of consultation and open community dialogues. Although the attempt may be to establish an open, participatory approach, local structures of power and authority may undermine genuine participation. Each local group has a power structure in which some people enjoy voice and privileges that are denied to others. Typically, there are particular people who are kept hidden away by prior orders from elite power brokers or by unspoken rules. In many communities, the poorest of the poor and people with disabilities are expected not to participate. Psychologists who are seduced by the rhetoric of inclusivity and romanticized images of community may find that there was no real participation by the people most in need of support. In this manner, psychosocial work in emergencies can serve to replicate social injustices that had been prevalent before the emergency or that had even caused it or exacerbated its negative impacts.

Raised Expectations

One of the greatest ethical issues in humanitarian emergencies is raised expectations. Typically, these arise less from false promises than from contextual considerations such as divergent perceptions of psychosocial workers and affected people. For example, an important first step in psychosocial work is to conduct a situation assessment and determine whether and how to intervene. Feeling desperate for help, however, the affected people may view the arrival of an outside psychosocial worker as a sign that aid is at hand and that there will soon be many improvements in their situation. Making matters worse, the assessment visit may not bring immediate benefits. Typically, assessments are conducted in part to provide agencies with data that are needed to develop grant proposals, the review of which may take months. Such long delays without action that benefits survivors often leave affected people feeling frustrated, resentful, and worse off than they had been before the psychosocial workers' visit. To prevent such harm, many practitioners work within a framework of rapid assessment and rapid response, following data collection with tangible supports even on a limited scale.

Poor Coordination

Poor coordination is the Achilles' heel of most emergencies (Minear, 2002), which occasion a massive influx of NGOs and humanitarians who provide urgent support yet often fail to harmonize their efforts. For example, many NGOs conduct psychosocial assessments without coordination, leading to duplicate assessments and raised expectations. The resulting assessment fatigue generates frustration and resentment, undermining the trust and partnership needed to build strong psychosocial supports. Uneven allocation of support is also an issue. Often, people in rural areas, where the need may be greatest, receive little support while the residents of the capital city receive much attention. Poor coordination enables this problem, which may receive little attention or action.

The coordination of mental health and psychosocial supports is particularly difficult because of institutionalized divisions in the field. In most emergencies, psychologists' work develops in two independent streams (Betancourt et al., 2008; Galappatti, 2003; Wessells & van Ommeren, 2008). First is mental health work conducted by clinicians, typically in the health sector, for the most severely affected people. The second is holistic, community-based psychosocial work, typically conducted in the protection sector, that supports a larger number of people through the activities of trained paraprofessionals and community members. Although these approaches are complementary and serve the wider good when coordinated, they often tend to develop in isolation. For example, in Kosovo in 1999, two separate coordination groups formed and failed to coordinate with each other: Neither one knew the other existed. Such poor coordination thwarts referrals for severely affected people or efforts to ensure the provision of comprehensive supports.

Many psychologists are poorly prepared to coordinate their work because they have little understanding of the international humanitarian system. Within this system, emergency aid is increasingly delivered through a system of twelve clusters, including the Health Cluster and the Protection Cluster. These two clusters have a joint responsibility for coordinating work on mental health and psychosocial support in the affected country (IASC, 2007), working closely with the government, international NGOs, and civil society actors. Key obligations of emergency psychosocial workers are to understand the emergency system, participate regularly in coordination group meetings, and work collaboratively toward the comprehensive, quality supports to which affected people are entitled. Understanding the workings of the international humanitarian system is an important part of training for any psychosocial worker who intends to work internationally.

Contextually Inappropriate Interventions

The chaos of large emergencies, together with the lack of research on effective interventions that was discussed above, helps to create an anything goes atmosphere conducive to the use of interventions of questionable value or the use of interventions that are inappropriate to the context. For example, the use of individual counseling may be inappropriate if participation in counseling brands one as a victim of a particular rights violation such as rape, thereby causing severe stigma and possibly even additional assaults. Individual counseling is also ill-advised in collective societies that honor group over individual well-being and in which participation in individual counseling could lead to social isolation and criticism at a moment when support is needed.

Furthermore, counseling methods in general place significant emphasis on disclosing feelings and personal information, which may be useful in some contexts. The disclosure of distress, however, is inappropriate in some cultures, particularly if negative disclosures reflect badly on one's family (Lee & Sue, 2001). Moreover, talking about one's experiences can be harmful in some contexts. In rural Angola, teenagers who had been recruited into armed groups and who had killed people were viewed as spiritually contaminated or haunted by the angry spirits of the people they had killed. Local people see these spirits as enormously powerful and capable of causing illness in one's family or crop failures in the community. To treat this affliction, traditional healers conduct purification rituals designed to clean the young people of the angry spirits (Wessells & Monteiro, 2004). At the end of the ritual, the healer often tells the young former recruits, "Don't look back," because talking about the ritual or one's experiences is believed to bring the angry spirits back.

An intervention that is often used inappropriately in large-scale international emergencies is *critical incident stress debriefing* (CISD; see Everly & Mitchell, 1999). Trained CISD facilitators try to reduce traumatic stress by helping survivors talk about their feelings and responses to traumatic incidents, to the point of describing the events in great detail. Although some evidence suggests the usefulness of this intervention in large-scale emergencies, other studies have failed to confirm its efficacy (e.g., Thabet, Vostanis, & Karim, 2005). There is also evidence that debriefing impairs natural recovery after traumatic exposures (see Mukherjee & Alpert, 2006, for a review). It is important to note that the problem with inappropriate interventions often resides less with the method itself than with its inappropriate use. Unfortunately, in most emergencies, there are no ethics boards or potent means of regulating practice. Without sanctions for harmful practices, do no harm issues may proliferate rapidly.

Individualistic Versus Systems Orientation

Western psychology is well-known for its individualistic orientation and its corresponding focus on the well-being of at-risk individuals and groups. This orientation, however, is poorly suited to address the scale of human suffering in emergencies. In recent emergencies such as the floods in Myanmar, the conflicts in Iraq and the Democratic Republic of Congo, and the political violence in Kenya, hundreds of thousands of people or more have endured multiple losses, displacement, and profound suffering and need psychosocial support. Beyond individuals, these emergencies damage or destroy physical and social support systems on a massive scale. When addressing such large-scale, systemic issues, it is important to organize an equally holistic, systemic humanitarian response. Exclusive focus on individuals gets the humanitarian response off on the wrong foot and can lead to superficial approaches to obtaining informed consent and the development of programs that target particular groups of people excessively and fail to provide holistic supports.

Informed Consent Issues

Informed consent is a cornerstone principle of ethical practice. If obtaining informed consent is always complex, the complexities are amplified considerably in emergencies, many of which occur in areas having low rates of literacy. In some cultures, problems with language and communication can make it difficult to ensure informed consent, as Western concepts often have no exact translation or do not fit the local context. Obtaining written consent can be even trickier in war zones, because people may be suspicious of written documents, which they fear may be used against them. In addition, norms of hospitality may mitigate against saying "no."

Underlying informed consent are two key assumptions: that people are autonomous and that people have access to all of the information needed about the implications of their participation (Fisher et al., 2002; Mackenzie, McDowell, & Pittaway, 2007). Both assumptions are tenuous in most emergency contexts. People in collectivist societies often put the good of the group above their own individual good and may be willing to endure excessive individual risk to help others. They may not regard their decisions as autonomous because they analyze the situation through the prism of their relationships and a web of hidden expectations, roles, and power dynamics. The decision whether and how to relate to outsiders is potentially very important to a group of affected people because of people's desperation in emergency settings. Saying "no" to an outsider, for example, may be perceived by local people as reducing the chances that the village or group will receive needed assistance. Local norms may dictate that important decisions are not made individually but through the appropriate system of leaders and relationships. If the chiefs or elders encourage everyone to help the outsider, it may become very difficult or impossible to say "no."

The second assumption, that prospective participants have the information needed to make informed decisions, is dubious in war zones, which are inherently fluid and unpredictable (Hart & Tyrer, 2006; Mackenzie et al., 2007). For refugees who have just spilled across a border, it may be impossible to know what tomorrow will bring. One-off collections of informed consent hold little validity in such a context. A preferred approach is to view informed consent as an iterative process in which there is renegotiation in light of changing circumstances and new information about the potential risks and benefits of participation. Unfortunately, many of the institutional review boards that are charged with ethics review in the United States have little experience in emergency settings and may be satisfied with a one-off informed consent process because that is appropriate in most Western contexts. A useful complement to institutional review board reviews is review by local ethics gatekeepers, who might include religious leaders, community leaders, respected women, youth, or national university professors. However, these reviews, too, may be biased by a variety of agendas.

Excessive Targeting

Because most war zones contain large numbers of affected people yet have scarce resources for psychosocial support, many donors and practitioners focus resources and programs on particularly vulnerable groups. Nowhere is this practice more widespread than in regard to former child soldiers, many of whom have suffered extensively and all of whom have had their rights violated (Wessells, 2006). After many armed conflicts, governments and international NGOs regularly organize psychosocial and reintegration programs that aim to rehabilitate formerly recruited children and to enable them to find a place in civilian life. Typically, these programs entail counseling and peer group supports, family reunification, mentoring, access to education and livelihoods, spiritual cleansing where that is indicated, and protection against re-recruitment.

Although the need to support former child soldiers is indisputable, programs that focus exclusively or excessively on formerly recruited children often cause significant harm by stigmatizing them. Not uncommonly, former child soldiers enjoy better access to food, medicines, and other necessities than do the people whom they had attacked. After the recent war in Liberia, local people decried the excessive targeting of cash and aid for formerly recruited children as blood money and wondered why equivalent supports were not extended to all war-affected young people. Similarly, in Sierra Leone, returning former child soldiers, well-dressed because of foreign aid administered as part of programs on disarmament, demobilization, and reintegration, often found that their arrival in their home vil-

lages triggered jealousies that led to reverse stigmatization and social tensions within the community. For these reasons, the recently developed Paris Principles (UNICEF, 2007) caution against targeting support for formerly recruited children and recommend the provision of simultaneous supports for all war-affected children.

Nonholistic Supports

Most seasoned emergency practitioners (e.g., Jacobs, 2007; Prewitt Diaz, 2008) take a public health approach that embodies systems theory and seeks to address population needs. Such an approach recognizes not only individual needs but also the importance of intertwined social ecologies such as families, communities, and societies (Boothby, Strang, & Wessells, 2006; Bronfenbrenner, 1979; Masten & Obradović, 2007). Quality intervention entails meeting the holistic needs of affected populations by working at multiple levels such as the household, community, and societal levels and by strengthening social supports. The latter is a key theme in the main guidelines for the field, the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007), hereafter referred to as the IASC Guidelines.

In contrast, less experienced emergency practitioners tend to take a narrow, clinical approach that does not address multisectoral needs. Indeed, many psychologists who enter emergencies with a focus on trauma, depression, and anxiety aim to support the most severely affected people using tools such as individual counseling and cognitive behavioral therapy. Although these supports have a place, they often run counter to local cultural norms. More worrisome, these psychologists typically fail to recognize that affected people often identify as their greatest sources of distress not the memories of past violence and horrific events but the problems of everyday living (Barber, 2001; Boyden & Mann, 2005; Miller & Fernando, 2008; Summerfield, 2001; Wessells & van Ommeren, 2008). These include insecurity, living in overcrowded camps without privacy, or lacking the livelihoods needed to obtain necessities such as food and health care. Psychological services such as counseling cannot address these needs, which warrant a wider, multidisciplinary approach that is beyond the training and orientation of many psychologists.

Recognizing the need for a holistic, systems approach, the IASC Guidelines call for a layered system of supports as enshrined in the intervention pyramid. The base of the pyramid, which benefits the largest number of people, is the establishment of security and provision of access to basic services such as food, water, shelter, and health care. Access to these things alleviates significant distress and allows the nonformal psychosocial supports that are extant in the affected population to take effect. The second layer consists of family and community supports that help to address the separations, disruptions, and dislocations that have occurred. Commonly used supports include family reunification, community action projects to address needs such as health and education, and support for women's and youth groups that aid and empower affected people. The third layer consists of focused, nonspecialized supports that help particular groups of affected people. For example, survivors of gender-based violence typically need support in accessing the health system, interacting with the police, and managing community issues such as stigma and social isolation. The top layer consists of specialized supports for people who have been severely affected, including those who had preexisting problems and who are unable to function. This system of supports should include mechanisms for referral and should be implemented not only by external actors but also by national actors such as community leaders, government agencies, and community-based organizations.

This multileveled system is often missing in emergencies, and psychosocial workers have done too little to correct the problem. As a result, in many emergencies, one sees either of two extremes, both of which are harmful. For example, in Bosnia during the wars of the former Yugoslavia, there was a surplus of clinically oriented work yet a paucity of the community-based work needed to support the larger population. In northern Uganda, which until 2006 had suffered repeated attacks and mass displacements by the so-called Lord's Resistance Army, the opposite problem existed. Extensive community-based supports were available, yet few channels existed for the referral of severely affected people. Either situation causes gaps that leave significant numbers of war-affected people without the comprehensive supports that are needed.

Often, these asymmetries of coverage are accompanied by stereotypes that cause additional harm. In many emergencies, there is a tendency to speak of mass trauma and to portray everyone as traumatized. This depiction not only pathologizes normal reactions to life-threatening events but also reduces to medical terms conditions that have complex political, historical, cultural, and social roots (Punamaki, 1989). Equally problematic is the opposite kind of stereotype of everyone as resilient, which can distract attention from survivors who have been severely affected and enable governments to dodge their responsibility to provide essential mental health services. It is vital to remember that *war-affected people* is not a homogeneous category: Their differences are as great as their similarities and warrant a holistic, multilayered response.

Deficits and Resilience

Because emergencies create dire human needs and shatter human rights, many psychosocial workers focus on psychological deficits such as mental illness, posttraumatic stress disorder, and substance abuse as well as social problems such as stigma, discrimination, social isolation, and break-

down of social controls and supports. However, an exclusive or excessive focus on deficits often enables or contributes directly to harm.

The Deficits Trap

The emphasis on deficits is visible in many emergencies in psychologists' epidemiological studies of the prevalence of posttraumatic stress disorder, depression, or locally defined maladies. This epidemiological focus is valuable because systematic data are needed to guide psychosocial programming. However, the exclusive focus on deficits frequently creates a biased picture that limits program alternatives, supports stereotypes of people as helpless victims, and reflects the researchers' biases rather than the complex realities at hand.

The primary bias is the underestimation of resilience, which occurs in diverse contexts (Bonano, 2004; Boothby, Crawford, & Halperin, 2006; Masten, 2001; Masten & Obradović, 2007; Wessells, 2006). Significant numbers of emergency-affected people exhibit remarkable resilience in that they function well despite adversity, do not experience profound suffering, and cope reasonably well with their problems of living. In my experience, resilience is the untold story of emergencies, and it is seldom addressed by researchers and workers conducting assessments. Striking an appropriate balance between deficits and resilience is a high priority in emergencies.

The deficits focus frequently creates an excessively bad picture, which can blunt the hopes of survivors at a moment when hope is desperately needed. The exclusive emphasis on negatives often encourages stereotypes of everyone as traumatized or as damaged goods. One of the great sources of harm in the humanitarian world is that agencies frequently exploit negative images for purposes of raising funds. Typically, survivors perceive such images as dehumanizing and humiliating, and as such the images suffocate hope.

Furthermore, the excessive focus on deficits distracts attention from the resources and assets that exist in any group of affected people and support resilience. Emergency survivors may have nonformal supports such as families, friends, and neighbors, and they may have formal supports such as traditional social organizations or organized community and government services. Too often, a deficits focus steers psychological workers conducting assessments away from asking fundamental questions, such as "What supports already exist?" and "What strategies are people using to cope with their difficult circumstances?" Answering these questions is essential for developing effective programs, which should build on extant supports, assets, and resources. A challenge to psychology is to overcome the current emphasis on a deficits model, because psychosocial workers with strong preconceptions are not in a good position either to pose such questions or to listen in a spirit of openmindedness and learning from local people. Indeed, for many humanitarians, a key question that ought to be asked is "How well are we listening?"

Victimhood and Empowerment

Emergency-affected people are often described as victims. Used judiciously, this language of victimhood is potentially useful in engaging international legal protections and absolving survivors of rape and other horrors of any felt responsibility for the assaults and bad things they have suffered. However, there is a widespread tendency to refer to all emergency-affected people as victims, an appellation that can leave people feeling helpless and paralyzed, creating a self-fulfilling prophecy. For example, in East Timor after the 1999 attacks by Indonesian paramilitaries, I worked with Timorese staff of a child-focused agency. A doctor had told the staff that they were all traumatized victims and had left without providing any psychosocial support. Having taken on the identity and role of victims, they sat listlessly and explained why they could not possibly help children in their overwhelmed condition. Through empowerment-focused activities, most demonstrated significant improvements in well-being and social interactions over the next several weeks and successfully organized activities to support children. They said that part of their transition was due to thinking of themselves not as victims but as survivors who have capacities and agency. An important lesson is that people often reconstruct their identity as victims after horrendous events, yet victims are not in a good position to take charge of their recovery and future.

In other settings, I have observed that the victims label makes people feel demeaned and shamed by their experiences at a moment when the restoration of their dignity is a high priority (IASC, 2002). To avoid such problems, most seasoned practitioners use the victims label sparingly, emphasize that affected people are survivors, and help to build the sense of self-help that enables people to recover and function well after overwhelming experiences (Hobfoll et al., 2007). The emphasis on emergency-affected people as survivors fits with a resilience approach (Bonano, 2004) that emphasizes the importance of self-help, social mobilization, and collective empowerment (Beristain, 1999; Jacobs, 2007; Wessells, 1999, 2007). As highlighted in the IASC Guidelines, these are the foundations of effective emergency response.

Capacity Building and Sustainability

The philosophy behind sustainability is embodied in the proverb "Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime." This empowerment approach of building the capacities of affected people contrasts starkly with the reality that at the end of many emergency psychosocial programs, the NGOs that had organized them leave little behind. It is common-

place to see psychologists and other humanitarians rush into emergencies and set up programs funded by soft money. When the funding dries up and the CNN cameras have moved on to the next crisis, the programs promptly collapse. Meanwhile, the NGOs and UN agencies rush to the next emergency, only to repeat the same pattern.

In addition to not providing the long-term support that emergencies warrant, this short-term approach may cause harm by raising expectations of longer-term support and then leaving affected people feeling abandoned. As the short-term relief teams pour in (a phenomenon people in Sri Lanka called "the second tsunami"), people may become dependent on outsiders for support, thereby causing or setting the stage for additional harm.

Dependency

Dependency causes harm in multiple ways. It robs people of dignity and contributes to a sense of helplessness that is the antithesis of self-help and empowerment. Worse yet, dependency may actually undermine the preexisting supports of affected people. For example, in tsunami-affected Sri Lanka, a village of 50 families that had never had NGOs present had 27 different NGOs offering or providing help a year after the tsunami. One villager commented that people previously had turned to neighbors and relatives for help whereas a year post-tsunami they depended on the NGOs (IASC, 2007).

Eager to implement supports on an urgent basis and wanting to bypass government bureaucracies and politics, NGOs often create dependency by setting up their own systems of mental health and psychosocial support independent of government systems. The creation of parallel systems may weaken government capacities by draining away important resources such as skilled psychosocial workers and can further erode government credibility and legitimacy. Also, these parallel systems tend to be unsustainable. An important question, then, for psychologists to ask in regard to their humanitarian work is "How am I helping to facilitate long-term supports for affected people?" Practically, the strongest approach to creating sustainable supports is to build on and strengthen supports that are already present and to institutionalize them within the government structures and nonformal systems.

Inadequate Preparation

Poorly trained psychosocial workers—a significant source of supports of poor quality—are a widespread problem in humanitarian response. Nowhere is this more visible than in regard to the quest for "instant counselors." In 2005, after the Asian tsunami, the Sri Lankan government planned to train in several weeks a cadre of 10,000 counselors, each of whom would then fan out and conduct a single counseling session with 100 tsunami-affected people. Fortunately, the plan was shelved as a result of criticism.

Nevertheless, the practice of inadequate training for counselors in emergency-affected countries remains a common problem. Too often, NGOs conduct short-term training and provide little supervision and ongoing follow-up support for psychosocial workers. Inadequate training often occurs through training-of-trainer approaches in which skill levels become progressively diluted the farther one goes down the training cascade and in which there is little monitoring of quality of supports provided or ongoing mentoring and support for the trainees.

The Trouble With Silos

The importance of long-term training that includes appropriate provisions for quality of support notwithstanding, training and capacity-building efforts often cause harm through the creation of vertical silos for the delivery of psychosocial support. A common error throughout Africa and Asia is to provide in-depth training for trauma counselors, who conduct their work independent of the wider health sector and mental health system. This practice fragments systems of care by creating separate silos, which often do not communicate or coordinate with each other. An extreme example of this has occurred in some situations having high rates of gender-based violence, where well-intentioned practitioners have created psychosocial support for rape survivors only. Beyond stigmatization, such a siloed approach leads to poor utilization of scarce resources, when the emphasis in any emergency setting should be to build back better by helping to establish sustainable, integrated systems of health and mental health care.

A related error is the tendency to put mental health and psychosocial support in a separate silo, even in a separate sector, by building capacities only for focused psychosocial support. To be sure, significant need exists for focused psychosocial supports that address the needs of severely affected people and provide nonformal psychosocial supports for people who are functional yet distressed. However, psychosocial support is a cross-cutting issue because the way in which aid is organized in various humanitarian sectors affects the psychosocial well-being of survivors (IASC, 2007). For example, refugees often report that overcrowding and lack of privacy are among their greatest sources of distress. These sources of distress are preventable if emergency shelters are designed with an eye toward protecting people's psychosocial well-being. To provide comprehensive supports, psychologists should avoid narrow capacity-building silos that train only psychologists or psychosocial workers. Indeed, emergencies require that psychologists get out of their box and build intersectoral capacities for supporting people's well-being.

Power and External Imposition

In international emergencies, Western psychology has much to offer, particularly when it is blended with local, culturally grounded supports (Wessells & Monteiro,

2001, 2004). However, many psychologists rush in and train nationals on the Western-derived approaches and tools that they know best without adequate attention to the possibilities of causing harm. In fact, the enormous power asymmetry between humanitarians and affected people, not to mention between doctorate-level psychologists and national psychosocial workers, makes it a challenge to avoid causing harm through the imposition of outsider supports and a concomitant weakening of valuable indigenous supports.

In 1997, during Sierra Leone's bloody war, I worked with teams of Sierra Leoneans who had been trained by American psychologists and social workers to focus on trauma and provide counseling for traumatized people. Eager to receive the support of a Western psychologist and ashamed of their own traditional culture, national staff and local war-affected people denied initially that they had cultural practices such as cleansing rituals to help support survivors. Subsequently, when more trust had been established and an Angolan psychologist had spoken on the importance of cultural practices in her country, numerous healers, leaders, and affected people disclosed that they did have valuable cultural practices related to healing and reconciliation (Wessells, 2006, 2009). They subsequently admitted that they had initially concealed these practices out of concern over appearing backward, a desire to please the Western psychologist, and hope that outsider methods would be beneficial. In essence, their self-silencing had marginalized their own cultural practices. Unaware of this trap, many psychologists start not by asking how local people understand their situation and how they customarily obtain support but by teaching their own methods of support, which may have no basis in the local culture. In this manner, psychology may become a tool of neocolonialism (Dawes & Cairns, 1998; Wessells, 1999). A key for psychologists in international humanitarian work, then, is to avoid the arrogance of power and make humility and learning from local people central parts of their practice.

An important caveat regards the importance of not romanticizing cultural practices, as may occur when the desire for cultural sensitivity dominates critical thinking. The fact that some cultural practices are harmful is evident in most societies. For example, in Sierra Leone, female genital cutting (circumcision) is widespread, yet few outside practitioners support that practice. In building on local supports, then, it is crucial to maintain a critical attitude and use international human rights standards as benchmarks for deciding which cultural practices are supportable.

Prevention

Humanitarian response in emergencies is notoriously reactive and ephemeral, and it is constantly at risk of applying band-aids rather than addressing underlying structural problems. In the acute phase, when funds are available and the sense of urgency is high, masses of humanitarians and NGOs pour in and conduct emergency work. A year or so later, after the acute phase, the humanitarian agencies rush on to the next crisis, despite the fact that there remain extensive needs and too few supports at the site of the previous crisis.

This crisis-chasing approach constitutes a massive failure of prevention and causes untold harm. Whereas the crisis-chasing approach waits for the disasters to occur and then tries to pick up the pieces and provide support, a prevention approach would recognize that some of the worst impacts of disasters are preventable and take steps to mitigate harm. For example, in floods, the most vulnerable people are often the deeply impoverished people who live on hills prone to mudslides. In this case, the term *natural disaster* is a misnomer. Humanitarian emphasis on responsive action should be coupled with commensurate efforts to prevent harm through disaster risk reduction and emergency preparation. Indeed, training people to be prepared for emergencies is an important part of reestablishing a sense of security in emergency-prone areas. Furthermore, human-caused disasters such as armed conflicts often have their roots in social or political exclusion, which is to some extent preventable. Addressing social injustice and other structural causes of political violence is a powerful means of preventing emergencies and an essential component of humanitarian work.

A key part of prevention is protection, defined broadly to include the reduction of risks of all forms of exploitation and abuse and the strengthening of systems of protection. An important element of protection systems is the establishment of community child protection committees during emergencies to monitor, report on, and address protection threats (Wessells, in press). For example, in northern Afghanistan after the defeat of the Taliban in 2001, young women suffered as a result of forced early marriage, as economic hardship led families to give their daughters into marriage at progressively younger ages. In Badakshan Province, suicide rates increased as girls as young as 11 or 12 years of age threw themselves off of bridges to avoid being forced to marry 55-year-old men. Community child protection committees reduced this problem by working closely with local imams (religious leaders), who realized that making girls marry at age 11 was not traditional practice and caused harm. In numerous cases, imams convened community dialogues in which people decided communally to ban such early marriages. These bans produced steep and immediate reductions in the suicide rates and the forced early marriages, as the average marriage age rose to 15 years. This example illustrates how community-based social protection can support psychosocial well-being by preventing harmful practices.

In emergencies, great need exists for psychologists to not only apply their traditional tools but also support sys-

tems of protection, which decrease abuse, reduce feelings of insecurity, and enhance people's well-being. Because protection and psychosocial support go hand in hand, psychologists should integrate protection components into all of their capacity-building efforts. A key way of doing this is to simultaneously remove or mitigate risks and strengthen the protective factors that support positive coping and resilience (Rutter, 1979, 1985).

Conclusion

Psychosocial workers encounter myriad do no harm issues in international emergencies, and the issues discussed above are by no means comprehensive. However, the diversity and severity of these issues should not be cause for inaction or excessive uncertainty about how to respond. That these and related problems are preventable or manageable is evident in the strong, contextually appropriate, and effective psychosocial work that psychologists, communities, agencies, and governments are doing in diverse countries and regions.

Broadly, there are four ways of preventing or minimizing violations of the do no harm imperative. Foremost among these is critical reflection on ethical issues before, during, and after each emergency response and on ways of preventing or minimizing them. Not only individual humanitarians but also agencies, coordinating bodies, and members of affected populations should engage in this critical reflection. A useful practice is to compare the views of outside psychosocial workers and local people, who may have divergent ideas of what the most significant ethical issues are and what constitute proper ways of handling them. Ideally, the reflection process itself should respect local people and avoid domination by outsider humanitarians and agencies.

Second is the provision of greater specificity in ethical guidance regarding appropriate behavior in international emergencies. The development of the IASC Guidelines is an important benchmark in this regard because they offer extensive guidance by the most seasoned practitioners on things to do and practices to avoid. In addition, the APA (2008) has issued more specific guidance relevant to work in international emergencies. Also, the APA Ethics Office and the APA Office of International Affairs initiated in 2006 a multinational dialogue on the ethics of international humanitarian response. This much-needed dialogue should be continued and used by the APA Ethics Committee on an ongoing basis to strengthen the APA Code of Ethics.

Third is improved documentation regarding the efficacy of psychosocial interventions in emergency contexts. Too few systematic evaluations are conducted, and outcomes research remains underdeveloped in this still young field. The conduct of contextually appropriate research on which interventions are effective will help to establish an empirical foundation on which guidance can be constructed. A particular need is for the documentation of do no harm violations and means of managing them, as we as psychosocial workers stand to learn at least as much from our mistakes as from our successes. Too often, humanitarians and agencies have been reluctant to document the unintended negative consequences of their interventions because of concerns over image loss, reputational damage, and possible loss of funding. These concerns, however, are trumped by the humanitarian obligations for transparency and protection of the rights of emergency-affected people. In my experience, humanitarian workers can be convinced to keep records of incidents of unintended harm if the documentation is done in a spirit of mutual learning and identifies ways of improving psychosocial practices without pointing fingers and naming and shaming particular agencies or people.

Fourth are improvements in the preparation of psychosocial workers in international emergencies. Badly needed are specific training on applied work in international emergencies, including both natural disasters and armed conflicts; mentored or supervised field experiences in which people learn by doing and reflecting in emergency contexts; the development of cultural and ethical competencies pertaining to emergency situations; better understanding of the humanitarian system; ongoing mentoring by seasoned practitioners; holistic frameworks that interconnect psychosocial work with work on wider social, political, and economic reconstruction and long-term development; mastery of elicitive, ethnographic methodologies that promote cultural learning; and analysis of the sociohistoric, cultural, and political dimensions of emergency contexts. Ultimately, the system for preparing the next generation of international psychosocial workers needs to be transformed to enable ethical practice in international emergencies.

Collectively, these steps amount to a systematic transformation in the approach that psychologists take to their work in international emergencies. Although this transformation will take time, it is vital to begin the process soon to provide the highest quality of support to emergency-affected people at a moment in human history when the frequency of disasters is expected to increase. I am confident that this journey of transformation will enable psychology to make its fullest contribution to meeting the urgent human needs spawned by emergencies.

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