Standing Committee on Victim Assistance, Socio-Economic Reintegration and Mine Awareness (SC- VASERMA)

Psychological Interventions and Peer Support for Landmine Survivors

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Introduction

Within the Standing Committee on Victim Assistance, Socio-Economic Reintegration and Mine Awareness, within the ICBL, and within the broader global disability movement, it has been recognized and accepted that assistance to landmine survivors and all persons with disability is not a purely medical issue. If the broken part of a landmine survivor is fixed or replaced, this does not return the person to his previous state. Elaboration of this point is already familiar to most of you in this audience, but for newcomers: The UN Standard Rules on the Equalization of Opportunities for Persons with Disability, the ICBL Guidelines for the Care and Rehabilitation of Survivors', and the language of the treaty all make reference to the fact that Victim Assistance includes a broad range of activities.

For the next 15 or 20 minutes I will be focusing your attention onto one of the non-medical issues, onto what happens to landmine survivors' heads and hearts when they lose a limb or lose eyesight or hearing or whatever else the trauma has done physically… we will be talking about what trauma can do to a person's psyche, and what can help someone adjust to the assault on his or her mind and heart.

Psychological Interventions and Peer Support are significant areas of endeavor for some of the organizations involved in assistance to landmine victims. Yet little discussion has taken place about these sorts of programs. This presentation and our discussions today are but first steps in a process to promote discussion about psychological interventions and peer support amongst the various stakeholders in the field.

Before proceeding with the task at hand it may be useful to briefly summarize the events that have led to this point. At the December 2000 meeting of the Mine Ban Treaty Standing Committee on Victim Assistance, Socio-Economic Reintegration and Mine

Awareness (SCE-VASERMA) a presentation by the Working Group on Victim Assistance (WGVA) made reference to importance of Psychological Interventions with Landmine Victims. Following this presentation it was decided that a fuller exploration of the topic was needed, and that it should form the basis of discussion at the next meeting of the Standing Committee in May of 2001.

Flowing from this directive the WGVA undertook a process of information gathering about activities, issues and concerns in the area. This has, to date, taken the form of a listserve for those involved in the area. Members have been encouraged to write and share their experiences and concerns. Along with this activity Landmine Survivors Network (LSN) hosted a half-day meeting of interested parties in Washington, DC, on March 29, 2001. A list of participants in the meeting, along with their organizational affiliation appears in Annex 1.

Participants at that meeting set the following goals for their time together:

- To learn who is doing what where in the field of psychological interventions
- To highlight the challenges or issues facing the field
- To summarize this information for the Standing Committee on Victim Assistance
- To discuss the future, in terms of possible goals and activities for interested parties beyond this meeting and this forum

What follows is divided into four sections. First, we will have a quick look at two branches of this type of work, psychological interventions and peer support—to see how they differ. Second, we will take a glance at where we are in the process of gathering a comprehensive review of current activities in the field. Third is a preliminary summary of issues and concerns of practitioners. Finally, we have some suggestions on how efforts in the field, and the work of this Standing Committee, can continue to improve the reach, the quality and the impact of psychological interventions and peer support.

1. Psychological Interventions and Peer Support: Part of a Continuum

Psychologists and psychiatrists treat people with psychological or psychiatric disorders. Some landmine survivors will have clinical disorders requiring treatment, but most will not. Adjusting to a disability is a normal - if extreme - variety of the difficult situations we all face and are challenged to adjust to throughout our lives. To use an everyday example, we may lose our job. This is a sobering disruption. We may feel useless and depressed, but by talking to a friend, someone we trust and respect, perhaps someone who we know faced this a few years ago and overcame the problem we often work through these feelings. If we stay depressed for a long time and become withdrawn and talk about suicide, THEN we would probably benefit from professional help.

In the process of recovery from trauma or adjusting to a disability, people are often overwhelmed by very strong, disturbing emotions such as anger, guilt, fear, anxiety, depression, hopelessness, frustration, bitterness, isolation and more. It is **normal** to feel any or all of these. But if the person recovering from trauma is not aware that strong emotions are normal, he or she may panic or give up. If the general perception within a culture is that having such strong negative emotions means you are abnormal, a person readjusting to a disability may believe that he or she is abnormal, or even “crazy”.

Misperceptions like this abound around the subject of disability and recovery from trauma. The problem in the disability field is that even well meaning people, professional helpers, program planners, and the general public are not aware of their own misperceptions. Professional health workers often underestimate the ability of ordinary people to adjust to disabilities and recover from trauma. They forget (or perhaps they do not believe) that self-healing and healing with the help of trained lay persons is possible. Instead, health care workers and others in the “helping” professions often **reinforce** the mistaken idea that persons with disability, **as a rule**, have unusual psychological problems.

Peer-counseling builds on the idea that disabled people who have had a traumatic injury (landmine related or otherwise) and have managed to put their lives back together are in the best position to talk to other people who have recently had an injury and become disabled. "Peer" means that two people are the same in some salient way, for example, that they have both gone through a similar experience or have had the same serious injury or illness. The difference is that one person has already dealt with many of the difficulties, while the other has not yet had the chance to face the issues.

Newly disabled and/or traumatized people often experience a great deal of difficulty understanding the circumstances they suddenly find themselves in. Dealing with the situation can be overwhelming. They need to be able to place these challenges in a proper perspective in order to deal with them and get on with life. They need information and someone they trust to talk to. Facts and professional advice are certainly of help in this regard, but the empathy and credibility that a trained peer counselor or peer support volunteer brings to the relationship is of immense value. It is one thing for an educated person to speak knowledgeably to you about the sense of loss you feel when ready to return home without your right leg. It is another situation entirely when the discussion is with someone you know has faced that same hollow fear him/herself.

With training, a person who has gone through the experience and dealt with the issues constructively can offer their natural wisdom to someone who is just starting down the same path. Probably most importantly, the experienced person can offer hope, in the form of living, breathing proof that life goes on after trauma, and that a newly disabled person can direct their own recovery. Training is key though. Clearly, not everyone who has had a traumatic injury is naturally empathetic or automatically a skilled peer counselor.

Training of peer counselors usually emphasizes active listening skills, and how to provide accurate and an appropriate amount of information.

Handled properly, peer counseling can be empowering by stressing that people "like you" have thrived and succeeded and therefore you may also expect to thrive and succeed. Professional counseling can unintentionally have the opposite effect. Receiving advice from an educated professional can send the unconscious message that you will forever remain a "patient" because you will need to rely on professional help to solve your problems. This potentially sad side effect is called Learned Helplessness. Learned Helplessness is not an inevitable consequence of professional counseling, and in some circumstances professional counseling is the most appropriate intervention. However these are real factors to contend with in choosing the appropriate mix of responses to effectively meet the needs of traumatically injured people, including landmine survivors.

The other common mistake of health professionals and the general public is to think of disabilities in the disease-cure model, as if disability is a purely medical problem. According to this misperception, a person with an amputation should be “cured” with a mechanical fix—someone has lost a leg, they are broken, replace the leg, they are fixed. Of course, it just doesn’t work that way. Peer counselors and peer support volunteers are in prime position to listen to the fears and concerns of a newly disabled person, to understand and explain common misperceptions, and to talk about recovery as it really is—a tough, complex, and very normal process of adjustment

2. Current activities: Who is doing What Where? (table in progress)

Organizations	Countries	Programs
Council of Canadians with Disabilities (CCD) and Social Services of Cambodia (SSC)	Cambodia	Pilot peer counseling training program for people with disabilities
SSC	Cambodia	Provides an array of community-based social and mental health services to people who seek them in one province in Cambodia
Vietnam Veterans of America Foundation	Angola, Cambodia, Kosovo, El Salvador, Sierra Leone, Vietnam?	Provides P/O, physical therapy, jobs in program, income generation, micro-enterprise. Needs assessment in Kosovo. No counseling services, per se, but outreach workers deal with survivors’ general life situations in addition to prosthetic needs.
Handicap International (HI)	Eastern Europe, Africa, Asia, South America	Seventeen programs on four continents. Work with local professionals and expatriate trainers using the psychodynamic approach to build the capacity of local mental health professionals.

		Target group is usually persons with serious mental illness or full-blown psychiatric disorders.
Landmine Survivors Network (LSN)	Bosnia, Ethiopia, Eritrea, Mozambique, Jordan, El Salvador	Provides peer support to landmine survivors and amputees – support includes peer counseling, referrals to existing services, and assistance to meet priority needs when no other solution exists. Philosophy is that the survivor directs his/her own recovery by determining how LSN can best support him/her.

3. Issues, challenges and concerns

Several issues and challenges as they relate to the development and provision of psychological and peer support have been identified. These categories are not definitive nor are they listed in any order of priority.

A) Contextual Factors

It is essential to have a clear understanding of the political, social and economic context into which psychological support is to be delivered because they influence the effectiveness and impact of psychological interventions. There are complex issues at play, and failure to appreciate them will render the program ineffective. Close consultation with survivors themselves is imperative.

- The societal context: How does one deliver a program when psychological interventions or peer support are unknown or not trusted in the culture or when that culture is defined by a strong sense of hierarchy? How to turn helpers away from judging, scolding, advising and towards empathy and respect? How to deal with attitudes toward disability as being “deserved”, or the fault of the victim? How to expose pity as a form of oppression?
- The political and legal context: Does the lack of knowledge about, and access to, human and disability rights change the way we might have to justify and implement any victim assistance program? How does a conflict or post-conflict context affect people’s ability or willingness to simply talk about their war-related injuries? How does the level of economic development and recent or recurring natural disasters impact the lives of persons with disability?
- The individual’s characteristics: for example, age, age at time of trauma, gender, family role, social status of the family, level of education, religion, occupational history—Are these “given” characteristics an indicator of how a traumatized person might adjust to a new disability? How does this in turn impact on the family and the community? What is the extent or the risk of secondary trauma to the support team, peer counselors, psychologists, or other helpers?

B) Program Design

Issues of funding requirements, evaluation, research protocols, and sustainability were raised, as follows:

- Under what conditions should one start a program?
- How long should it go on?
- When might it be useful to embark on partnerships?
- What is the best way to include persons with disabilities in program design?
- Should a program target individuals or communities?
- Have tools to gather baseline information and to evaluate impact been developed? What research has been done so far? Have we learned lessons from the programs in place and if so, what are the results and how can one access them? Or are programs still too young to have developed credible outcome-oriented results?
- What are the expectations of those providing psychological care, and of their funders?
- Is there a single “model” program design that is appropriate and effective in all cultures?

C) Program Implementation

While psychological support may be a stand-alone service, it may also be delivered integrated into larger rehabilitation programs like emergency medical care and vocational training. In either case, program planners must balance the delivery of medical and vocational supports with the delivery of psychological and social supports.

Psychological support planners must be alert to the tendency to “therapize” or “medicalize” their approaches. For example, the desire to get back to work or to earn a living becomes “the need for vocational reintegration;” if an able-bodied person wants to do some gardening, they do it whereas a disabled person gets “horticultural therapy”. Planners should question the origins of this tendency and try to reduce it.

Psych support providers should address the contextual issues raised in A) and adjust their activities accordingly. For example, in countries that lack infrastructure, how can psych support services be made more accessible to the users? In societies that do not have disability policies and that discriminate against persons with disability, what is the best way to advocate for better practices with the public, local leaders, health care professionals and governments? In communities observant of local traditions, healers, and beliefs, to what extent should such practices be incorporated a psychological support program?

The required professional qualifications of program implementers also need to be resolved. What are the pro's and con's of paid vs. volunteer staff, local vs. expatriate staff, psychology vs. social work frameworks?

In addition, some programs use survivors who have had success in adapting to their new situation. Others rely on training professionals such as medical personnel, psychologists, and social workers, and some programs use both types of personnel. This raises a number of questions about the value of peer support compared with professional intervention and the nature of the training that staff would require in each type of program. How can/should lay workers handle mental health crises when no trained mental health professional exist? Can peer support/peer counseling be effective across disabilities? Can a man effectively peer counsel a woman and vice-versa? How should standards for training of peer support workers, psychologists, social workers be developed? Should there be overlap between professional and lay training?
Other operational policies that need to be resolved are:

- When and for how long should there be a given psychological intervention?
- Who should have decision-making power?
- How broad-based should psychological intervention be? For example, six factors have been identified as being important to recovery from trauma: family, work, exercise/sports, early intervention and information, faith, and peer/social support. Should all six be part of every program?
- Should survivors be able to choose to receive or not receive services, to demand different services, even to make "bad" decisions?
- How to ensure that psychological interventions include support for family members as well as address the new dynamics (family + trauma) of the family as a whole?

4. The way forward

As stated in the introduction this is the second step in the process of clarifying and improving efforts at psychological interventions and peer support for landmine survivors. To that end, we put forward these recommendations:

- Efforts should be made to compile a more ***complete list of programs and program implementers in this area***, and to put program implementers in touch with each other. Therefore, we ask government representatives present today, as well as NGO and IO participants, if you know of existing programs of the types we have been talking about today, please put them in touch with the ICBL Working Group on Victim Assistance.

- Given that resources are scarce and activities are scattered around the world, efforts to share information on program successes will be important in order to move this field forward as quickly and effectively as possible. From the government side, a ***Victim Assistance Focal Point*** would greatly facilitate information sharing especially about ground level efforts that we may not otherwise be aware of.

- As part of this strategy, ***evaluations of programs should be shared amongst all interested organizations, and a free and open dialogue about successes and shortcomings should be encouraged***. In the final index of this paper you will see a list of a few such documents already gathered, plus a list of email addresses of the listserve so far, and contact information on how to join the listserve.

Annex 1:
Participants of the April 29 meeting in Wash DC

1.	Laurie Beachell	Council of Canadians with Disabilities
2.	Alain Devaux	Handicap International
3.	Sue Eitel	Landmine Survivors Network
4.	Benjamin Gobin	Handicap International
5.	Becky Jordan,	Landmine Survivors Network
6.	Mike Kendellen	Vietnam Veterans of America Foundation
7.	Beth Sperber-Richie	Landmine Survivors Network – Meeting Facilitator
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Annex 2:
Listserve members: Psyforlandminesurvivors@yahoogroups.com

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