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# Mental and social health in disasters: Relating qualitative social science research and the Sphere standard

Rajaie Batniji, Mark Van Ommeren*, Benedetto Saraceno

*World Health Organization, Geneva, Switzerland*

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**Abstract**

Increasingly, social scientists interested in mental and social health conduct qualitative research to chronicle the experiences of and humanitarian responses to disaster We reviewed the qualitative social science research literature in relation to a significant policy document, *the Sphere Handbook*, which includes a minimum standard in disaster response addressing "mental and social aspects of health", involving 12 interventions indicators. The reviewed literature in general supports the relevance of the Sphere social health intervention indicators. However, social scientists' chronicles of the diversity and complexity of communities and responses to disaster illustrate that these social interventions cannot be assumed helpful in all settings and times. With respect to Sphere mental health intervention indicators, the research largely ignores the existence and well-being of persons with pre-existing, severe mental disorders in disasters, whose well-being is addressed by the relevant Sphere standard. Instead, many social scientists focus on and question the relevance of posttraumatic stress disorder-focused interventions, which are common after some disasters and which are not specifically covered by the Sphere standard. Overall, social scientists appear to call for a social response that more actively engages the political, social, and economic causes of suffering, and that recognizes the social complexities and flux that accompany disaster. By relating social science research to the Sphere standard for mental and social health, this review informs and illustrates the standard and identifies areas of needed research.


*Keywords:* Mental health; Disaster; Sphere; Policy; Anthropology; Qualitative methods

## Introduction

Yearly, millions of people are affected by disasters, including conflict, with the vast majority of affected persons living in resource-poor countries outside the West. Disasters—as discussed in this article—can be either natural or human-made, and include conditions that surround political violence and displacement. No adequate measures exist to assess the full human cost of disasters, especially the social and non-pathological mental health effects.

Quantitative social science research has shown that exposure to disaster increases the risk of depression, anxiety, and somatic complaints, with various risk factors, such as female sex, prior psychiatric history, severity of disaster exposure, perceived lack of control during disaster, and inadequate social support after disaster (for a review, see Bromet & Havenaar, 2002). Despite their merit, quantitative studies do not provide a contextualized view of the experiences of and

*Corresponding author
*E-mail addresses:* rajaie.batniji@ucsf.edu (R. Batniji), vanommerenm@who.int (M. Van Ommeren), saracenob@who.int (B. Saraceno).

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humanitarian responses to disaster. Qualitative social science research—which incorporates the observations of anthropologists (Heggenhougen & Pedersen, 1997), sociologists and health professionals writing within a qualitative social science research framework—is especially relevant to public health in situations that defy quantitative measures of health and well-being.

In this paper we will relate the Sphere Project's (2004) minimum standard for "mental and social aspects of health" to the qualitative social science literature. In 1997, the Sphere Project was launched by non-governmental organizations (NGOs) in response to criticism of aid provided during the 1994 Rwandan crisis (Sphere Project, 1998; Walker & Purdin, 2004). The Sphere Project has involved a global consultation process leading to minimum standards, endorsed by over 200 NGOs (Sphere Project, 1998). The handbook combines: (a) a description of minimum requirements for human survival with dignity (basic human needs), (b) the concept that such requirements must be understood as universal human rights, and (c) concern for quality of humanitarian assistance and accountability of service delivered (Darcy, 2004; Salama, Buzard, & Spiegel, 2001). The bulk of the handbook is a description of minimum standards (with indicators and guidance notes) for key sectors in humanitarian aid, including food, water, sanitation, shelter and health services. A rights-based approach is articulated in a first chapter, the "Humanitarian Charter". The book has been translated into over 20 languages, and its website has been accessed more than 5 million times. In an external evaluation in 2003, nearly two-thirds of 581 survey respondents—working in 99 countries for 193 humanitarian agencies—reported attending interagency meetings at which Sphere standards were promoted. Also, almost two-thirds of respondents reported having changed their programming in direct response to Sphere (Van Dyke & Waldman, 2004).

The recently published revised version of the handbook covers for the first time mental health (Sphere Project, 2004). The Sphere standard on "mental and social aspects of health" involves assessment through 12 intervention indicators. The standard—strongly influenced by a WHO (2003) document—uses the term "social intervention" to describe those activities that primarily aim to have social effects, and "psychological intervention" for interventions that primarily aim to have psychological (or psychiatric) effects (Sphere Project, 2004). This distinction was made with explicit acknowledgment "that social interventions tend to have secondary psychological effects and that psychological interventions often have secondary social effects, as the term 'psychosocial' suggests" (Sphere Project, 2004, p. 291). The stated aim for the standard is: "People have access to social and mental health services to reduce mental health morbidity, disability and social problems" (Sphere Project, 2004, p. 291).

Disaster is a time of flux in cultural and religious beliefs and practices, historical understanding, ethnic identity, and family and community relationships (Atlani & Rousseau, 2000; Foxen, 2000; Kagee, 2003; Lubkemann, 2002; Munczek & Tuber, 1998; Sideris, 2003; Weine et al., 2002). Aid workers are challenged to identify appropriate responses across populations, and within a population changed by disaster. How can social science understandings inform and illustrate the relevance and appropriateness of existing disaster mental and social health recommendations? This study reviews the available qualitative social science research in relation to the Sphere standard on mental and social aspects of health.

## Methods

A source list was developed by searching titles and abstracts from the following journals using the EBSCO database: *Anthropology and Medicine* (March 1998–March 2004); *Current Anthropology* (October 1990–June 2004); *Culture, Medicine and Psychiatry* (September 1993–June 2004); *Disasters: Journal of Disaster Studies, Policy and Management* (March 1998–June 2004); *Journal of Refugee Studies* (March 1996–June 2004); *Medicine, Conflict and Survival* (March 1998–June 2004), *Social Science and Medicine* (January 1984–June 2004); and *Transcultural Psychiatry* (March 1997–June 2004). In addition, *Social Science and Medicine* and *the Journal of Refugee Studies* were searched using journal websites. Key words describing traumatic events (trauma, conflict, disaster, war, violence, earthquake, flood) were queried to identify articles. When necessary, aforementioned words were matched with additional key words (anthropology, psychology, psychiatry, mental, sociology) to narrow search results. Only qualitative, social science research articles were included. Articles on the experiences of and aid responses to disaster (including war) in non-Western, resource-poor

settings were identified. Studies of refugees living in the West were excluded when their content was not relevant to the experience of disaster survivors living outside the West. The preliminary source list was complemented by additional, selected, social science research articles and book chapters deemed relevant by the authors. The final source list (available upon request) contains 118 articles (including book chapters) involving qualitative social science research.

Notes were taken on areas covered in the eight social and four psychological/psychiatric key intervention indicators identified by the Sphere "mental and social aspects of health" standard (Sphere Project, 2004). Additional interventions and concerns addressed in each article were noted, and these observations were used to guide presentation of results.

The results section should be read cognizant of the following limitations. First, the source list was drawn from a limited number of journals and—although comprehensive—could be extended. Program evaluations and project documents, which could contain valuable qualitative assessments, have not been included. Second, the studies reviewed are focused in specific geographic and ethnic contexts. Our attempt to identify common themes in the literature inherently departs from the focus of the studies. Third, since the qualitative studies are mostly concerned with narrations, we acknowledge that any preliminary conclusions drawn from the literature need further evaluation.

## Results

### *Sphere social intervention indicators*

#### *Information*

*Sphere social intervention indicator 1: People have access to ongoing, reliable flow of credible information on the disaster and associated relief efforts.*

In a brief commentary on this intervention indicator, the Sphere text adds (a) that information should be on the nature and scale of the disaster, on efforts to establish physical safety, and on relief efforts and (b) that information should be "understandable to local 12 year olds" (Sphere Project, 2004, p. 292; WHO, 2003, p. 3). Research is scarce in this area of intervention. In a study in Sri Lanka Argenti-Pillen (2000) identified that the translation of information into "high Sinhalese," as opposed to the locally spoken language, made aid workers less useful by keeping them inaccessible to much of the population and inadvertently supported religious extremism by empowering "high Sinhalese" speakers. In another Sri Lankan study, Argenti-Pillen (2003) observes that war widows seeking compensation from NGOs did not share information on available help with one another. Here, the lack of broad and direct communication from NGOs may have caused animosity and additional stress.

Writing on the Chernobyl disaster, Giel (1991) emphasizes the need for detailed information to disaster victims to avoid rumours and panic: "The combination of unconfirmed rumour and ignorance…must have promoted apprehension rather than prevented it." (p. 390) Regarding the risks of mass communication, Weine and Laub (1995) chronicle the evolving myths of ancient ethnic hatred constructed in the Balkan conflict, detailing the historical revisionism driven by the political agenda. Moreover, Summerfield (1999) notes that specific information in psychiatric language, on the effects of trauma to the public at large, may potentially be harmful (see section on psychological and psychiatric intervention indicators below). Overall, little qualitative research has been conducted on the mental and social effects of mass communication in disasters.

#### *Culture, religion, ritual and tradition*

*Sphere social intervention indicator 2: Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies.*

The literature emphasizes the importance of burials, ceremonies, and religion. Religion is used to bring meaning, context and purpose to psychological healing (Gozdziak, 2002). De Voe (2002) describes the continuity through displacement provided by Islam, and McMichael (2002) describes Islam as an "enduring home" that is carried by Somali refugees (p. 171). The focus on maintaining or re-establishing "cultural and religious events" is supported by the literature, with the important caveat that proper conditions for these events need to be facilitated rather traditional rituals being executed artificially and out of context (Atlani & Rousseau, 2000; Englund, 1998).

Proper cremation and burial have been described as essential to reduce or prevent psychological distress. The power of rituals to symbolically transform situations and pain is described by Cole

(2004) in a study of a Madagascar community. Writing from personal experience with loss of family in the Rwandan genocide, Bagilishya (2000) expresses the crushing nature of a death that is not associated with the tradition of burial. A related sentiment is expressed in a testimony of Mozambican refugees, in which not burying dead relatives is thought to bring bad luck and threats from angry ancestors (Sideris, 2003). Even when proper burials are possible, great distress can come to those who are unable to attend the burial (Lubkemann, 2002). Eppel (2002) describes the prominence and frequency of requests by community leaders and families in Zimbabwe, "for an intervention to appease the aggravated spirit of people who had been murdered and buried in unacceptable graves" (p. 870). Facilitated exhumations and reburials allow communities to discuss violence, mourn with dignity, "witness the truth of the past," and then lay that past to rest in a way that the community agrees will allow healing (Eppel, 2002, p. 870). Englund (1998) claims that spirit exorcisms can help put trauma in a meaningful, existential framework "by identifying the source of the affliction in the spirit of a specific deceased person" (p. 1171). Interventions to facilitate proper burial could involve providing food for funeral guests, supplying materials for burial, and sponsoring travel to burial (Englund, 1998).

Burial and proper religious and cultural events link suffering not only to the spiritual world but also to the socio-political context. Englund (1998) notes that spirit exorcism brings together relatives and friends, places the affliction in social context, and does not consider the affliction "as a problem of the individual psyche" (p. 1172). Similarly, Igreja (2003) argues that the goal of sessions by Gamba healers is to achieve justice. These sessions end with "acknowledgement of abuses and traumatic experiences that took place in the past and the family members repair the havoc." (Igreja, 2003, p. 479). Of note, Igreja (2003) contrasts the communal form of resolution of *Gamba* healers with a form of conflict resolution employed in Eastern Uganda where conflict and tension are kept hidden from others. Thus, while it has been demonstrated that spiritual events can link suffering to the broader context, drawing uniform generalizations is problematic.

While the mental health benefits of proper burial and grieving ceremonies have been noted across cultures, the cost of these ceremonies must be considered. Discussing the 1988 earthquake in Armenia, Giel (1991) argues that grieving as an enduring activity, while potentially beneficial for psychological healing, may prevent development of infrastructure and progress and may promote too great an emphasis on the cemetery in the post-disaster period. Thus, context again plays a key role in determining appropriateness of activities.

While religion can provide a stable base for understanding, religious pluralism (involving the use of more than one set of religious beliefs by an individual or group) must be recognized in any intervention that seeks to facilitate religious events. Lubkemann (2002) describes the religious pluralism that was mobilized to understand the social conflict in Mozambique: "Machazians consulted *nyangas* and *nyamossolos*, two types of traditional healers and diviners, as well as local church *profetas* (prophets) in order to diagnose the sources of social conflict" (p. 192). Gozdziak (2002) argues that agencies serving refugees are often unprepared to deal with religious diversity. Similarly, Argenti-Pillen (2003) describes "fearless women" in south Sri Lanka who do not believe in the efficacy of local cleansing rituals for healing. In short, the literature suggests avoiding the assumption of uniform or consistent religious beliefs.

*Purposeful activity and recreation*

*Sphere social intervention indicator 3: As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities.*

This intervention indicator is consistently supported by the literature discussing schooling and recreation for children. In a study on Eritrean youth returning from exile, Farwell (2001) identifies continuity of education as critical for returning youth and describes the role-modelling and transfer of skills that can be facilitated by informal mentoring relationships with elders. The Eritrean family sacrifice for, and community solidarity behind, education during crises appears enormous. Farwell describes youth living alone to avoid disruptions in education, and parents selling rations to cover school expenses. She notes the anxiety caused by the separation, bolstering the case for making education available during crisis. One youth describes the support for education from his elders, "You just keep on with your studies—we'll face them (the enemy) and protect you" (Farwell, 2001,

p. 56). Farwell (2001) recommends the creation of informal schools, "staffed by skilled community members" that can temporarily fill in for formal education and decrease family separation (p. 64). A powerful testimony on the importance of education in producing skills is provided by Peters and Richards (1998), quoting a young Sierra Leonean combatant, "What we need to do is get back to school and start learning something. At the very least let me learn how to make a cutlass blade so I can go back and brush a farm." In describing the need for organized recreational activities and sports teams, Farwell (2001) assesses that there exists a consensus among youth about the desirability of such activities and recommends "designated land-mine-free areas for playing that would not conflict with other uses such as grazing" (p. 64). Perhaps surprisingly, the literature reviewed seems to omit one potential risk of educational activities, which is the potential misuse of the classroom to incite ethnic hatred. The literature seems unquestionably positive about education.

*Sphere social intervention indicator 4: Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities.*

The value of participating in purposeful activity, especially economic activity, is frequently noted. The anthropological literature is replete with accounts from disaster survivors that discuss economic constraints as primary causes of stress (Ager, Ager, & Long, 1995; Farwell, 2001; Peters & Richards, 1998; Sideris, 2003). A woman interviewed by Sideris (2003) comments, "in Mozambique we were ploughing…we were respected for the work we did. We had a place in the community. Now we are lost" (Sideris, 2003, p. 719).

Loss of responsibility seems potentially to lead to loss of belonging. Sideris (2003) writes, "In their testimony, the women reflected on how war deprived them of their daily practices, kinship arrangements, social rules and obligations which gave them a sense of purpose and dignity, anchored their sense of who they were" (p. 716). Gibbs (1994) concludes that in building houses and planting fields individuals experience healing. These views reinforce interventions that re-establish responsibility and purpose. Interventions and community responses that allow persons to work towards a purpose, especially an economic purpose, and to assume responsibility, carry a strong mandate from the literature reviewed.

*Community connection and ownership*

The literature does not focus on distinct community "activities," but rather on the broad need to facilitate community inclusion. Observers have chronicled the importance of community belonging during and after disasters (Coker, 2004; Eyber & Ager, 2002; Rousseau, Rufagari, Bagilishya, & Measham, 2004; Sideris, 2003). As the community changes during disaster, the same structures that persons depended on before are often no longer available for support afterwards (Boyden, 1994). Kagee (2003) describes the stress caused during political transition when some South African organizations were perceived to have abandoned their members' ideals and interests. Munczek and Tuber (1998) note that people in Honduras expressed "feelings of being deceived by society and the futility of social action" when social networks did not mobilize support after political violence (p. 1707). However, positive change can also come, because the upheaval from disaster may mobilize social cohesion and "demonstrate the capacity for resistance" (Pedersen, 2002, p. 186).

*Sphere social intervention indicator 5: Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without their families, have access to activities that facilitate inclusion in social networks.*

Eyber and Ager (2002) provide a powerful testimony that lends perspective on the needs of a widow in Angola, "So she [a widow] needs conselho [advice or consolation] first of all. This is not enough. This person needs a community of relatives or friends who will play the role of her husband" (p. 871). McCallin's (1998) discussion of protection of and reintegration of child soldiers into the community emphasizes the important roles that the family, rather than aid organizations, must play. Farwell (2001) suggests in her aforementioned study of Eritrean youth that many young Eritreans separated from their families to avoid disruptions in schooling, or to allow adult family members to find work. Recognizing the high levels of distress associated with such separations, Farwell recommends addressing structural needs (including lack of schools and employment) to prevent social isolation.

Discussions on including the elderly in social networks emphasize the benefit that multigenerational networks can have for the community in terms of providing "cognitive tools: instruction and information on how to deal with the difficult

circumstances based on prior experience'' (Farwell, 2001, p. 56). Similarly, Sideris (2003) describes the importance of elder relatives in supporting women in Mozambique; she notes that women ''lamented the absence of elder relatives who they argued could support, protect them, and negotiate their relation to men'' (p. 718). The above Sphere intervention indicator resonates with the literature.

*Sphere social intervention indicator 6: When necessary, a tracing service is established to reunite people and families.*

Petty and Jareg (1998) demonstrate the dangers of institutional care for children, and promote family reunification. However, no qualitative description of family reunification in developing or non-Western settings was identified in the literature. Nevertheless, the value of family re-unification, accompanied by a careful warning to recognize changes that have occurred, is well-described in Rousseau and colleagues' (2004) study of the family reunification process for Congolese refugees in Canada. The authors write,

> While the family reunion is a turning point that can lend meaning to the many losses refugees have experienced in their long journey, it also disrupts the fragile balance that has been established during the waiting period (p. 1096).

Furthermore, the authors note that changes in body, mind, and worldview become obvious during reunion, leading to their suggestion to prepare people for reunion to minimize problems. This Canadian study refers to reunification in the West often after years of separation, and may thus not generalize to reunions at home or elsewhere after shorter separations.

*Sphere social intervention indicator 7: Where people are displaced, shelter is organized with the aim of keeping family members and communities together*

Interventions to keep communities together in shelter are supported by literature covering the importance of family and community (e.g., Coker, 2004; Eyber & Ager, 2002; Farwell, 2001; Lubkemann, 2002; Rousseau et al., 2004; Sideris, 2003). Evacuation of children from conflict situations (away from their parents) is controversial. Boyden (1994) suggests that separation and social disruption are more harmful to children than exposure to violence.

*Sphere social intervention indicator 8: The community is consulted regarding decisions on where to locate religious places, schools, water points, and sanitation facilities. The design of settlements for displaced people includes recreational and cultural space.*

The calls of the social science literature extend beyond the aim of ''community consultation and participation,'' to give the community a primary role in initiating and executing any ''intervention.'' Igreja, Schreuder, and Kleijn (1998) describe how the social-structural changes of settlement can be highly distressing when the community is not able to adequately participate in designing settlements. Igreja notes that,

> The apparently positive strategy of communalization in the name of the development of the rural areas disrupted the agrarian way of life and was locally classified as a traumatic experience…the massive concentration of people forced to live in the same place was against their historical and traditional way of living in a community… (Results, para 10).

The emergency settlement had violated the Mozambican principle of separated households. Further, as people traditionally congregated for grieving ceremonies, concentrated housing may have symbolically carried these moments continuously (Igreja et al., 1998).

### *Sphere psychological and psychiatric intervention indicators*

Debate on the universality of posttraumatic stress disorder (PTSD) is frequent in the qualitative literature. As these issues have been explored and discussed elsewhere (e.g., Bracken, Giller, & Summerfield, 1995; Coker, 2004; Eisenbruch, 1991; Elsass, 2001; Munczek & Tuber,1998; Zarowsky & Pedersen, 2000), we will only give brief mention here.

Many social scientists—critical of imported nosology and medicalization—consider PTSD a contemporary western construct and are concerned that focusing on PTSD, even in the face of symptoms, will personalize social distress and isolate individuals from the political, religious or social struggle from which the suffering arises (Bracken et al., 1995; Coker, 2004; Gozdziak, 2002; Sideris, 2003). In South Africa, Kagee (2004) conducted semi-structured qualitative interviews to assess symptoms of PTSD and demonstrated that experiences approximating those of PTSD symptoms exist outside the

clinical interview. Nevertheless, respondents' main expressed concerns were on poverty, unemployment and the political situation. Examining the collective work of anthropologists would suggest that even if an important diagnosis (such as PTSD) can be made, it, by definition, does not cover culturally relevant symptoms outside the imported diagnostic framework (cf., the "category fallacy", Kleinman, 1977). One potent criticism of the PTSD model is the hypothesis that PTSD symptoms are not strongly associated with disability in non-western cultures (e.g., Kagee & Naidoo, 2004; Summerfield, 1999).

The discourse on psychological care has been critical of trauma-focused talk therapy. Englund (1998) suggests that talk therapy is incompatible with Mozambican refugees' own methods of dealing with stressful events (p. 1172). Eyber and Ager (2002) discuss the common advice "don't think too much" offered in Angola, suggesting that counselling and discussion are likely to be unpopular in that setting (p. 871). Similarly, McKelvey (1994) proposes that in Vietnam, there is "no culturally acceptable model for the open disclosure of painful and shameful truths to a stranger, even a 'professional stranger'"(p. 372). Critiquing trauma programs, Pupavac (2001) expresses concern that psycho-social interventions at the "micro-social level may potentially erode community and family cohesion" (p. 368) and foster dependence on institutions. Not all social science research is this negative regarding the use of clinical models. Acknowledging that treating symptoms as independent of social and political history counters Somali efforts at reintegrating victims of injustice and political violence into the moral community, Zarowsky (2000) argues that clinical models, even those that "bracket power, history and politics," can be useful if used sparingly (p. 400). In interviewing Somalis, she observes that, "There was no perceived incompatibility between 'local' or 'traditional,' and 'foreign' or 'modern,' interventions" (p. 394). Of note, neither PTSD nor clinical care for traumatic stress are covered in the Sphere Handbook.

*Sphere psychological or psychiatric intervention indicator 1: Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community.*

In a commentary on this indicator, the Sphere Project (2004) describes psychological first aid (Raphael, 1986) as:

> Basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm (p. 283).

In other words, the Sphere text describes an approach to trauma that focuses on pragmatic support. The literature reviewed does not discuss psychological first aid as an intervention. The literature, however, is critical of (a) a focus on traumatic distress (a reduction of which is the aim of the psychological first aid model) and (b) clinical talk (which is explicitly *not* part of the psychological first aid model). Zarowsky's work (2004) suggests that natural, not clinical, talking reinforces social connections and allows for contextualization. "Talking about distress and their histories was important because it represented an attempt both to do something about their circumstances and to enhance people's capacity to carry on materially and emotionally" (p. 202). Creating space for natural talk—as opposed to clinical conversation or silence—is one of the features of psychological first aid, which needs to be studied by social scientists.

*Sphere psychological or psychiatric intervention indicators 2 and 3: Care for urgent psychiatric complaints is available through the primary health care system. Essential psychiatric medications, consistent with the essential drug list, are available at primary care facilities.*

*Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed.*

Considering anthropology's traditional interest in marginalized groups, it is notable that the reviewed literature ignores the study of severely mentally ill persons in disasters, whose needs—although addressed by a few programs—tend to be underserved (Silove, Ekblad, & Mollica, 2000; van Ommeren, Saxena, Loretti, & Saraceno, 2003). The literature contains no substantive discussion on severely mentally ill people in disasters beyond the criticism of the medical model. In studies of mental health in disasters, qualitative researchers—similar to most psychiatric epidemiologists—seem to have exclusively focused on trauma, while ignoring the existence of highly vulnerable persons with pre-existing severe mental illness.

*Sphere psychological or psychiatric intervention indicator 4: If the disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase.*

The literature reviewed focuses discussion on a comprehensive *social* response. The authors did not identify any substantive discussion of comprehensive community-based *psychological* interventions. Rather, the focus of the literature—when discussing psychological interventions—is on critiquing trauma-focused programs (discussed above), most likely because that has been the focus of most mental health programs in disasters.

Many criticisms of psychological interventions highlight the culturally specific origins of the psychotherapeutic paradigm (Bracken, 2001; Bracken et al., 1995; Munczek & Tuber, 1998; Muecke, 1992; Ong, 1995; Pupavac, 2001; Summerfield, 2001). This paradigm is seen as a reductionist one in which disaster creates dysfunction, symptoms and problems within individuals. Given the frequency of criticisms of psychological approaches in the social science literature, it is surprising that we identified no observational research on psychological interventions in disasters outside the West. For example, reporting on an ethnographic study, Eyber and Ager (2002) argue convincingly why it is unlikely that their Angolan subjects would want to receive Western-style psychological counselling. Direct research of the counselling process itself is not reported in the literature reviewed. Qualitative research that fully examines the experience of local and biomedical forms of psychological interventions is needed in light of recent outcome research on the usefulness of western-type therapy in Uganda and Chile (Araya et al., 2003; Bolton et al., 2003).

This Sphere intervention indicator contains a note emphasizing (a) the need for understanding the socio-cultural context when doing interventions, (b) the importance of using functional, cultural coping mechanisms in interventions, and (c) collaboration with community leaders and healers when feasible (Sphere Project, 2004). These three points appear to resonate with the social science literature.

### *Beyond the current sphere standard*

Among the most salient messages articulated by social scientists is that of the need to record and address the structures that facilitated or created the trauma. Zarowsky (2004) emphasizes the need for aid workers to situate suffering in relation to the broader political and economic forces. Sphere is philosophically founded on a rights based approach as articulated in the "Humanitarian Charter" (Sphere Project, 2004). Nevertheless, this charter has often not been linked to the minimum standards when used in the field (Walker & Purdin, 2004).

The qualitative research literature refers frequently to human rights violations and social justice, as is common in current medical anthropology research.

> While we repatriated to our homelands, we didn't get our farming lands, …Our property is being eaten in front of us. That is how you see our people. Some are demoralized (*niyed jabay*), some become mad (*waalliy*)… . Because our farming lands have been taken by force and still the government is eating the lands in front of us… (Zarowsky 2004, p. 196).

This narrative from a Somali woman suggests that not only is her suffering understood in socio-economic context, the eventual solution must also lie in that context. The demand for recognition of socio-political injustice obliges aid workers to try to protect populations from human rights violations and to act as recorders that make others aware of these violations. This has been the predominant approach of organizations acting within a human rights framework. Breslau (2004) suggested, that the spread of the PTSD model in some aid organizations has been driven by PTSD's power to connect "individual subjectivity" with politics and social justice; this model, which "identifies victims and perpetrators" may have perceived political value for advocacy (Breslau, 2004, p. 119). Demands for recognition of injustice are expressed by Hondurans whose fathers had disappeared or been "assassinated" in political violence. Munczek and Tuber (1998) note "several of the subjects insisted that they did not want anonymity, they wanted their father's situations and their individual and family's trials and tribulations known, recorded and remembered" (p. 1702).

In a recent article describing testimonial psychotherapy with young Sudanese refugees, Lustig, Weine, Saxe, and Beardslee (2004) note that this therapy focuses on and documents recent world events. Response, recognition and record are thus merged in this exercise.

Despite the need for a central place of human rights in disaster response, engagement with human

rights can present substantial dangers that may jeopardize interventions needed for basic survival. Indeed, by becoming actively, "political," the health apparatus, including foreign intervention, may become a target of violence. In advocating for human rights, the cause of ill health is addressed directly, but the purity and protection enjoyed by "health interventions" may be jeopardized, and access to the population at risk may be diminished. The dangers of human rights advocacy must be recognized and assessed on a case-by-case basis.

Pedersen (2002) has argued that "social epidemiology and critical social theory converge in arguing that structural inequalities are the most important determinants of population health" (p. 187). As structural inequality, and structural violence (Farmer, 2003), may be exacerbated in disaster, efforts to advocate for the social and economic well-being of the affected population are critical.

## Discussion

The qualitative social science research literature and the Sphere social intervention indicators both emphasize the value of information; culture, religion, and tradition; purposeful activity and recreation; and community connection and ownership. Yet the literature goes beyond Sphere in emphasizing that interventions should (a) allow beneficiaries to respond to suffering in socio-political and socio-economic context through appropriate recognition and advocacy, and (b) recognize that social structures and practices are complex, diverse and in flux. Based on our findings, the following intervention indicator could be considered for addition to the Sphere mental and social aspects of health standard to make the Sphere Project's human rights framework more operational:

*The aid response records and raises awareness of human rights violations, increases protection from further violations and advocates for rights and dignity.*

This statement would need to be accompanied with operational guidance drawn from existing documents (e.g., Inter-Agency Standing Committee, 2002).

Given the diversity and complexity of disasters and the populations they affect, it is reasonable that the use of standards to guide the response to disaster inspires criticism (e.g., Dufour, Geoffroy, Maury, & Grünewald, 2004). Universal standards and indicators risk being inappropriate for certain contexts and can never be exhaustive. While our study has identified some universal themes that should be addressed in a health response, we also highlight that the specific approaches to addressing these themes cannot be considered universally appropriate. Indeed, the Sphere Handbook's opening pages clearly state that it should not serve as a prescriptive protocol. Rather, it is a tool by which to assess and potentially improve assistance. The handbook reminds actors of which questions should be asked in disaster response.

Disaster mental health policy has been considered an area of controversy (van Ommeren, Saxena, & Saraceno, 2005). However, in a survey of mental health experts, substantial agreement was noted on the value of social interventions, while opinions differed regarding the value of trauma-focused care (Weiss, Saraceno, Saxena, van Ommeren, 2003). The qualitative literature reviewed seems to support this conclusion; however a number of the themes related in the social interventions need further qualitative research. These include: mass communication in disasters; family re-unification; misuse of the classroom to incite hatred; community consultation to guide decision-making; and recording, recognizing and addressing rights violations as part of the aid response.

Discussion of psychological interventions in the qualitative social science research literature is limited mostly to criticisms of the PTSD model. A fundamental question that needs further assessment is whether (non co-morbid) PTSD is associated with impaired daily functioning in non-Western, resource-poor disaster settings. We note that the reviewed literature does not cover psychological first aid and ignores vulnerable persons with pre-existing severe disorders (e.g., psychosis) and institutionalized persons. Through research, social scientists may play a key role in promoting socially appropriate mental health responses and contributing to a more balanced interpretation of the bio-psychosocial clinical model, which is increasingly dominated by psychopharmacology, also in resource-poor countries outside the West.

As the Sphere Handbook is influential in practice, the Sphere frame has provided a relevant approach for discussing qualitative social science research in relation to public health recommendations. Had the review been based on an alternative framework, our observations of the qualitative social science research literature may have differed. While

constructing generalizations from the qualitative literature could be seen as problematic, the identification of themes is essential. A full anthropological study on every intervention, in every disaster location, at every point of time during social change after disaster, is not feasible. However, an integrative study of program evaluations and reports is needed to further understand how the Sphere standard relates to actual practice.

The results show that social science understandings can inform and illustrate disaster mental and social health recommendations. This paper has shown that the qualitative literature contributes by delivering voices from the community that may be used to increase the likelihood that planned interventions address true needs—without harm. For public health practitioners and others involved in disaster response, our analysis highlights that interventions should not be mechanistically implemented without consideration for context. Clearly, no intervention can be assumed to be appropriate at all times in all settings. Strategies are needed to communicate the messages of qualitative social science researchers more effectively to national and international aid workers.

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