Trauma Rehabilitation After War and Conflict

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Editor

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Community and Individual Perspectives

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Reflections on Healing

How people survive
in a circle of hell
I'll never know.

How they trust
again in the
human family
I'll never know.

How they can
smile once more
after seeing evil
deeply and repeatedly
I'll never know.

How they let the
horrors fade and
live for the future
I'll never know.

How they learn
to trust themselves
again and find their voices–
this I know.

Erin Martz

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A researcher meets many minds along the path of investigation. While the ideational influence of many researchers is acknowledged by citations in this book, other individuals have been influential by their interaction with me at various stages of the development of this book; these include, but are limited to, the following people.

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I would like to thank my parents for providing encouragement and creating early-life conditions, in which I could expand my mind, absorb ideas, and eventually explore the international sphere (even though the latter may have caused them a lot of anxiety); I am dedicating this book to them out of appreciation. And a hearty thank-you goes to all of the chapter authors for their dedication and hard work—*I learned a lot from you!* Echoes of the horror of war prompted my writing of the preceding poem called "Reflections on Healing" that seemingly 'fell out' of me after visiting a former site of World War II atrocities.

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Chapter 1
Introduction to Trauma Rehabilitation After War and Conflict

Erin Martz

> *If a meaning is to be assigned to life after trauma. . .the meaning of the future could be as important as that of the past. . . rehabilitation [is] in line with this concept of healing forward.*
>
> Shalev (1997, p. 421, emphasis added).

Abstract This book investigates the topic of individual-level and community-level rehabilitation after war or armed conflict, with an emphasis on human rehabilitation on a psychological and physical level. In this chapter, the multidimensional concept of rehabilitation is explored and the definitions of disability and the multidimensional trauma membrane (intrapsychic, interpersonal, and communal) are described. In addition, the topics of the psychosocial effects of war on individuals and communities and the possible interventions to address the ripple effects of war on individuals and communities are reviewed. This chapter also introduces and references the topics that are explored in other chapters of this book.

The present chapter will examine several theoretical models and intervention frameworks that encompass human rehabilitation interventions on both the individual level and the community level. Because rehabilitation interventions consist of processes to facilitate healing on multiple aspects of human life, human rehabilitation in the post-conflict context can help individuals and communities regain their functioning after experiencing severe traumas and numerous losses.

Introduction

Ursano, Fullerton, and Norwood (1995) called war the "oldest human-made disaster" (p. 197). There are huge costs connected to war and armed conflict: The World Bank (2009) estimated that the *yearly* economic cost of global conflict is around $100 billion. The global *psychological* costs of war have not been quantified

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and may not be quantifiable. How do individuals and communities recuperate from the terror, fear, loss, and destruction caused by war and armed conflicts? War and armed conflicts often create humanitarian disasters and crises by violence, leading to injuries, deaths, displacement of individuals and groups, the disintegration of civil and social organizations, and the destruction of physical infrastructure of a country; hence, there are both direct and indirect consequences of war and armed conflict for individuals. Because war and armed conflicts create a ripple effect and cause a range of stressors on multiple levels—not only psychological stress, but also physiological, economic, and social stress—a multidimensional perspective is then needed when examining post-conflict/post-war recovery.

Rehabilitation theory and practice offer multidimensional approaches to facilitating recovery after trauma, injury, or disability. While many definitions of rehabilitation can be found (e.g., building rehabilitation, economic rehabilitation), this book will examine post-conflict *human rehabilitation* from an interdisciplinary approach, which includes a variety of viewpoints, philosophies, and a multidimensional lens by which issues are examined. The major purpose of this book is to analyze the multi-level processes and programs that have led to the successful protection and rehabilitation of both individuals and communities after armed conflicts or wars. The present chapter will examine several theoretical models and intervention frameworks that encompass human rehabilitation interventions on both the individual level and the community level. The definitions of concepts, such as rehabilitation, disability, and the trauma membrane, will also be presented in this chapter.

Boundaries of This Book

This book is delimited to a focus on the human-made disaster of war and armed conflict, not natural disasters. A natural disaster (e.g., earthquakes, hurricanes) may have some similar elements as an armed conflict, in that the outcomes may look the same on a physical level (e.g., extensive destruction of personal and communal property and deaths). Natural disasters, for the most part, do not involve the same types of tensions, anger, and intentional violence that create, and result from, the national or international armed conflicts and wars. A meta-analysis conducted on 160 studies on traumatic stress indicated that traumas caused by humans (e.g., mass violence) are associated with a higher level of psychological distress than those caused by environmentally caused disasters (Norris et al., 2002). Also relevant to this book is Norris and colleagues' findings that psychological impairment after trauma was more likely among individuals in developing versus developed countries, although their meta-analysis only included studies that investigated the consequences of one-time events, not chronic exposure to trauma, such as may be found in war-torn countries.

This book will cover the community-level (i.e., after war-related humanitarian disasters) and individual-level (i.e., after accidents or injuries) rehabilitation interventions that can be implemented after war or armed conflict. The coping resources

of an individual or a community are often exceeded after widespread violence; hence, external support, in the form of people, agencies, and humanitarian aid, is temporarily needed until individuals are able to more fully and adaptively cope with the trauma of the events. Chapter 2 (by Martz & Lindy) will discuss the "trauma membrane," which is a concept that depicts intrapsychic, interpersonal, and communal processes that may occur after traumatic events to protect individuals from experiencing further stress.

This book is also delimited to primarily examining adults' reactions to trauma. There already exists a large body of research on the topic of the effects of war on children; however, one exception to the limited scope of this book is Schauer and Elbert's chapter (Chapter 14) on child soldiers. This chapter was included because child soldiers were forced into participating in adult, war-related roles, and hence, the topic was deemed appropriate for inclusion in this book.

Further, this book is delimited to examining the effects of armed conflicts or war, not tragedies at the hands of a few individuals (e.g., multiple homicides in the workplace or at a school, suicide bombings). Those kinds of incidences rarely last more than a few hours or days, unlike war and armed conflict; while they are horrific and may result in permanent physical and psychological consequences, these types of events do not typically require community-wide systemic interventions and processes to rebuild social infrastructures and thus are not included in this book (interested readers can refer to Wilson & Raphael, 1993). Numerous other areas could be covered in this book, such as developing educational systems in post-conflict situations (World Bank, 2004), rebuilding economies and political systems, or post-conflict peacebuilding (Schnabel & Ehrhart, 2005; Williams, 2005). Yet, not all issues could be included in this book, due to restricted space and the focus on rehabilitation topics.

The term "post-conflict" is used in this book with the understanding that post-conflict environments "do not necessarily imply a completely peaceful atmosphere" (Isturiz, 2005, p. 75) or complete cessation of all violence. The term "conflict-affected" is also employed in this book to reflect the unfortunate fact that some conflicts appear to be cyclical or difficult to resolve.

Creating a Trauma Membrane

The concept of a multidimensional trauma membrane, which acts as a type of post-trauma buffer zone that shields an individual or groups of individuals from further psychological stress, is explained more thoroughly in Martz and Lindy's chapter (Chapter 2), and is referenced in other chapters. Briefly, the concept of a "trauma membrane," as outlined by Lindy, Grace, and Green (1981) and Lindy (1985), originally referred to the interpersonal protection that individuals (e.g., family, friends, or even mental-health professionals) provided to individuals after trauma.

Yet, after armed conflicts and war, communities' physical and social infrastructures may be destroyed or damaged, consequently decreasing the naturally occurring process of a protective, interpersonal "trauma membrane" to individuals. Martz and

Lindy described in more detail the description of the concept of an intrapsychic membrane, which may occur within individuals after trauma that protects them against traumatic memories.

Rehabilitation interventions, as planned interventions that are performed with individuals and communities, can be viewed as *actions taken to create trauma membranes* around those who have survived a conflict or war. Multiple international agencies (the United Nations, Organization for Security and Co-operation in Europe [OSCE], the European Union) and local and international non-governmental organizations (NGO) have, for years, provided humanitarian assistance of various forms in war-torn countries. Though not called as such, their work could be viewed as creating trauma membranes around displaced, homeless, traumatized, and/or injured populations. Thus, the "trauma membrane" perspective is implicit in international agencies and NGO's work. Their humanitarian work also includes rehabilitation; yet, in such contexts rehabilitation is poorly defined as acknowledged by many agencies and individual researchers, (OSCE, 2000).

Despite the fact that post-conflict rehabilitation can facilitate healing and encourage stability on multiple levels and thus may help to prevent future conflicts, some researchers have noted that humanitarian relief money often is invested in "hard" reconstruction projects, and not the "soft" projects related to the social side or the human dimension of rehabilitation (Pugh, 1998). This reflects a trend that post-war investment often targets the rebuilding of the physical components of a society—with less effort invested into the humanitarian aspects of helping to rebuild people's lives. Yet, the psychological component of rebuilding is acknowledged by Williams (2005, p. 268), who said that "the critical determinants of successful peace-building and sustainable recovery will always be *internal* [within a country or community, because being]. . .supported by the donor community cannot serve as a substitute for the willingness of local actors to renounce violence and to devote domestic resources to reconstruction."

Thus, the treatment of the *human factor*, which not only acknowledges the influence of human motivation, volition, and choices but also focuses on healing human physical and psychological factors, is essential for rebuilding countries. If the human factor is not acknowledged in post-conflict reconstruction, it may disrupt the process; one example is the situation in which interpersonal violence is not reduced to manageable levels or violence restarts between warring parties after conflict, causing international humanitarian relief to be withdrawn from areas that are no longer deemed safe for international aid workers.

In summary, the trauma membrane involves more than providing physical sustenance and resources after a traumatic event: it involves a form of psychological first aid, aimed at temporarily supporting individuals and communities after trauma. Because the psychological healing of communities is a more invisible aspect of community-level reconstruction after war or conflict, it receives less financial investment, which may reflect a lack of awareness of the impact of non-physical needs on the healing of individuals and communities. Yet, the targeted facilitation of human healing after war by means of rehabilitation interventions may contribute to a longer-lasting peace.

War and Disability

Disability is ubiquitous in all cultures, and individuals with disabilities are the world's largest minority (United Nations, 2009b). It is estimated that 10% of the world's population has a disability (caused by a variety of factors); this percentage increases to an estimated 20% disability among the poorest communities (United Nations, 2009b).

Disability is generally defined in terms of the functional limitations of an individual that arise due to impairment in the bodily or cognitive systems. For the purpose of this book, the term disability can also be loosely applied on a community level; that is, communities can become "disabled" due to an impairment in social or civil processes. For example, war may cause community-level (i.e., country-level) destruction of its infrastructure, hence impairing operations and creating functional limitations of the government or civil structures, which have ripple effects on the functioning of individuals. The term "complex emergency" is used to describe when multiple factors create compounded social stress, such as an armed conflict coexisting with a famine; this term reflects multiple traumas on the community level, but not the coexistence of an individual-level trauma (e.g., disability) and a community-level trauma (e.g., war).

War and armed conflict can cause lasting harm to individuals—not only from the psychological shock of war-related trauma but from physical injury and disability as a result of the war. According to the United Nations (2009c), the most important way throughout the world to *prevent* disability is the avoidance of war. The main focus of this book is not preventing war, but on helping individuals who are living with the consequences of war or armed conflict. The toll of war is high, in that for "every child killed in warfare, three are injured and acquire a permanent form of disability" (2009b, p. 3). The World Bank (2009) estimated that 40% of post-conflict countries will relapse into conflict within 10 years of ceasing hostilities. Yet, multiple authors in the present book assert that resolving psychological trauma may help to reduce the reoccurrence of war.

Weisaeth (1995) noted that during a disaster or accident, individuals may experience severe physical stress—"the worst of which is the serious physical injury" (p. 407). Not only does an individual with a physical injury or disability have to deal with the physical and psychological stress related to disability, but often there are economic consequences of having a disability, in addition to the poor economic conditions created by a war or armed conflict. For example, the United Nations Economic and Social Council (2009, p. 2) noted that "there is a strong bi-directional link between poverty and disability": disability can cause poverty (e.g., by lack of employment for individuals with disabilities) and that poverty can cause disability (e.g., due to poor nutrition, lack of adequate health care). Poverty and disability may exponentially increase individuals' stress loads when added to the traumatic events that can occur in a war zone (e.g., loss of living quarters, witnessing death, experiencing rape, or other kinds of interpersonal violence). Please see McDevitt-Murphy, Casey, and Cogdal's chapter (Chapter 13) for an overview on healing from the trauma of rape in conflict-affected areas.

Referring to the treatment of disability in war, the International Federation of Red Cross and Red Crescent Societies (2007) noted that war-related disasters create disability and that those with disabilities that existed *before* the war may become marginalized and excluded even more than prior to its occurrence (e.g., individuals with war wounds might receive more services and attention than those with disabilities that existed prior to the war). This agency noted that those with injuries sustained during the war or armed conflict may be vulnerable to developing a permanent disability, due to the lack of medical services, social support services, malnutrition, a changed environment, inaccessible and discriminatory humanitarian aid services, or even discrimination among individuals with disabilities in receipt of services. The International Federation of Red Cross and Red Crescent Societies also described how the existence of a disability can create difficulties in disaster risk-reduction measures, ranging from trying to secure one's house before a disaster strikes (i.e., in the context of war) to conducting post-disaster cleanup, or not receiving appropriate warning information about a disaster or conflict because the information was not put in formats that were accessible for certain types of disabilities.

Posttraumatic Reactions and Disability

Regarding reactions to traumatic events, Terr (1991) posited that there were two types of traumatic stress responses that individuals may experience after a trauma: type 1 traumatic responses following unanticipated, one-time events (e.g., hurricanes, rapes) and type 2 traumatic reactions to long-term, repeated traumatic exposure (e.g., childhood sexual abuse, political torture). Terr also noted the existence of "cross-over" traumas, which she defined as sudden events that cause a disability and that may trigger both type 1 and 2 traumatic reactions because the onset of a disability may be a one-time event with long-term, continuous consequences. This indicates that the psychological response to an injury or disability may consist of a complex set of traumatic reactions.

Individuals with disabilities have many factors that make them more vulnerable to traumatic events and may increase their traumatic stress reactions. Factors may include being unemployed and thus often not living in secure, safe environments, being isolated and visibly vulnerable (e.g., to attacks or robberies), being dependent on others for care and/or being in institutions and thus more vulnerable to abuse (Mueser, Hiday, Goodman, & Valenti-Hein, 2003). In addition, in situations of conflict or disaster, individuals with disabilities may not be able to flee dangerous environments, to navigate in destroyed streets and buildings, and to obtain supplies (e.g., food and water) from outside sources; these physical and medical challenges are in addition to the previously existing "obstacles in the social landscape of their communities" (Mueser, Hiday, Goodman, & Valenti-Hein, 2003, p. 136), such as social stigma and discrimination.

There is a huge body of research on posttraumatic stress disorder (PTSD) and the kinds of traumatic events that have the most psychological impact on individuals. In

a second article about their meta-analysis of trauma studies, Norris, Friedman, and Watson (2002) documented the association, found in numerous studies, between injury and poor psychosocial outcomes; they also stated that injury (and threat of or loss of life) was one of four event factors in disasters that appeared to exhibit the greatest impact and to require widespread, professional mental-health interventions, in order to curtail the risk of severe, chronic psychological impairment. In Hobfoll and de Vries' (1995, Appendix A) list of risk factors for developing PTSD or other forms of mental issues, some of these factors were related to disability or injury (i.e., experiencing physical harm or injury during a disaster, the intentional harm of an individual, or the visibility of an injury to others). Hobfoll and de Vries also listed other risk factors for PTSD as including whether individuals were members of a group that lived on the "margin" of society or were part of a group that is likely to be overlooked, which is often the case with individuals with physical or psychiatric disabilities.

Ursano, Fullerton, and Norwood (1995) depicted physical injury (measured by number of injured and type of injury) as one indicator of the severity of a disaster. They also stated that physical injury is a risk factor for the development of a psychiatric disorder, "reflecting both their high level of exposure to life threat and the added persistent reminders and additional stress burden accompanying an injury" (p. 199). They noted that not many empirical studies have been published on this topic. Ursano, Fullerton, and Norwood described other physical ramifications of disasters that may add to an individual's stress load, which can include injuries, head trauma, metabolic problems due to disturbed food and water intake, infections, water-borne illnesses, and lack of access to regularly taken medications. The aforementioned research suggests that as part of post-conflict rehabilitation, disability-related trauma must be addressed on the individual level, in addition to providing community-focused interventions.

There is a growing trend among researchers and field clinicians to assess for and treat not only traumatic stress reactions, such as PTSD, but other psychological consequences of surviving war and conflict, such as anxiety, depression, and a array of adaptive or non-adaptive coping responses. In a chapter on PTSD and co-occurring disorders, McFarlane (2004) described a range of models (e.g., Psychodynamic Model, Common Diathesis Model, Interactional Model) that suggest ways of understanding the existence of multiple psychological disorders after a traumatic event. Tanielian and Jaycox's (2008) extensive document on the "Invisible wounds of war" listed PTSD, depression, and traumatic brain injury (TBI) as primary mental-health and cognitive disorders arising from participation in a war zone. Campbell, Pickett, and Yoash-Gantz's chapter (Chapter 8) in the present book describes the processes by which U.S. veterans are assisted. In addition, Chapter 11 by Van Vliet and Chapter 12 by Johnson and Chronister detail research that examines other aspects of the psychological sequelae of war, and Chapter 15 by Ohry and Solomon describes research on the psychological impact of being a prisoner of war.

Readers, who are interested in the range of possible psychological responses after the onset of disability, should refer to texts in the field of rehabilitation psychology (e.g., Frank & Elliott, 2000; Livneh & Antonak, 1997; Martz & Livneh, 2007);

Wright, 1983). Other chapter authors in this book also emphasize that PTSD should not be the sole psychological focus after war or armed conflicts (e.g., Chapter 15 by Ohry & Solomon, and Chapter 16 by Schauer & Schauer).

Psychological Reactions After War or Armed Conflict

As previously mentioned, even if individuals do not experience the direct physical impact of war or armed conflict in the direct form of injury, or disability, or other interpersonal losses, such as family and friends, they may experience stressful effects resulting from the destruction of a part of a country's infrastructure, such as the loss of jobs, health care, and normally available resources (e.g., food, clean water, electricity). The stress caused by the breakdown of political, social, and economic systems can multiply the effects of individually experienced stress; for this reason, a sole focus on identifying and treating posttraumatic stress reactions (e.g., PTSD) would provide an imbalanced perspective, which not only discounts the numerous environmental stressors after war (e.g., fighting for basic survival, seeking food, water, and shelter), but also frames psychological reactions primarily in terms of pathological processes.

Some literature on posttraumatic adaptation and growth has been published. Tedeschi and Calhoun (1996) reviewed such literature, as well as created an instrument called the Posttraumatic Growth Inventory. This scale was based on the concept that growth can occur after trauma and that positive events after trauma may occur in three areas: (a) alterations in the self-perception, such as emotional growth and a new sense of strength; (b) changes in relationships with others, such as a greater appreciation of and sensitivity to one's relationships, an awareness of how quickly those relationships can be lost, a greater emotional expressiveness, and learning how to develop more positive intimate relationships with others; and (c) changes in the philosophy about life and in some of the assumptions about life, such as a greater appreciation and enjoyment of life, living a more fulfilling and meaningful life, and developing a heightened spirituality.

Unwanted recalling of traumatic memories, such as intrusions and flashbacks, do not necessarily have to be viewed as pathological, but as part of a psychological healing process; this will be explained in more detail in Martz and Lindy's chapter (Chapter 2). For example, Freud's concept of the defense mechanism of "repetition compulsion," which was an extension of his stimulus barrier formulation, explained the revisiting of traumatic events as active efforts to cope with and master the situation, rather than the passivity of the trauma when it was first experienced (Brett, 1993). The concept of a non-adaptive response to trauma gradually evolved into a reactive process to trauma that did not necessarily reflect an underlying psychological disorder in one's personality. Currently, PTSD is viewed by some trauma researchers as a process of adaptation to trauma (Lifton, 1988; McFarlane, 2000; O'Brien, 1998; Van der Kolk, McFarlane, & Van der Hart, 1996).

Lifton (1988, 1993) depicted PTSD as a normal adaptive process of reaction to extreme stress or an abnormal situation. Yet, the low prevalence rates of PTSD

assessed in some traumatized populations demonstrate that PTSD is not necessarily a normative reaction to trauma. Though many researchers continue to debate whether PTSD should be viewed as a mental disorder versus as a reactive, adaptive process to trauma, Wilson (1995) commented that "the psychopathology of traumatic reactions is discerned when the presence of the symptoms persists and exerts an adverse effect on adaptive functioning" (p. 19). Lifton (1988) viewed posttraumatic stress reactions as "an effort or restore or create anew the reintegration of the self" (p. 30). According to Lifton, posttraumatic symptoms are both adaptive and necessary for the traumatized part of the self to be integrated into the larger self.

Mastery over psychological trauma is evident when individuals have authority over the memory processes and can choose whether or not to think about the trauma (Harvey, 1996), in contrast to intrusive memories of the trauma that may impinge upon the person without apparent control over such occurrences. In addition, an individual's emotional reactions related to the trauma will no longer consist of overwhelming memories with the "terrible immediacy and fierce intensity" as they used to have (Harvey, 1996, p. 12). According to Harvey, the following conditions reflect mastery over traumatic memories: (a) traumatic memories are experienced as controllable; (b) other emotions are tolerable and are differentiated from the affective reactions to the trauma; (c) other symptoms related to the trauma may be present or occur sometimes, but they are predictable and manageable, such as reactions to stimuli that remind the person of traumatic events; (d) restoration of self-esteem and self-caring behaviors; and (e) the pursuit of a self-fulfilling life. In addition, if trauma has included the victimization and betrayal of trust by others, the possible reaction of isolation and avoidance of interpersonal relations will be replaced by an expansion of their social networks, a new striving to trust people, and views "the possibility of intimate connectedness with some degree of optimism" (Harvey, 1996, p. 13). Harvey proposed that a final sign that individuals have healed from their trauma is their ability to name and grieve their traumatic pasts, while finding meanings that are both "life-affirming and self-affirming" (1996, p. 13), such as finding new strength, compassion, social action, or spiritual growth.

While a body of research is rapidly expanding about the psychological consequences of trauma, such as in the aftermath of war (Tanielian & Jaycox, 2008; Wilson & Raphael, 1993), the reverse of the aforementioned association may also be true: psychological disequilibrium can lead to war. That is, unresolved, inter-group psychological issues (e.g., hatred, disagreements over boundaries, inter-group hostilities, or aggression against other groups) can create conditions that lead to widespread violence and escalating conflict. In Solomon, Greenberg, and Pyszczynski's (2003) Terror Management Theory, they argued that three psychological factors—the psychological threat posed by others who are different than ourselves, the tendency to scapegoat others, and rigid adherence to one's identities (e.g., as part of a certain cultural identification)—contribute to war and inter-group conflict. Olweean (2003) noted that "psychological and emotional injuries may be the most enduring effects of war" but often are the "least addressed" (p. 271). He also noted that "communal psychological wounds are one of the most—if not the most—powerful fuel of war and violent conflicts" (p. 271). Based on their clinical

experiments, Solomon, Greenberg, and Pyszczynski asserted that ultimately the aforementioned three factors arise from humans' fear of death and from a projection of that fear on others, such as by asserting power or annihilating those who do not share our particular worldview.

While post-war medical and physical issues are often given priority over the mental-health ramifications of exposure to psychologically traumatizing events, it is understandable that agencies address the urgent need to provide sanitation, water, food, and other necessities of living over psychological ones after conflict or war. International organizations, such as various United Nations (UN) branches, and humanitarian non-governmental organizations (NGO) have focused on providing the basic necessities of survival and treatment of acute medical needs after natural or human-made disasters. Yet, Mollica, Cuit, McInnes, and Massagli (2002) commented that one consequence of this focus on acute aid responses is a general neglect of the mental-health needs of individuals in post-conflict zones.

In this book, Schauer and Schauer (see Chapter 16) presented strong arguments for providing evidence-based psychological rehabilitation, which they assert may help to interrupt the cycles of violence and under-development in countries. They and others propose that the treatment of mental-health issues on the individual and communal level may help to prevent future armed conflicts and thus should be considered as an integral part of post-conflict rehabilitation. Further, learning how to reach reconciliation, which is the topic of Worthington and Aten's chapter (Chapter 3), also can prevent the reoccurrence of armed conflicts. As del Castillo (2008, p. 270) noted, "One thing the UN cannot do—or anybody else for that matter—is to impose reconciliation" on populations in post-conflict environments.

A Multidimensional Approach to Rehabilitation Interventions

Rehabilitation interventions can be discussed on two levels: responses to the stress created by injuries and disabilities (*individual-level rehabilitation*) and the responses to the destruction of a community or country's infrastructure (*community-level rehabilitation*) after war or armed conflict occurs. In view that there is an interaction between the many disturbances and stressors that can occur on these two levels, multidimensional models of intervention will be discussed as a means of understanding the ripple effects of war or armed conflict on human lives.

Definition of Individual-Level Rehabilitation

Generally speaking, rehabilitation is viewed as a time-limited intervention to facilitate more independent functioning for individuals with injury or disability. Thus, while there may be various shades of meaning in different cultures, *individual-level rehabilitation* is viewed as a holistic intervention for helping individuals live with an injury, chronic illness, or disability; the intervention can encompass multiple aspects

of an individual's life (e.g., vocational, social, familial, economic, recreational). The United Nations (2009a) defined rehabilitation for individuals as the following:

> [A] goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment.

For decades, rehabilitation philosophy has been viewed as holistic and multidimensional; its perspective includes understanding the effects of the person interacting with their environment (Wright, 1983). Some models of rehabilitation (i.e., the "social model") have claimed that it is an inaccessible environment, not individual factors, that "disables" individuals. Yet, the World Health Organization's (2009a) latest definition of disability includes an interaction of *both* individual factors and environmental factors, which are explained in the context of a continuum of health; this will be the definition of disability that is adopted in this book.

Individual-level rehabilitation interventions may include the following types of services (United Nations, 2009c): a diagnosis of disability, which may necessitate medical care and treatment; social, psychological, and other types (e.g., interpersonal) of counseling; training in activities of daily living (i.e., self-care), which may include mobility, communication, and self-care and may require specialized forms of accommodations (e.g., hearing aids or sign language, Braille print, mobility aids); and vocational rehabilitation services, which may include training and assistance in obtaining and maintaining employment. While individual-level rehabilitation interventions can occur in many different forms, physical rehabilitation and vocational rehabilitation are the two most commonly known. For a detailed overview of human physical rehabilitation, please refer to Rockhold's chapter (Chapter 7) in this book. Zanskas' chapter (Chapter 6) mentions vocational rehabilitation, while three other chapters (Chapter 8 by Campbell, Picket, & Yoash-Gantz; Chapter 9 by Maedl, Schauer, Odenwald, & Elbert; and Chapter 10 by McDonald) examine, in detail, various aspects of psychological rehabilitation.

In the twentieth century, numerous countries passed national laws to protect individuals with disabilities from discrimination and to provide a minimal level of community accessibility (e.g., the U.S.'s 1991 Americans with Disabilities Act). Groups of nations, such as those participating in the Organization for Security and Co-operation in Europe (OSCE), have made agreements on policies about how to treat individuals with disabilities. For example, OSCE-participating states made an agreement in 1991 to protect the human rights, equal opportunities of, and access to programs and services specifically by individuals with disabilities, in addition to vocational and social rehabilitation (OSCE, 2005). The International Labor Organization (ILO) also has worked for many years to improve the rights and treatment of individuals with disabilities in the workplace (ILO, 2009). More recently, the United Nations Convention of the Rights of People with Disabilities (United Nations, 2009d) entered into force as an international treaty covering the human

rights of individuals with disabilities in multiple areas of their lives. This extensive convention includes one section related to rehabilitation.

Despite international and national laws banning discrimination against individuals with disabilities, their experiences in a war zone may be full of extreme difficulty. For example, if most of the community or country is living in a survival mode due to society-wide destruction during war, it is possible that individuals with disabilities may be viewed as a lower priority group for assistance and humanitarian aid. This may occur because individuals with disabilities might be perceived as requiring the most help (and sometimes sustained help) to function independently. Thus, help and resources may be directed to those without disabilities, who are viewed as able to become independent more quickly. This diversion of resources is one reason why there has been a movement to intentionally include disability as a cross-cutting issue in programs such as poverty-reduction strategies (Handicap International and Christoffel-Blindenmission, 2006).

Definition of Community-Level Rehabilitation

In contrast to individual-level rehabilitation, broad-based or *community-level rehabilitation* is an intervention with the *community as its focus*. This form of rehabilitation should be distinguished from community-based rehabilitation (CBR), which is a form of rehabilitation that is practiced with individuals in developing countries (CBR is the subject of Dr. Eide's research, Chapter 5). According to the Commission of the European Communities (1996), community-level rehabilitation can be defined as

> An overall, dynamic and intermediate strategy of institutional reform and reinforcement, of reconstruction and improvement of infrastructure and services, supporting the initiatives and actions of the populations concerned, in the political, economic and social domains, and aimed towards the resumption of sustainable development. People—both victims and participants in violent conflicts—must be reintegrated into civil society, in its economic, social and political aspects (p. 7).

The Commission of the European Communities (1996) defined rehabilitation on the community level as consisting of "restoring productive capacities and providing everyone with a certain access to basic means of production (land, seeds, tools)" (p. 13).

Further, the New Partnership for Africa's Development (2005) defined community-level rehabilitation as

> [A]ction aimed at reconstructing and rehabilitating infrastructure that can save or support livelihoods. It overlaps with emergency relief and is typically targeted for achievement within the first two years after the conflict has ended (p. iii).

OSCE-participating states have agreed that the OSCE "has to be an integral part of the complex rehabilitation effort" (2001, p. 35) by addressing multifaceted issues, such as economic rehabilitation, institution-building, rule of law, encouraging civic

participation, and helping to address the environmental impact of armed conflicts. All of these suggested activities reflect community-level interventions.

Community-level rehabilitation can be distinguished from two other types of community-level interventions: (1) the humanitarian aid that is given in response to acute disasters and (2) the more long-term programs of development. The Commission of the European Communities (2001) noted that the first type of assistance (humanitarian aid for acute crises) was typically provided through non-governmental organization and international aid organizations, while the latter type (i.e., developmental programs) was created by programs in collaboration with the partner country, in order to agree upon development policies and strategies.

Rehabilitation can be viewed as the intermediate "link" between relief assistance for emergency situations and the developmental planning. This continuum of community-level interventions can be simply described as "emergency-rehabilitation-development" (Commission of the European Communities, 1996, p. 12). Or, in another model, it is called "emergency-transition-development" (New Partnership for Africa's Development, 2005). Yet, De Zeeuw (2001) cautioned that calling rehabilitation as the intermediate link is an artificial distinction and that a large amount of overlap exists between relief assistance, rehabilitation, and developmental programs. Further, he noted that this "continuum" model has largely been discredited and that a "conceptually a more integrated and multi-directional approach for relief, rehabilitation, and development is being put forward. . . [that] takes into account the more inclusive, coexisting, and even overlapping aspects of relief, rehabilitation, and development and channels the appropriate mix of assistance activities to a specific conflict situation" (De Zeeuw, 2001, p. 12).

The United Nations Relief and Rehabilitation Administration (UNRRA) was an example of broad-based community rehabilitation. UNRRA had a short existence (1943–1949), but provided billions of dollars to help multiple countries after the end of World War II (Yale Law School, 2008). Modern-day efforts in assisting the rehabilitation of countries still occur and typically require extensive funding. According to Lefèbvre (2003), the European Union funded international projects for the post-conflict and socioeconomic rehabilitation sector totalled 277,236,341 Euros. Yet, economic rehabilitation appears to be the primary or typical focus of post-war reconstruction efforts. For example, in an extensive grid that mapped out post-war interventions, the United States Department of State (2005) mentioned rehabilitation only once, and economic rehabilitation was the sole type of rehabilitation that was listed. However, the importance of an economic focus should not be derided.

After war or armed conflict ends, the process by which community-level restoration occurs typically begins with implementing the political agreements that ended the war, which then proceeds toward economic re-establishment. Yet, it is noted that this process is not linear:

> Field experience from post-conflict rehabilitation confirms that the resolution of regional conflicts is a precondition for large-scale political and economic co-operation, but that, conversely, economic activities can also give a decisive thrust to the peace process (OSCE, 2001, p. 38).

Reconstruction is a term that should be distinguished from rehabilitation. On the international level, reconstruction is defined as a broad-based rebuilding of countries after conflict or war, especially in terms of rebuilding infrastructure (e.g., governmental functioning and physical resources, such as roads). Reconstruction can be viewed as part of development. Rehabilitation, on the other hand, refers to the *healing and repair on a human dimension* (*both psychological and physical*). This may include interventions on the individual level, such as for psychological trauma or physical injuries/disabilities of individuals, to interventions on the community level, such as the economic, social, and political restoration and reintegration of groups of people.

Frameworks for Individual-Level Interventions

The International Disability and Development Consortium (2000) published a multifaceted report on disability and conflict—ranging from suggestions on actions to take in pre-conflict to post-conflict situations—framed in terms of what, how, and who. They noted that in post-conflict situations, the government structure is typically very fragile and not able to provide specialized services and that non-governmental organizations (both national and international) play a big role in providing services to individuals with disabilities. Mueser, Hiday, Goodman, and Valenti-Hein (2003) also made recommendations of how to address disability issues on various levels (i.e., international/national, community, institutional, families, and individuals) in times of war and peace. The layered nature of their proposed interventions focusing on disability-related issues reflected a multidimensional framework of rehabilitation interventions.

Regarding other specialized kinds of individual interventions, programs have been developed that focus on assisting individuals who were former combatants (whether in formal military groups or non-state military organizations). These are called disarmament, demobilization, reintegration (DDR) programs, or disarmament, demobilization, rehabilitation, and reconstruction (DDRR) programs. The United Nations agencies coordinate a program called the "4R's": repatriation, reintegration, rehabilitation, and reconstruction (United Nations Development Program, 2009). The topic of DDR types of interventions on the individual level will be addressed in Chapter 9 by Maedl, Schauer, Odenwald, & Elbert. Del Castillo (2008) noted the difficulties in reintegrating targeted groups:

> No peace process has ever succeeded without the reintegration of former combatants, as well as other groups affected by the conflict, taking place in an effective manner. This is because effective reintegration promotes security by limiting the incentives to these groups to act as spoilers. Reintegration, however, is the longest and one of the most expensive reconstruction activities. . .[and] is typically neglected, as major donors shy away from open-ended commitments to the costly social and economic programs that are often essential for sustainable peace (p. 257).

Vocational Rehabilitation As an Intervention

> From the point of view of psychiatry, it is important that these individuals [who have traumatic memories] should be re-engaged at any cost in some form of activity (Kardiner, 1941, p. 236).

Vocational rehabilitation is a small but growing field that focuses on helping individuals with physical or psychiatric disabilities to obtain competitive employment as a means for greater independence and economic stability. While vocational rehabilitation is typically defined as an individually tailored intervention, it reflects the intersection of individuals with communities: that is, it is an intervention provided to individuals with disabilities for not only becoming economically more independent, but also for integrating into the community. Such an intervention also can cause changes in the community. For example, helping individuals with disabilities obtain employment may be one of the best forms of social inclusion and devices to change negative attitudes toward individuals with disabilities that exist in the community. A substantial amount of empirical research and books has been published in recent years on the topic of vocational rehabilitation for those with psychiatric disorders (for overviews and intervention ideas, see Anthony, Cohen, & Farkas, 2001; Fischler & Booth, 1999; Pratt, Gill, Barrett, & Roberts, 2007), but the topic of trauma has not yet been integrated into this research.

Limited research has been conducted on employment after post-conflict situations. The International Labor Organization (1998) is one exception; they have worked in the area of employment in post-conflict environments. Further, in Mollica, Cuit, McInnes, and Massagli's (2002) research among Cambodian refugees ($n = 993$), the only significant risk factor for depression (after controlling for demographics and trauma) was having a non-working status. They suggested that "work introduced during the early phases of the refugee crisis may have a significant antidepressant effect on traumatized refugee survivors" (p. 164) and that vocational rehabilitation interventions can be a beneficial shift away from a focus on trauma or pathology. This research suggests that vocational rehabilitation can be a powerful intervention that can assist individuals in recovery after war or armed conflict. However, there is a paucity of empirical studies specifically on disability and employment in post-conflict environments.

Reintegration programs can be described as an individual-level intervention, although they require systemic planning (as do other forms of individual rehabilitation) and targets certain groups, such as former combatants. Del Castillo (2008) observed that

> There can be different avenues for reintegration. Reintegration often takes place through the agricultural sector, micro-enterprises, fellowships for technical and university training, and even through the incorporation of former combatants into new police forces, the national army, or political parties. Reintegration programs for the disabled are particularly important. These involve not only short-run emergency medical rehabilitation. . . .but also programs to reintegrate as many as possible into the productive life of the country. . . (p. 259).