PSYCHOLOGY IN HUMANITARIAN ACTION
AND ARMED CONFLICT
– A case story from the field

Tine Meyer Thomsen & Rasmus Bjerngaard

> *»Peace is a dream about having enough food*
> *to eat and a dream about attending school«.*
> GIRL, 12 YEARS OLD, AND BOY, 13 YEARS OLD,
> NORTHERN UGANDA, AFRICA.

From early 2004 to end 2006 Médecins sans Frontières (MSF)
provided a protective night shelter for night commuting chil-
dren in Northern Uganda. Originally the night shelter con-
tained up to 4000 children and the children commuted every
night from their villages to the shelter in fear of being abducted
by the rebels for use as soldiers, sex slaves and porters.

As the security situation improved and the number of night
commuting children decreased during 2006 MSF conducted
a qualitative research based screening of all 745 children
remaining in the shelter in order to identify the psychosocial
needs and level of vulnerability of the children. The screening
was designed with advocacy and applied short term response
in mind.

The medical and mental health work with children and the
screening work in particular brought forward general observa-
tions and reflections about the challenges and constraints of
the clinical psychologist's work in a humanitarian action and
conflict setting. These are reflected in a set of lessons learned,
one of the main points being the need of a an integrated men-
tal health approach that communicates within a simplified
»diagnostic« culture-sensitive system based on psychosocial
interventions.

1. Introduction

Based on the work as clinical psychologist for MSF in Northern Uganda,
this article describes the psychological field work in a context of humanitar-

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ian action and conflict. With outset in the screening of 745 nights commuting children (Thomsen & Bjerngaard, 2008) it tries to collect lessons learned and characterise the role of the psychologist.

First the general situation of conflict and night commuting in Northern Uganda is introduced. Taking outset in a psychosocial screening conducted among night commuting children the article continues to discuss the challenges met during the screening work and psychological practice, such as research methodology, ethics and contextual constraints. Finally a set of lessons learned and recommendations are presented.

2. Humanitarian action in a conflict setting

In February 2008 the government of Uganda and the Lords Resistance Army signed a permanent ceasefire in an effort to end more than two decades of war and armed conflict. At the present moment Northern Uganda faces a psychosocial challenge of dimensions in a region where everyone has lost someone they know to war.

The war in Northern Uganda began in 1986 as an ongoing armed conflict between the LRA (Lords Resistance Army, a rebel group which has been condemned by the UN and was declared a terrorist organization by the US in 2001) and the UPDF (Ugandan Peoples Defence Force that constitutes the armed forces of Uganda). The war affected nearly 2 million people, most of them being displaced and living in IDP camps without sufficient humanitarian assistance and protection. In Northern Uganda an estimated 30.000 children became night commuters having to commute every night from their villages and camps in fear of being abducted by the rebels for use as soldiers, sex slaves and porters (Barton and Mutiti, 1998). More than 20.000 children have been abducted during the conflict (Falk, Lenz and Okuma, 2004).

In early 2004 MSF opened a child night shelter at the St. Mary's Hospital Lacor compound near Gulu, Northern Uganda, to protect children from rebel abductions during night time. In addition to shelter and protection, the MSF shelter provided free access to medical health care and mental health care for up to 4000 night commuting children each night.

Lately the context in Northern Uganda has improved, marked by peace negotiations that have been ongoing since mid 2006. As a consequence the number of night commuting children in Gulu has decreased significantly. As the context improved and the number of children decreased it became evident to MSF and other aid organizations that the night commuting children – and likely other children as well – in Northern Uganda have important needs that are not met in shelters for night commuting children.

As advocacy is part of MSF's work[1], MSF decided to use its position and involvement in the local context to advocate for an updated and improved effort towards the current needs of the children in the region. A comprehensive advocacy roadmap was devised involving local, national and international initiatives.

Advocacy in MSF means raising awareness about the plight of the population we help taking the implications of our actions into account (MSF, 1995; MSF Holland, 2005). It is important to note that advocacy is an integrated part of the relief aid. In general the term lacks a unified theory that catches psychological and political phenomenons (Elsass, 2003) though several advocacy guidelines exist (e.g. Elsass, 1982; Erikäinen, 1997; Safarjan, 2002; APA, 1993; APA, 2003; Sphere, 2004).

With the explicit goal of advocacy and immediate applied action where possible a screening investigating the day-to-day reality of all the remaining children attending the child night shelter was performed in the time period from September till October 2006 (Thomsen & Bjerngaard, 2008). The screening had theoretical outset in humanistic psychology (Maslow, 1970), cultural psychology (Shweder, 1991; Cole, 1996) and practice-in-science (Schön, 1991).

3. Identifying children at risk

The screening investigation involved 745 children in the age group from 5 years to 17 years[2]. Main part of the children being from 7 years to 15 years. 716 screening forms were valid. Screening forms were invalid either because the child did not want to participate or because the answers were too inconsistent to be useful (as evaluated by the psychologist). Only the valid screenings are taken into account in the data analysis.

Based on the conversation with the child, the interviewer filled in the screening form including his/her subjective evaluation of the openness and consistency in relation to the interviewed child and the vulnerability level of the child. All 745 screening forms were further evaluated and scored by the psychologist.

Finally, the data from each form was entered into a database and analysed. Only the most important[3] subset of the data available in the screening forms was used due to time and resource prioritization.

63 children were identified as *at risk*, this equals 8.8 % of the total valid

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1 The MSF term »témoignage« covers advocacy and more. It is defined in the MSF Chantilly declaration (MSF, 1995).
2 Except one boy being 18 years and mentally retarded.
3 As defined by the goal of advocacy and immediate applied action where possible.

screenings done. All *at risk* children have more than one risk indicator; virtually all the cases are multi-complex and the risk indicators are of the more severe kinds.

Case 1: sick child, child protection, and basic needs

This boy is 10 years old. He is living in the Lacor area together with his grandmother. His mother is dead and the father has abandoned him. The grandmother is generally weak and can not take care of him. He has been sleeping at the night shelter since the opening 2 years ago. He has never been attending school and has no education due to lack of school fees. Some years ago he was abducted by the LRA for a short period of time, and he has traumatic stories to tell of the time when he was in the bush. He would not feel comfortable sleeping at home because he fears re-abduction. He also suffers from epilepsy and is being beaten by his grandmother, older brothers and others at home when he has fits. He gets aggressive when he feels threatened and often gets into fights. He also often feels sad and copes with this by keeping quiet and become withdrawn. In addition to that there is absence of food and he only eats one meal per day – if he is lucky.

Case 2: sick child, sick caregiver, and basic needs

This girl is 15 years old. She is living in the Lacor area with her mother. The mother is suffering from HIV and the father is dead. The mother is often sick and the girl has to take care of herself. She has been sleeping at the night shelter since the opening. She has some primary school education but currently she is not attending school because of lack of school fees. Some years ago she was abducted by the LRA and was witnessing her father being killed. She would not feel comfortable sleeping at home because her mother is quarrelling with her and beating her. Therefore she is planning to sleep at the veranda at the Lacor hospital if the night shelter closes. She sometimes feels threatened by boys but does not know what to do. She tried to cope with her life situation by spending time with friends in the shelter. She suffers from severe chest pain and she feels sick at days when she is doing excessive labour by digging in peoples gardens in order to earn money for food and clothes.

Case 3: sick child, child protection (orphan), and basic needs

This girl is 12 years old. She is living in the Lacor area together with her 3 siblings in a child headed family. Her mother is dead and her father is unknown to her. The eldest sister, 14 years old, is functioning as the head of the family and the sister is always upset and full of worries. She has been sleeping at the night shelter since the opening. She would go home together with her siblings to the hut they have inherited from the mother if the night shelter closes. She has some primary school

education because an uncle on the mothers side sometimes helps her with school fees. She is suffering from HIV and gets medicine from Lacor hospital, but she does not want to talk about her illness. She says she is sometimes feeling sad when she thinks about her dead mother. She does not eat every day. When she does it, it is maximum once per day in the evening.

Some risk indicators correlate strongly with *at risk*, which includes *physical violence* where 94 % (15 out of 16) of the children are *at risk* and *formerly abducted* where 57 % (16 out of 28) of the children are *at risk*.

The triangular in Figure 1 gives an overview of the *at risk* children by grouping the risk indicators in three main categories:
1. Child medical (includes *disabilities/chronic illness* risk indicator)
2. Caregiver medical (includes *disabilities/chronic illness, elderly/drug abusing caregiver* risk indicators)
3. Child protection (includes *orphan/child headed family, physical violence, sexual abuse, forced marriage, excessive labour* risk indicators)

A fourth category is defined as
4. Basic needs (includes *absence of food, no attendance to school* risk indicators)

The figure indicates that there is 2+6 *child medical*, meaning that out of 8 in total 6 shows also *basic needs*. 4+11 show both *child medical* and *caregiver medical*, out of 15 in total 11 further show *basic needs*. All children having a component of *child medical* are encircled; in total 37 children have medical needs.
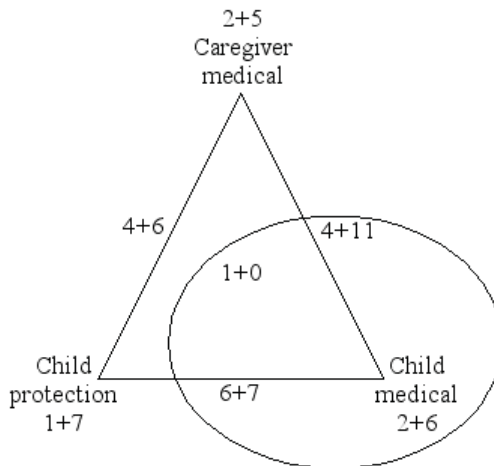

Figure 1: Grouping at risk children.

4. Definition of risk indicators

As mentioned the screening identified the level of vulnerability to identify
   The most vulnerable children – the »at risk« children.
The level of vulnerability was evaluated based on
   *The number and severity of risk indicators in the child's present life*.
To minimize discrepancy in perception of expression the *risk indicators*
were predefined:

1. *None*: No risk indicators present in the child's life.
2. *Orphan/child headed family*: No biological parents and no other caregivers – or parents alive but have sent the child away/rejection e.g. because of epilepsy or other disease.
3. *Disabilities/chronic illness*: No objective differentiation in level of difficulty, range from chest pain to HIV/AIDS. The child's subjective perception was assessed by the psychologist.
4. *Chronic sick/elderly/drug abusing caregiver*: No objective differentiation in level of difficulty, range from chest pain to HIV/AIDS. Drug abuse primarily in relation to alcohol.
5. *Beating*: Discipline by beating as a common element in Acholi[4] upbringing. This category was introduced to make a distinction between culturally accepted disciplinary beating and more extensive physical violence (Koenig, 2003).
6. *Physical violence*: Physical violence on a regular basis for no reason within the last 3 months. E.g. alcohol abusing father beating the child when he is drunk.
7. *Sexual abuse*: Abuse within the last 3 months. The child's subjective perception was assessed by the psychologist.
8. *Forced marriage*: As de facto.
9. *Excessive labour*: Daily or nearly daily work in order to earn money that usually also prevents the child from attending to school.
10. *Absence of food*: When less than one meal per day.
11. *No attendance to school*: As de facto.
12. *Formerly abducted*: No objective differentiation in level of experienced trauma, range from few hours of abduction to 3 years of abduction. The child's subjective perception was assessed by the psychologist.

Three risk indicators stand out:
1. Chronic sick/elderly/drug abusing caregiver
2. Beating
3. Absence of food

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4   The Acholi tribe is the main population in Northern Uganda.
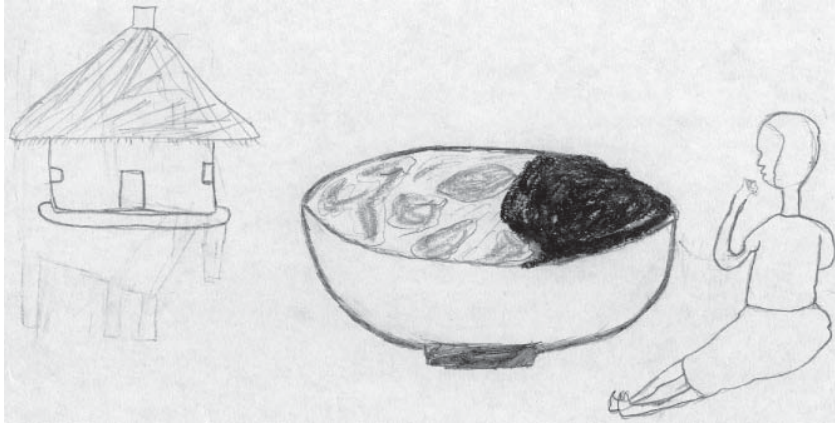
»A dream about having enough food to eat«, girl, 12 years old.

»A dream about attending school«, boy, 13 years old.

More than half of the children show one or more of these risk indicators. A significant part of the children is not presenting any risk indicator.

5. Mental health work in a medical field setting

Maslow (1970) was the humanistic psychologist to analyse the needs of human beings. Humans are described as having a hierarchy of needs. Higher level needs emerge when basic needs are meet. This holistic, integrated approach to case work and counselling emphasises the uniqueness of each person and their perspective of the world. It sees humans as striving to realise themselves once their basic needs have been meet. It focuses on helping

people to explore their feelings and problems as well as their resources. It means that persons working within the area of mental health must take into account a client's physical needs (food, clothes, rest, »basic survival«), emotional/social needs (security and attachment), psychological needs (confidence, sense of worth and competence), intellectual/spiritual needs (need for order and beauty and self-actualisation through fulfilment of potential). In working with children, specifically this has been useful in understanding their basic psychosocial needs and providing the relevant responses to their needs as far as possible.

In Uganda – as in many non-Western countries – there is a lack of mental health professionals and mental health understanding. This was confirmed by a conference held by the Uganda Counselling Association in July 2006. The association wants to eliminate the wide spectrum of people naming themselves counsellors on the basis of a 2 days course (which is common in Uganda). The association wants to make »counsellor« a protected title in order to avoid the »para counsellors« practice of today.

The role of counsellors should not be mistaken for that of psychologists and doing therapy. The aim of counselling is to enhance the client's functioning by reinforcing his/hers coping skills (MSF-Holland, 2005). Curing or treatment in terms of therapy can not be the main focus because in (post) emergency contexts the risk of new traumatic experiences is substantial. In this context it is essential to name the clinical activities and their content by their right name. Through supportive counselling symptoms can be reduced but the causes of the symptoms are not addressed. Addressing the causes to do prevention in a longer term perspective, demands a strong commitment to the local community in order to provide a culture-sensitive and flexible response to the changing needs in the given context.

To ensure an adequate level of quality counsellors were trained and worked under supervision. Their job was to coordinate and support mental health in the medical field setting. The most common interventions done involved combinations of mental health education, psychosocial counselling in terms of listening, exploring (thoughts, feelings, coping skills and support network) and structuring, clarifying, non-directive advice – working on acceptance and on future perspectives (MSF Holland, 2005).

6. Methodology of the actively participating psychologist

The screening aimed to identify and understand the needs and level of vulnerability of each child in the child night shelter – as an outset for advocacy – rather than to solve the problem. Principles similar to practice-in-science were applied in integrating theory and practice. As described by Schön, the role of the researcher is to facilitate a reflexive conversation. In a context dominated by complexity, uncertainty, instability, uniqueness and value

conflict the challenge is »problem setting« rather than »problem solving« (Schön, 1991:39). From a reflectionist perspective the researcher is not an objective and neutral observer but »an active participant« (Elsass and Lauritsen, 2004:171). She becomes actor in the development strategy, and the recipients become participants in developing the methodology and concept definitions (Dreier, 1998; Nissen, 1995).

The large number of children attending the child night shelter and the relatively short time period in which the children were accessible[5] caused practical constraints that basically translate into human resource/time constraints. Thus, a two step approach was devised:

1. First a screening of all children was done. The screening looked for predefined *risk indicators* to identify potentially vulnerable children. The average screening time per child was around 30 minutes
2. Assessment only of children that the screening identified as potentially most vulnerable

Based on the assessment in step 2 case-by-case management of the children could be implemented. A screening form was developed with inspiration from grounded theory procedures and techniques (Strauss and Corbin, 1998). When designing the form the main challenge was to ensure that it would correctly identify as many vulnerable children as possible. Principles of qualitative interview research were applied, namely a qualitative semi-structured interview that makes it possible for the child to answer the questions by telling its story in its own words[6]. The screening form, screening process and the evaluation of the screening data used applied qualitative methods from cultural psychology theory. Culturally specific explanations were taken into account in an attempt to understand the local situation rather than seeking a universal objective truth (Cole, 1996; Shweder, 1991).

Each screening interview was assessed by the interviewer according to certain *risk indicators* that were predefined based on practical experience from the work with children in the child night shelter.

The basic screening form was designed in collaboration with a group of people from authorities and other aid agencies working with night commuting children. As commitment to facilitate appropriate follow-up of the work done by the group did not realize, MSF continued improving the form based on practical experience from the implementation of the screening.

The screening interviews were done by a paraprofessional screening team consisting of nine national MSF staff working as counsellors, translators or caretakers in the child night shelter, all having attended minimum 6 months

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5   The shelter was open from 6 pm and most of the children came between 7 pm and 9 pm. The shelter closed at 7 am.
6   In contrast to e.g. multiple choice questionnaires where the options are given beforehand (Strauss and Corbin, 1998).

part-time counselling course plus specific training on the screening. The MSF expatriate psychologist supervised the screening including follow-up coaching and continuous training. The child night shelter manager took care of the administrative part of handling the screening forms, and the expatriate child shelter programme coordinator took care of the data processing and statistics, and collaboration with other aid organizations. A procedure paper was created to ensure a standardized way of handling the interview process.

7. Implications of the screening

The main target of the screening was to create a firm base for advocacy and applied short term response within the area of mental health in humanitarian action. The conclusions are observations and indications that we find highly useful in understanding and justifying what is required to respond to the needs of children and youth, both those that are night commuting and those that are not.

The screening supports the widely promoted view that the children have needs that are not currently met. A closer look at the data indicates that the needs can be grouped into four main areas:
• Basic needs
• Child protection
• Medical (physical/mental health) needs of the child
• Medical (physical/mental health) needs of the child's caregiver(s)

Being a medical organization, MSF started attending to the medical needs of the children showing such needs (as an extension of the existing medical program). Naturally, this was done in strict confidence and on a voluntary basis. Children choosing to accept the offer for assistance were treated on a case-by-case basis. It may occur that the contact with the child leads to assistance provided for the caregiver. Since the information in the screening is confidential it is not possible to use it to identify caregivers with medical needs pro-actively.

MSF has been active advocating for the needs of children and youth – including the night commuting children. But MSF also wish to underline that MSF was and is unable to address the main part of the needs within its medical mandate, namely the basic and psychosocial needs.

8. Discussion

A thorough screening of the entire population of night commuting children in the MSF child night shelter was made. Effort was put into ensuring that

children were properly registered to ensure the validity of data. Among other that meant excluding 'new children' that were sent 'to be registered' for what was erroneously hoped to be of later benefit[7]. As the caretakers in the child night shelter know the children attending their particular shelter[8] well and effort was put into registering properly, the error from the registration is assumed to be negligible.

The screening form was developed by a group that to some extend have relevant competencies, further the MSF psychologist extended and improved the form based on direct experience with it. The screening form was perceived to be useful and the content relevant but an actual validation was missing.

The subjective assessment done by the interviewer is sensitive towards the different levels of qualifications among the individual interviewers. Although all the interviews were further assessed by the psychologist in order to validate the content no unambiguous consensus criteria were made. To counteract errors in the subjective assessment predefined risk indicator were used, and following up, continuous training and coaching of the interviewers were done[9]. Further, the variability between different interviewers was checked during the screening.

The overall impression is that the error from this part of the screening has significance on the precision of the result. Further the screening is merely a glance into the complex situation in Northern Uganda. Thus, conclusions shall be limited to a level of observations and indications, and the data material shall not be used for conclusions other than those presented herein.

Any case management of children would be based on a comprehensive assessment of each case, not the screening in itself, this means that children erroneously identified as vulnerable will be found. However, it does not cover for children not identified as needy but in fact being it. Some subjects such as sexual abuse, and possibly physical violence and some stigmatized diseases are difficult to talk about (possibly also for the interviewers). It is expected that the screening did not catch all these cases, e.g. only 2 cases of sexual abuse were reported which is not in line with MSF's general experience and other sources of information (Mugisha, 2006). Unfortunately, this means that the screening may fail to identify some of the most vulnerable children.

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7   This was expected beforehand. When the word gets out that a registration is in progress some people opt for the chance of benefits though they are not part of the target population.

8   There were nine big plastic tents and three fixed structures used as sleeping areas in the child night shelter, these were – confusingly – called shelters.

9   In an ideal setting a team of professionals would discuss these criteria in depth. In the actual setting the only thing feasible was to do follow-ups and discuss the interview content with the individual interviewer in case of doubt and uncertainty.

Some structural features of community, culture and the child night shelter may influence. Most prominently only one forced marriage was reported but as forced married girls are likely to be sent to the new family and since girls with babies could not attend the child shelter this was an expected result.

Correlations in the data are useful for understanding the root causes and possible response to the needs of the children better. As an example there is a correlation between *formerly abducted* and being *at risk*. From a psychological point of view one can imagine that the experience of trauma due to abduction reduces the internal resources meaning lack of coping skills and increased vulnerability. Deeper understanding of these relations calls for further investigation.

As the screening was designed for advocacy purposes and »...the reasoning behind advocacy will never be 'purely scientific', in essence it contains other dimensions, e.g. moral and ideological...« (Elsass, 2003:521), this has implications for the results. The scientifically based screening has been a mean to achieve a foundation for our advocacy, so advocacy has been defining for what we chose to focus our research resources on. We are not pursuing an objective truth but usable indications for action founded on firm research.

The research work has been highly involved with the local community, authorities, other aid agencies and media, as well as numerous stakeholders on national and international level. Getting access to the target population has only been possible due the direct involvement, knowledge and confidence MSF possesses in the specific context. Further the cultural and sociopolitical reality related to night commuting in Northern Uganda is unique[10] and highly sensitive. In this setting where statements may be used for unintended purposes, it is imperative to clarify any implications the research may have for the affected population.

Thus, as researchers we have an ethical obligation to ensure that our research does not worsen the conditions for an already exposed population. At the same time we hold an ethical mandate to speak out if it may help the population: »...to make the connection between social context and individual symptoms [...] is an ethical mandate for any professional...« (Fischman, 1998:28).

It is problematic to investigate people in distress solely with scientific intentions and no intentions of relief aid because the involvement creates a relation and easily an expectation with the investigated people. The researcher will not only ask questions but also *be asked* questions.

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10 Night commuting does not exist elsewhere in the world.

9. Lessons learned

We need to use an integrated mental health approach to achieve a simplified »diagnostic« culture-sensitive system. This means that mental health services need to be integrated into the existing medical services. It should not exist on its own. The medical staff – national as well as expat – needs to be trained in basic communication skills and techniques to have a minimum understanding of mental health and to recognise mental and psychosocial reactions in the medical setting. Therefore ongoing field training and supervision should be mandatory.

In acknowledgement of the lack of national psychologists and trained, qualified counsellors usually experienced in the field, counsellors and psychologists should not use the traditional psychiatric diagnostic system, but use a simplified »diagnostic« system to categorise problems presented by a client into five areas in prioritized order:
1. Practical social problems
2. Lack of coping skills
3. Complaints and behaviours related to traumatic experiences or extreme stress
4. Overwhelming feelings
5. Inner problems

The above categories are used to provide direction to a counselling intervention. They are not used for differential diagnostic purpose since this is not the primary need in the field. Clients often express multi-complex problems such as practical problems and overwhelming emotions. It is part of the mental health professional's job to define, in collaboration with the client, the most prominent area of dysfunction to be reduced first. This means that lengthy intake procedures should be avoided. We should not build strong attachments in a context of emergency/post emergency. The aim should be »help to self help«.

In this context it is important to be aware of the qualitative difference in psychotherapy and counselling. Therapy requires a regular and durable relation between therapist and client in order to contain inner conflict on a deeper level. Counselling does not open for inner conflicts on a deeper level and does not require the same long-term commitment and attachment in the relation between client and therapist. Counselling is an assistant relationship where the counsellor/psychologist uses various strategies to clarify and expand the clients understanding and resources; to assist the client to develop and implement strategies and coping skills for changing how he/she thinks, acts and feels in the aim of attaining life-affirming goals under the given life conditions.

The screened children do not have big chances for actually changing the causes of their un-well being. In this context it is feasible to relieve the

symptoms of the causes and teach the children how to relieve their symptoms as well. From a clinical perspective this can be done by addressing the resources the children are showing – without being able to change the causes of their present life situation. This is also to avoid re-traumatising – emphasizing the ever-quoted statement in clinical psychology: »You do not do psychotherapy in a concentration camp«. Simply because one has to ensure the basic needs are met first – a level of psychological settlement – otherwise the risk of a break down is facilitated exploring the reflections and awareness of your situation but not having the means to cope differently.

Instead of stating doing »therapy«, we should state and work within the more proper term »psychosocial counselling« – and be accurate to the content and limitations of our clinical interventions. In addition other elements of health should be addressed in humanitarian action: referral to social services/NGOs (for practical and social support etc.), involvement of the support network in the local community, collaboration with traditional healers or use of personal/family rituals (e.g. visiting meaningful places).

Finally context sensitive advocacy, particularly towards authorities and local leaders about problems can contribute to the effects of interventions e.g. increased awareness and protection – as in this case of the night commuting children from the Lacor Night Shelter.

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