Berghof Foundation

Working on the Psychosocial Gap

Challenges, Hopes, Perspectives

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www.berghof-foundation.org/handbook

Content

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To cite this article: Becker, David, 2015. Working on the Psychosocial Gap: Challenges, Hopes, Perspectives. Comment on a contribution by Hamber, Brandon, 2015. Dealing with Painful Memories and Violent Pasts. Towards a Framework for Contextual Understanding,, in: Beatrix Austin and Martina Fischer (eds). Transforming War-related Identities. Berghof Handbook Dialogue Series No. 11. Berlin: Berghof Foundation. ‹http://image.berghof-foundation.org/fileadmin/redaktion/Publications/Handbook/Dialogue_Chapters/dialogue11_becker_comm.pdf ›. First launch 2/12/2015.

1 Introduction

In his scholarly article, "Dealing with painful memories and violent pasts", Brandon Hamber explains and reflects on "the relationship between how individual (largely victim) processes of coming to terms with mass atrocity (a micro perspective) relate to the collective or political process of finding ways of dealing with the past (a macro perspective)" (Hamber 2015, 2). In any discussion of war, mass atrocities, political repression and their impact, one is unavoidably forced to think about this relationship and deal with it – to confront the challenge of having to talk about both perspectives without being able to fully integrate them or grasp their linkage in all its complexity. Hamber does a masterful job in confronting this inherent problem but inevitably succumbs, at least in part, to the impossibility of the task. The reason for this might be what I call "the psychosocial gap", and I believe this needs closer examination.

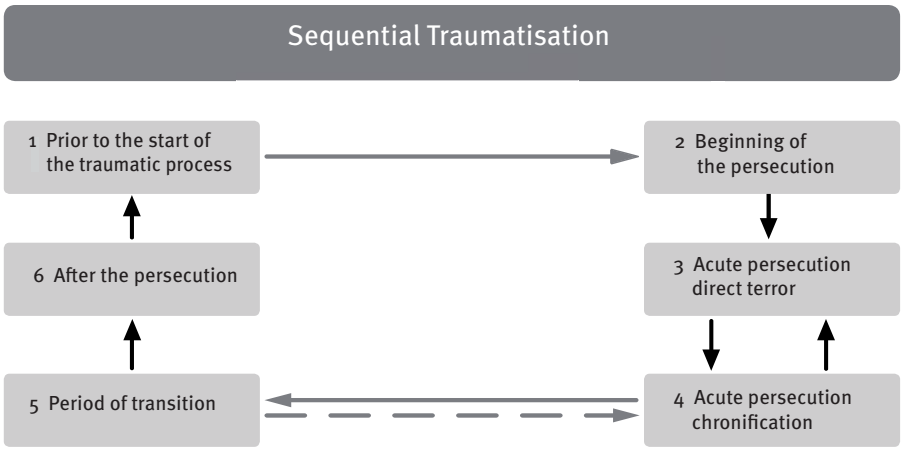
The word "psychosocial" conjures up an illusion. It links the word component "psycho-", which relates to the individual and intra-psychic dimension, to the "social" dimension of existence – the collective, societal reality. But this linkage is neither defined in the word, nor is it in any way clear. It is created simply by the magic of the word connection. "Psychosocial" does not represent an actual relationship. It merely implies an intention, a wish, at best perhaps a process. When reflecting on massive destruction within societies, we are always talking about concrete human beings – about bodies with flesh and blood. But at the same time we are talking about collectives – about social relationships, politics and power. When we look at these issues from only one perspective, the other perspective is missing. When we try to address both perspectives at the same time, we easily become disoriented, confusing concepts and metaphors. In fact, all our theories can be understood as ways to try to bridge the gap.

In what follows I will discuss three potential bridges that Hamber refers to in his article and reflect on their load-bearing capacity: the trauma concept; the concept of mental health and psychosocial support (MHPSS) and the intervention pyramid; and the construction of meaning on different levels. A short reflection on the power of discourse ends this article.

2 Insecure bridge 1:
the trauma concept

Hamber rightly criticises conceptual thinking on post-traumatic stress disorder (PTSD), because it "tells us little about the context of violence, its cultural specificities, and how dealing with violence is linked with the socio-economic, political and cultural context" (Hamber 2015, 4). He understands that PTSD pathologises a social phenomenon and that it "drives thinking towards homogeneity, as if all experiences of violence have the same outcome or need the same treatment". (Ibid.) He offers some alternative understandings, referring to authors such as Martin Baró, Laub, Kornfeld and myself, but does not actually discuss the conceptual issue in depth. Yet in my opinion this is a key challenge, because the way we describe the wounds of the victims has an enormous influence on their suffering and on the perception of their suffering in society. In fact, the trauma concept seems to be the first bridge through which the psychosocial suffering of persons in a given society is defined. PTSD provides quite a clear description of individual suffering but completely ignores context and social reality. Instead of making a connection between the victim and the social cause of suffering, it deepens the divide, transforming a societal issue into a personal illness. Other trauma concepts emphasise the social dimensions more, for example those of Martín Baró (1992) or myself (Becker 1992) but possibly do not fully grasp the profundity of the individual wound. These concepts are probably better bridges for linking the psychological and social dimensions but are nevertheless insecure.

In my opinion the concept of *sequential traumatization* by Hans Keilson (1992) is probably the best bridge on the market today. Keilson developed the term with reference to Jewish war orphans in the Netherlands. Being himself a psychoanalyst and at the same time a clear political thinker, he was interested in the inner psychic processes of his clients, yet he always understood that the key definition of trauma had to refer to the external context. He also understood that trauma in a political context is not a single terrible event with consequences, but a long and complicated process in which ruptures, breakdown, restructuring, new breakdowns etc. occur. The idea of sequence is thus key to his trauma concept, while at the same time preserving the idea of intra-psychic rupture and breakdown, so central to most other trauma definitions. Keilson originally defined three such sequences, focussing on the beginning of persecution, the time of direct terror and the post-war situation. Barbara Weyermann and I (Becker/Weyermann 2006; Becker 2014/2006) expanded this to six sequences, constructing a framework that could be used to contextualise trauma in very different cultural settings, always insisting on the process character of trauma. The framework presented in figure 1 shows that the specific characteristics of suffering cannot be predefined universally (like a fixed set of symptoms) but have to be described and understood again and again in the different circumstances out of which they emerge.



Source: Becker/Weyermann 2006.

Figure 1: Sequential Traumatisation. A basic framework of traumatic sequences in a given social context.

The *first sequence* relates to a period of relative *normality*. It is not easy to decide what "normality" looked like before the start of the traumatic process, i.e. before the official beginning of war or persecution, but this decision is necessary because this "normality" itself comprises a history marked by traumatic realities of varying intensity that play a role in what follows. In Bosnia and Herzegovina, for example, we might define the sequence of "normality" as the time before 1992, when Yugoslavia still existed and war had not yet broken out. This Yugoslavia, however, was built on the traumatic experiences of World War Two, and these again surfaced during the war of 1992–1995. Thus, while defining the first sequence is a pragmatic necessity, it is also a recognition of the power and importance of history.

The *second sequence* covers the *initial period of persecution*, before it becomes completely overpowering. In the case of Bosnia and Herzegovina this would cover the years directly prior to the break-up of Yugoslavia, which saw a burgeoning nationalistic discourse and the beginning of hostilities in the months leading up to open war. *Sequences three and four* describe the *times of acute terror* in which two types of situations need to be differentiated from each other: War does not unfold in real life like in a movie, where years of destruction are summed up in a few hours. In actual war and conflict, periods of direct terror alternate with moments of relative calm, in which people return in some measure to a normal life while awaiting the next phase of acute destruction. This is why we differentiate between two – constantly alternating – sequences. During the phases of direct terror people suffer terribly and are focused on surviving. They might not even

have the time to notice their traumatisation. But then follows what we call "chronification", a period of partial normalisation. In these phases people are under less acute threat, but they notice their suffering more. Fear is omnipresent.

Sequence five is the period of *transition*, which can last for a longer or shorter time. In the case of Bosnia, we could say that the country has never overcome this sequence and has been locked in an insecure period of transition since the signing of the Dayton Agreement in 1995. In many cases this transition does not lead into a post-conflict setting but back into war. Finally, the *sixth sequence* is the *time after conflict*, in which, as Keilson has convincingly proved, the trauma does not end but continues to provoke varying degrees of pathology, depending on the way power relationships in the society develop, the way it treats its victims and the extent to which it deals constructively with its own past of destruction.

The trauma concepts and interventions currently being applied seem to follow the idea that the simpler and the less context-oriented they are – the more oriented towards quick impacts – the better. Keilson's approach is more complex than other concepts but provides a much more suitable framework for a contextual discussion of trauma, one that acknowledges both psychological and social dimensions. As Hamber points out, trauma in the context of mass violence is not a one-off event, a single breakdown, nor does it have a clear pathology. It is a long and complex process, one that is sometimes more and sometimes less pathological. It is characterised by a difficult dialectical relationship between the individual and the collective. Our trauma language must try to reflect this as adequately as possible.

3 Insecure bridge 2:

the concept of mental health and psychosocial support (MHPSS), and the intervention pyramid

Hamber introduces the reader to the concept of mental health and psychosocial support (MHPSS), and to the intervention pyramid contained in the Inter-Agency Standing Committee's (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007). These guidelines are an attempt to structure the different types of needs of populations living through emergencies. Although I agree that these guidelines probably represent the most comprehensive approach to the issues to date, I think there are some serious problems with them that need to be understood. In other words, the IASC guidelines only partially manage to bridge the psychosocial gap.

The IASC guidelines define the composite term "mental health and psychosocial support" as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC 2007, 1). On the one hand this definition assumes a link between mental health (MH) and psychosocial support (PSS), connecting different types of intervention. On the other hand the logic of the definition is confused, because PSS necessarily describes one or several *activities*, while MH is a generic term that refers first of all to a *state of mind* and only at a secondary level to an activity. This logical confusion has important consequences, because it enhances the idea held by many practitioners that mental health is not a state of being but something psychiatrists deal with, while psychosocial support is something undefined that basically implies recreational activities for people who are suffering. This is obviously not the intention of the IASC guidelines, but they are not clear enough on the issue. From a conceptual point of view it makes more sense to speak of "mental health and psychosocial *well-being*" (MHPSW).

> *The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work*

> *productively and fruitfully, and is able to make a contribution to her or his community" and adds that the "positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'"* (WHO 2014, 1).

Closely linked, but with a slightly different emphasis, is the definition of psychosocial well-being given by the Inter-Agency Network for Education in Emergencies (INEE): "The term *psychosocial* underscores the close connection between psychological aspects of our experience (e.g., our thoughts, emotions, and behavior) and our wider social experience (e.g., our relationships, traditions and culture)." Elaborating, the INEE states that "[m]ental disorders, which often benefit from clinical treatment, tend to involve severe psychosocial difficulties in managing thoughts and feelings, maintaining relationships, and functioning in expected social roles. However, many psychosocial problems do not require clinical treatment but are rooted in stigmatisation, lost hope, chronic poverty, uprooting, inability to meet basic needs, and inability to fill normal social roles such as that of student/learner. *Well-being* is a condition of holistic health in all its dimensions: physical, cognitive, emotional, social and spiritual. Also a process, well-being consists of the full range of what is good for a person: participating in a meaningful social role; feeling happy and hopeful; living according to good values, as locally defined; having positive social relations and a supportive environment; coping with challenges through the use of appropriate life skills; and having security, protection, and access to quality services" (INEE 2010, 1).

The terms "mental health" and "psychosocial well-being", therefore, complement and enhance each other. In addressing the consequences of mass atrocities it seems vital to stress the linkages between the two concepts. At the same time, deeper reflection is needed to create different forms of intervention, ones based on an understanding of psychosocial support not as something broad and undefined but as specific activities that can stabilise or enhance well-being in a traumatising environment without recourse to medicalised models of treatment.

In relation to this complementary relationship between mental health and psychosocial well-being, the confusion in the logic of the IASC guidelines may seem trivial at first glance. Yet it can be important on the ground. For the last four years I have been cooperating closely with the United Nations Relief and Work Agency (UNRWA) in their work with Palestinian refugees in Gaza, the West Bank, Jordan, Lebanon and Syria. In all these places and under very difficult circumstances UNRWA offers basic health, education, and relief and social services. It has a wealth of experience in dealing with MHPSS issues, but only recently has it begun to coherently structure and plan its work so that dealing with these issues becomes a permanent ingredient of everything they do.

In the many discussions I have had with UNRWA colleagues in the field, the abovementioned confusion has been a permanent issue. It manifests itself, typically, as a division between health and education professionals. On the one hand, health professionals gladly discuss mental health but seem to think that psychosocial support has no place in their work. On the other hand, many education professionals think that mental health is for psychiatrists. All of them think mental health issues lead to specific interventions by psychiatrists and therapists, while psychosocial support is something anybody can provide and involves a lot of recreational activities.

So instead of a linkage between personal states of well-being, social process and political reality – instead of a permanent connection between health, education and social work – what I have often met on the ground is separation and conceptual splitting, and a non-acknowledgment of the very valuable practical MHPSS work many of these professionals are doing. The IASC confusion tends to enhance this problem instead of overcoming it. And if one compares the WHO definition of mental health with the INEE definition of well-being, their conceptual closeness is clear, but it is also clear that the WHO is focused on mental health and INEE on psychosocial support.

In his article Hamber also explains the intervention pyramid contained in the IASC guidelines. In my opinion, this pyramid has similar problems. It creates the illusion that while all people need basic

services and security, not as many need community and family support, even fewer need specialised support, and only a very small number need specialised services such as psychotherapy. According to this understanding, deep psychological and psychosocial issues, and the need for trauma treatment, are mental health problems suffered only by a small group of people, while basic services and security are non-psychological needs shared by everybody. While I don't doubt the good intentions behind this pyramid, to me it seems to cement a separation between *basic needs* (ie. physical needs) and *psychological needs*, creating a false hierarchy and furthering the confusion of reality.

After a decade of quite close involvement in psychosocial projects in the Gaza Strip, which gave me insight into the debilitating consequences of several wars, I would prefer to turn the pyramid upside down. In a war-torn environment, with a population that is constantly being traumatised and re-traumatised, people need not only basic services and physical security. They also need acknowledgement and understanding of their ongoing extreme psychological suffering, and of the complex survival mechanisms they have had to employ. In such contexts, dealing with trauma cannot be considered part of "specialised services" but needs to be understood as an element of every social interaction. Intervention strategies must be deep and broad. It is not a case of "therapy here and security there", but of working to build relationships that acknowledge suffering and are able to deal with it not only in a therapist's clinic but also in schools, social gatherings, institutional settings and other everyday contexts.

4 Insecure bridge 3:
the construction of meaning on different levels

I strongly agree with Hamber's view that "creating a sense of meaning of what happened is a critical part of coming to terms with a legacy of political violence" (Hamber 2015, 10) and that "creating meaning is an ongoing, messy process of negotiation and re-negotiation between the individual and society". (Ibid., 11) To strengthen this bridge, I could even phrase his argument more radically: in its arrogance, international academic discourse on peacebuilding mechanisms looks for *the* solution, *the* mechanism, *the* framework for the construction of meaning. In reality, the construction of meaning always involves a conflict both within individuals and between them. It has to be messy. Any attempt to make it clear-cut and definite is just another attack on meaning, on the healthy capacity for conflict, on process. Yes, in one way the construction of social meaning will have to fight for *the* truth, for clear-cut distinctions between victim and victimiser, for a final working-through of the past. But when all is said and done there are different and contradicting truths at both an individual and a social level, and the only thing that would be harmful would be for the construction of meaning to end. In Germany we have been negotiating and re-negotiating the meaning of our Nazi legacy for 75 years. Fortunately, we still have not finished.

Between Israelis and Palestinians there is an ongoing asymmetrical conflict, with no peace in sight. Israeli social psychologist Dan Bar On and Palestinian Professor for Education Sami Adwan worked for years with a group of Israeli and Palestinian teachers to write a joint history book for children (Adwan/Bar On, 2011). In this book they did not pretend to produce one narrative. They divided each page into three segments. On one side of the page we find a Palestinian truth, on the other side we find an Israeli truth, and in the middle we find an empty space for the reader. The authors belong to societies at war with each other. There is no chance of mutual understanding and reconciliation right now. But there is room for acknowledging different ways of constructing meaning, and perhaps there might be a little room for curiosity about the way the enemy constructs their meaning. To me, Bar On, Adwan and their team are sending out a very powerful message about the multiplicity of narratives and the need to acknowledge this multiplicity, to work with it and on it.

5 The power of discourse

In concluding I would venture to suggest that Hamber's article, and my own and other people's comments – in fact, the whole dialogue issue – are part of the problem under discussion. This is neither good nor bad; it is just part of reality. There is no way we can talk about the impact of mass violence without impacting on it. We are not outside of the issue we are discussing – we are part of it. Societies have changing discourses about good and bad, about victims and victimisers, about suffering. These discourses are sometimes political, sometimes medical, psychological, literary etc. So the question is not only how we acknowledge, or fail to acknowledge, suffering, but also, how we shape suffering by the way we talk about it.

Trauma is never only trauma; it is not only a complex psychosocial process we can define and/or diagnose. It is also always a social discourse about morality, and this discourse can in itself be an agent of traumatisation. Brunner (2014) analyses this as "the politics of trauma". The French sociologists Fassin and Rechtman (2009) speak of "the empire of trauma". They convincingly explain the current trend of seeing the historically evolving trauma concept as being based on a dual genealogy: "...the reconfiguration of the relationship between trauma and victim, in which the victim gains legitimacy as trauma comes to attest to the truth of his or her version, has a dual genealogy – on the one hand scientific, based on the definition of trauma, and on the other moral, focused around the acknowledgement of the victim" (Fassin/ Rechtman, 2009, 29). Like Brunner, Fassin and Rechtman reflect on a reality in which our willingness to acknowledge suffering that is caused by political realities seems to have grown. But they also show that whatever we hear about this suffering is intimately linked to ongoing power struggles, and that scientific discourse mirrors these struggles and is in fact a part of them.

The psychosocial gap is not something we can avoid by being cautious, like the gap in the London subway. It is, and continues to be, a political challenge. Probably it cannot be bridged. I believe the only way to deal with this gap appropriately is to acknowledge it as a space of conflict, to try to make it a space in which healthy conflict can take place, and to try again and again to bridge it, even if this attempt is bound to fail. In more practical terms I believe it is very important to continue to struggle with the trauma concept, refusing to accept decontextualised, quick-impact treatments, and to continue to invite professionals to invent meaningful trauma work in their specific contexts. It is very important not to leave the trauma discussion entirely to the limited clinical world, which is where some professionals try to put it. I agree with Hamber when he says we have to understand trauma in its many dimensions (Hamber 2015, 3-4), and I think the four broad approaches through which he tries to bridge the psychosocial gap are adequate and useful, not *in spite of* the contradictions and shortcomings they describe, but *because* of the honest ambivalence they promote (Ibid. 11-16). I might be over interpreting, but I believe that the common thread running through Hamber's thoughts in this article is an essential belief in justice: justice understood not as an either-or – *either* an individual moral category *or* a normative social framework – but as both. On a more specific level I believe we need to bridge some of the unnecessary gaps between health-related and education-related approaches to the issue of trauma. And, finally, we have to accept and understand that discussing trauma is, and always will be, political – that it is, therefore, a vital part of any conflict transformation process.

6 References

Adwan, Sami & Dan Bar On 2011. Side by Side: Parallel Histories of Israel-Palestine. New York: New Press.

Becker, David 1992. Ohne Hass keine Versöhnung. Das Trauma der Verfolgten. Freiburg: Kore.

Becker, David 2014/2006. Die Erfindung des Traumas – Verflochtene Geschichten. Gießen: Psychosozial Verlag.

Becker, David & Barbara Weyermann 2006. Toolkit: Gender, Conflict Transformation & The Psychosocial Approach. Bern: Swiss Development Cooperation.

Brunner, José 2014. Die Politik des Traumas. Frankfurt a. M.: Suhrkamp.

Fassin, Didier & Richard Rechtman 2009.The Empire of Trauma: An Inquiry into the Condition of Victimhood. New Jersey: Princeton University Press.

Hamber, Brandon 2015. Dealing with Painful Memories and Violent Pasts: Towards a Framework for Contextual Understanding. Available at www.berghof-foundation.org/fileadmin/redaktion/Publications/Handbook/Dialogue_Chapters/dialogue11_hamber_lead.pdf.

IASC Inter-Agency Standing Committee 2007. Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

INEE Inter Agency Network for Education in Emergencies 2010. INEE Thematic Issue Brief: Psychosocial Well-Being. Available at www.toolkit.ineesite.org/toolkit/INEEcms/uploads/1128/INEE_Thematic_Issue_Brief_Psychosocial.pdf.

Keilson, Hans 1992. Sequential Traumatization in Children, Jerusalem: Magnes Press, Hebrew University.

Martín-Baró, Ignacio 1992.War and Mental Health, in: Writings for a Liberation Psychology. Essays by Ignacio Martin-Baró, edited by Adrianne Aron & Shawn Corne. Cambridge, MA: Havard University Press, 108-121.

WHO World Health Organization 2014. Definition of Health. Available at www.who.int/features/factfiles/mental_health/en/.

All links have been accesessed on 10 November 2015.

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Prof. Dr David Becker teaches Psychology at the Sigmund Freud PrivatUniversität in Berlin. He is co-founder and director of the Office for Psychosocial Issues (OPSI) at the International Academy Berlin for Innovative Education, Psychology and Economy (INA) gGmbH. He also serves as a consultant to international organizations on trauma and related issues in regions of crisis and conflict, currently especially in the Middle East.