

# Foreword

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This book represents a *benchmark* in academic publication on the psychological consequences for people who have been uprooted against their will. The editor, Frederick Ahearn, has brought together some of the most well-known researchers in refugee studies from a number of disciplinary backgrounds to discuss how they have met the challenges of researching in this cross-cultural, comparative field. This book will soon be required reading for mental health practitioners and all who conduct research on refugees, for one reason especially—its emphasis on *wellness* rather than *pathology*. As such, it will act as a profoundly important corrective to much of the contemporary literature in the field.<sup>1</sup>

The study of populations that have been forcibly uprooted, whether they have crossed a border or remain “internally displaced,” is necessarily multidisciplinary. Were we, however, to create a “hierarchy” of disciplines in terms of relevance to refugee studies, psychology should be among the first.

From research conducted after the Second World War, it has been known that those who have been forcibly uprooted are at greater risk of mental ill-health than are those who voluntarily migrate, but it is only since the 1990s that non-governmental organizations (NGOs) have focused on providing “therapy” for refugees.<sup>2</sup>

In the early 1980s, when I was conducting my own research among Ugandan refugees in southern Sudan, it was not possible to convince NGOs working there that special attention should be paid to the mental health of African refugees, much less to designing interventions to mitigate the stresses associated with their experiences—violence, death and bereavement, uprooting, flight or the challenges of survival and adaptation in exile.<sup>3</sup> Indeed, up to the late 1980s, calls for basic socio-psychological research to be conducted—beginning with refugee children, encountered stiff resistance. An emphasis on research was interpreted by humanitarians as implying they were neglecting their duties.

For NGOs and refugees, the war in Yugoslavia was a watershed. By this time the diagnostic criteria, “PTSD”<sup>4</sup> had become part of the agency jargon. Millions of dollars became available for humanitarian agency-sponsored “psychosocial” interventions and a myriad of foreign organizations migrated there to establish programs on behalf of the victims of war. These interventions were underpinned by the assumption that *all* former Yugoslavians, including their mental health professionals, were too traumatized to help themselves or their fellows.<sup>5</sup>

This “fashion” for mounting psychosocial interventions has now spread throughout Africa, with the reins of control still firmly in the hands of foreigners who have access to donor funds. We now even have “barefoot” psychologists even though the concept of barefoot doctors was long ago found to be inappropriate. For example, in northern Uganda, there are several agencies working with abducted children who have been released by—or who have escaped from—the Lord’s Resistance Army. The “therapies” offered are diverse. For example, some insist on the religious conversion of these children.<sup>6</sup>

Unfortunately, the principal driving force behind so many of these psychosocial interventions in these refugee situations is and remains, as Alistair Ager notes in this book, “concern rather than reasoned extrapolation from rigorous empirical study.”<sup>7</sup> This book will reverse that trend by not only promoting the dignity and agency of refugees, but also by providing the methodological tools for gathering data that will assist NGOs who aim to meet the specific mental health needs of the uprooted.

Barbara Harrell-Bond

## Notes

1. See Summerfield, D. (1995). Assisting survivors of war and atrocity: notes on “psychosocial” issues for NGO workers. *Development in Practice*, 5:352-356.
2. Ager, A. (1994). *Mental health issues in refugee populations: a review*, Working Paper of the Harvard Center for the Study of Culture and Medicine, Harvard Medical School, Department of Social Medicine.
3. Harrell-Bond, B.E. (1986). *Imposing aid: Emergency assistance to refugees*, Oxford University Press, Oxford.
4. Post-Traumatic Stress Disorder. See Summerfield, D. op. cit. But see also Worden, Jessica Lind “Tossing the baby with the bath water: Controversy over cross-

cultural Use of DSM diagnostic categories in situations of armed conflict,” unpublished, RSP Documentation Centre.

5. See Agger, I. (1994) *The Blue Room: Trauma and testimony among refugee women: A psychosocial exploration*, Zed Books, London and Agger, I. *Theory and practice of psycho-social projects under war conditions in Bosnia-Herzegovina and Croatia*, ECHO, Brussels, and Ajdukovic, Dean (Ed.) (1997). *Trauma recovering training: Lessons learned*, Society for Psychological Assistance, Zabreb.
6. The agency that is perhaps the best funded in Gulu District takes the latter approach and regards it as more important than reuniting children with their parents. According to a member of staff of another agency that bitterly objects to such practices, in one case at least the parents were not informed for more than a year that their child was safe.
7. Chapter Two and also see Ager, A. (1994) op. cit.