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Bringing Order Out of Chaos: A Culturally Competent Approach to Managing the Problems of Refugees and Victims of Organized Violence

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The collaborative program of the Transcultural Psychosocial Organization (TPO) provides a community-oriented and culturally sensitive public health response to the psychosocial problems of refugees and victims of organized violence. This paper describes the 9-step model that TPO has developed as a blueprint for each new intervention. Beneficiaries participate in determining priorities and there is an orientation toward culturally competent training, capacity-building, and sustainability. Two cases, one related to Sudanese refugees in Uganda and the other to internally displaced persons and returnees in postwar Cambodia, show how the TPO intervention protocol is adapted to local settings. The paper provides preliminary evaluative comments on the model's performance.

KEY WORDS: community-oriented; public mental health; posttraumatic stress; traditional healing; culture; cultural competence.

The international refugee problem is of alarming proportions. One out of every 275 persons on Earth is "of concern" to United Nations High Commissioner for Refugees (UNHCR, 2002). More than 21 million are displaced within their own country, a 25% increase on the year before. Many are afflicted by formally definable mental health illness and all can be said to have psychosocial difficulties.

Eighty percent of refugees are women and children (Forbes, 1992) and together with the elderly are obviously vulnerable (Desjarlais, Eisenberg, Good, & Kleinman, 1995). Families face the added stress of high infant mortality rates, and resort where possible to culturally familiar coping strategies (Eisenbruch, 1998). Men are vulnerable in different ways, often seriously afflicted by a threat to their former social identity. The surviving elderly often carry a heavy responsibility as the bearers to the younger generation of cultural values. There is continuing debate whether rates of PTSD in survivors of community violence are enduring or transient (Becker, Weine, Vojvoda, & McGlashan, 1999; Berthold, 1999), and how well PTSD can assess the multiple effects of torture and trauma (Silove, 1999).

Many refugees live in camps that have become "total institutions" with the attendant "process of mortification"(Goffman, 1961). Dependency is a feature in many camps and especially in those that reproduce the authoritarian regimes from which the refugees escaped (Marsella, Bornemann, Ekblad, & Orley, 1994). Others are suffering from the multiple traumatic effects of torture. Nor is going "home" necessarily a solution. An outbreak of peace may mean fewer violent deaths but entering the repatriation and resettlement phase of the cycle is yet another challenge for the disempowered (Eisenbruch, 1997; Tseng, Cheng, Chen, Hwang, & Hsu, 1993).

Research into postconflict sequelae has been focused on symptoms rather than on full psychiatric diagnostic assessment (de Jong, Komproe, & Van Ommeren, 2003).

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The few studies carried out in Asia and Africa, where most refugees are located and from where the cases described are drawn, provide evidence that a significant proportion have formal psychological problems such as psychosis, posttraumatic stress disorder, or depression (Mollica et al., 1993; de Jong, 2002; Van Ommeren et al., 2001). Earlier studies focus on epidemiology or on potential ameliorative factors for refugee mental health (Punamaki, 1990; Ressler, Boothby, & Steinbock, 1988), whereas later studies venture treatment suggestions and propose scrutiny of the subjective experience of survivors of torture (Silove, 1999; Wilson & Raphael, 1993).

In response to this large-scale psychological and social suffering in environments with little or no mental health infrastructure, and supported by the growing literature attesting to the value of traditional healing in postwar contexts (Bracken, Giller, & Summerfield, 1995; Gibbs, 1994; Taussig, 1986; Wilson, 1989) the Transcultural Psychosocial Organization (TPO) has over the past decade sought to develop and refine a multidisciplinary, collaborative, sustainable, and culturally sensitive trauma intervention program with a strong capacity-building element. The Organization fields approximately 400 staff for a target group of 7 million people in 15 countries through Africa, Asia, and Europe.

The perspective of local people in emergency situations is often very different from external imposed categories. The Angolan refugee perspective described by Bakewell (Bakewell, 2000) is a clear illustration of this. Angolan refugees had dissolved into Zambian border villages to the extent that it was not possible for humanitarian agencies to target their efforts by trying to distinguish between refugees and hosts.

The right treatment in the wrong cultural garb, with the best of intentions, may further undermine identity and might exacerbate signs of posttraumatic stress disorder. Schreiber (1995) documents the case of an Ethiopian woman who lost a child whilst fleeing her country and was unable to undergo traditional purification rituals. Her symptoms for 2 years were interpreted as bronchial asthma, then psychosis, and only resolved when purification rituals were performed after her symptoms were diagnosed correctly as bereavement. The TPO program therefore strives to attain culturally competent diagnosis and clinical management. Each TPO project integrates as far as possible traditional, local, and Western healing methods. Programs integrate experience and methodologies from public health, psychology, psychiatry, and anthropology in order to find practical solutions to the complex problems of cross-cultural mental health diagnosis, effective interventions, and ongoing management. With sustainability and capacity-building in mind, the program emphasizes community participation, training and supervision, and the use of community resources.

Method

This paper describes the methodology of the TPO program and how it operates within the host country. Two case examples, one from Africa and one from Asia, highlight the ways in which the nine steps in TPO's intervention protocol are adapted to local settings.

Each TPO program follows a nine-step protocol, developed by one of the authors (J de J), which serves as a blueprint and combines intervention and action research as shown in Table 1. The methodology aims to capture idiomatic descriptions of mental health problems that fit local cultural illness experiences. In this way indigenous coping strategies are bolstered. The research aspects of the program underpin the structure of the TPO methodology and implementation.

Program Implementation

TPO works in countries and refugee situations by invitation. There is a memorandum of understanding and a definite association with at least one government department, such as the Ministry of Health, Women's Affairs, or

Table 1. TPO Protocol for Intervention and Action Research

Step	Activity	Intervention	Research
1	Selection of participating area including a matching control group	+	+
2	Identification of psychosocial problems, stress responses and trauma, cultural validation of instruments	+	+
3	Pilot multicenter training program and pilot psychosocial interventions	+	
4	Pilot testing structured interviews, sample selection, culturally informed epidemiological survey		+
5	Design of a monitoring system	+	+
6	Modify psychosocial intervention program, stimulate rural development initiatives		+
7	Optional studies		+
8	Evaluation of the pilot phase	+	+
9	Transferring the program through training and evaluation	+	+

Social Development. Local programs are established on the initiative of local organizations with the will to commit for the necessary number of years. The program arrives into a desolate mental health context, with next to none trained mental health workers, and local officials focusing on more immediate priorities.

In each country, primary participant research identifies the local understanding of distress and the local system of treatment, such systems having evolved over centuries and been used by the society to positive effect in its estimation. Training manuals are created in local and Western languages that weave the most salient (as defined by the recipients) local, traditional healing methods with Western healing protocols. This participant research informs the direction of the program.

Local staff may have little formal training, since most of the low-income and postwar countries where the program is active have few, if any, psychologists or psychiatrists. A core group is trained which fans out to train others as community workers, some of whom in turn become trainers. As the program develops, it is gradually handed over to local people to manage. The expatriate NGO gains host country registration and begins to function as a local NGO.

The intervention strategy uses a combination of Western and local methods. Without delay, expatriate trainers "exchange" knowledge and upgrade the knowledge and skills of local members of the core group about the consequences of trauma—even if the local cultural concepts of trauma do not match Western categories.

The process is best elucidated by referring to an actual intervention. The scenario evolved as follows in Cambodia. Before the civil war, Buddhist meditation was regarded as one effective way of dealing with stress. Monks stayed in their monasteries and their "patients" came to them. During the Khmer Rouge regime, the social structures of Buddhism and of traditional healing were all but destroyed but with postwar reconstruction they were beginning to resurface. So TPO actively involved the traditional healing sector: Buddhist monks, *kruu* (professional traditional healers), mediums, and traditional birth attendants. In due course, some monks were recruited into core training groups, expanding the canvas of the core group work and in turn were enriched by grounding in a mental health framework. With a more proactive focus, some monks subsequently emerged from their monasteries to visit depressed people at home, regaining a significant role in society and strengthening a local mental health infrastructure. A similar approach was followed by reempowering traditional village leaders to engage in socially constructive activities that many had to give up during the previous regimes.

Both preventative and curative interventions are used and they take a different form to the treatment regimes of the developed West. The TPO model adopts a community-based approach to mental health and starts in the village. Rehabilitation may come through, for example, a return to crop production increasing self-esteem. Interventions may take the form of rural development initiatives, vocational skills training and income-generating activities, public education, community empowerment, crisis intervention, capacity-building, family reunion, group activities with children, strengthening coping skills, as well as managing particular identified cases (cf. de Jong, 2001). TPO conducts participatory action research in order to evaluate programs in each country, with local staff quickly involved. In this way, local capacity is built to continue evaluation after TPO's departure.

The identification and assessment of psychosocial and mental health problems takes place by means of a multimethod approach combining qualitative ethnographic with quantitative epidemiological methods. This helps to elicit indigenous coping strategies and culturally mediated protective factors. The latter are used for training and for reinforcing self-management and self-help activities within the framework of a psychosocial intervention program. In addition, different categories of people who will be trained by the program are identified. The sessions produce culturally relevant material on grief, trauma, and coping and is used to upgrade the existing training manuals for health workers, teachers, and local healers and to design preventive interventions in the field of psychosocial assistance and mental health (de Jong, 1995).

The implementation of this culture-specific approach is discussed in relation to two settings. The first case, drawn from northern Uganda, highlights intervention activities related to: initiating contact with the target population; focus groups, and themes; involvement of traditional healers; the multicenter core group training program; post-training support activities; and the handover process to the local organization. The second, drawn from Cambodia, highlights activities related to the inclusion and integration of culture-specific selection criteria for the identification of psychosocial problems; pilot development of modules for data collection; comparison of Western and traditional clinical profiles; interviewing and surveying the population; feedback into the intervention program and modification of it; and the interventions of the core group.

Case One—Northern Uganda

TPO was invited to work in northern Uganda in 1994 in the hope it might assist 150,000 Sudanese refugees

living under difficult conditions in transit centers, camps, and rural settlements on both sides of the Nile. This group of refugees was indeed found to have high rates of trauma and psychosocial problems (Peltzer, 1999) and Sudanese children in the camps reported significantly more depressive and PTSD complaints and behavioral problems than Ugandan children (Paardekooper, de Jong, & Hermanns, 1999). From 1999 onwards, the program was extended to provide psychosocial and mental health services for 500,000 Ugandans living in the same area.

Contact was initially made with government and other officials from every administrative level in the camp. A discussion was held on the nature and scope of the problems confronting the refugees. Subsequently, focus groups were formed, with informants selected as representative of the various ethnic groups and both sexes, who enjoyed respect and trust in the community, were community residents, and who had contacts with many people or with a specific part of the community. They included welfare community chairmen, chiefs, block leaders, religious leaders, youth groups, women leaders, elders, healers, health workers, teachers, and income-generating groups.

The focus groups explored themes including opinions about the personal and social consequences of psychological problems as perceived by the refugees; explanatory models on the population level (Kleinman, 1980); opinions about positive coping strategies and protective modifiers such as mutual help, employment, the presence of human rights organizations, cultural practices (bereavement, possession cults/religious practices, creation of networks in case of disruption of the extended family, political movements); help-seeking behavior; information about health care facilities, relief organizations, and local or allopathic practitioners, or healing cults. Demographic data were also collected.

These data yielded priority problems. Environmental problems were related to overcrowding; medical problems focused on poor sanitation and high infant mortality rate; food problems related to shortages and changing food ratios; and social problems were connected to for example, alcohol and unlawful detention. Participants also mentioned traumatic events such as killing in public, rape, looting, bombardments, torture, and forced conscription; trauma problems and symptoms such as *azilasa*, pain in the heart and *lungoro nateiliy*, sudden shock as a reaction to a traumatic incident making the heart jump. The greatest gain in public health may be obtained by addressing clean water supplies, sanitation, and infant mortality but health gains in these areas would not eliminate the emotional reactions to trauma. Explanatory models and coping styles included hearing stories from others, praying, brewing and drinking, fishing, building and selling huts, and making musical instruments.

At the same time, an anthropologist was engaged in research among healers in order to explore problems of families and children, trauma-related folk illnesses, emotional expressions and idioms of distress, relevant rituals such as healing, purification, reconciliation, and mourning rituals in the context of the "cultural bereavement" (Eisenbruch, 1988) of the community as a whole. The information served to adapt the program and the training materials to the local culture, and to engage the healers who were invited to share part of their knowledge with the programs while being offered training on the psychological effects of trauma and ways to treat the consequences. Thus those trained initially to deal with such cases as war-related suicide attempts were later called upon to counsel those suffering from AIDS.

Twenty-five counselor candidates and two research assistants with a background in social science, health, or community development were selected from the refugee population and the surrounding Ugandan populations. After basic training the cotrainers gradually took responsibility and became part of the core team, training other health workers, teachers, or healers. The content of the training courses, the training material, and the subsequent supervision were on the basis of the WHO/UNHCR Book "Mental Health of Refugees" (de Jong & Clarke, 1996) but each site adapted it according to local demands and the cultural context. The initial training (for the core group) took place over 3–5 weeks and consisted of: a) An introduction to counseling, stress, and psychotrauma. The training elicited the participants' experience with dislocation, disruption of social networks, acculturation stress, and other traumas. b) The assessment of the seriousness of the participants' own stress responses. This assessment was done before and after the training course. c) Common stress responses and how to deal with them. The participants learned group and individual counseling techniques and directive psychotherapeutic techniques while practising with each other and dealing with their own traumas. d) Psychiatric consequences of trauma. Participants received training on the treatment of the mentally ill and on integration of mental health into their primary health care activities. For participants with limited training, basic flow charts were found to work (Essex & Gosling, 1982). For those with more training, the relevant chapter in the WHO/UNHCR book was used. The culturally enriched questionnaires were administered and discussed in subgroups. Practical exercises played an important role, and d) The use of basic forms for registration, supervision and monitoring. After the course the trainees received regular supervision from trainers and program staff.

During further training the counselors learned how to do home visits and to integrate behavioral, insight-oriented, traditional, sociopolitical and marital, family and group, and HIV-counseling. The best ten counselors were selected and after additional training started to design and implement training seminars for 300 psychiatric nurses, medical assistants, pastoral workers, local healers, and teachers. In addition they gave 1-day workshops to about 5,000 leaders, camp administrators, and development workers. The staff, teachers, healers, and pastoral workers saw refugees in groups, within their families or individually. Major psychiatric disorders were referred to medical staff who received training in integrating mental health into primary health care. Trainees received supervision from the 25 counselors or mental health workers. This refugee-oriented program has been expanded towards the Ugandan public health structure by adding a mental health component to the national primary care program. In addition to the Sudanese refugees, the program now covers about 1.5 million local Ugandans (Baron, 2002).

Case Two—Cambodia

In Cambodia the TPO approach was applied to the rehabilitation process of the nation divided—those resettled, those repatriated, and those who had faced internal displacement within Cambodia's borders had to be reconciled (Eisenbruch, 1994). Returnees repatriated under UNHCR schemes and internally displaced persons were included in the program and were found to be suffering similar pain. Low intensity warfare was still threatening those people who had remained in the country and although the first batch of physicians was being trained in psychiatry, the country as a whole lacked any mental health system, and the entire population had endured massive and successive traumatic events. It was necessary to understand the nature of psychological suffering in the Cambodian context before practical support could be offered.

The history of civil war and genocide in Cambodia had affected the whole population (van de Put & Eisenbruch, 2002). Instruments applied to discern trauma were of little use when everyone in the nation had been supersaturated by it. In order to provide assistance to the families most in need, selection criteria had to be developed – compare de Jong (2001). The research group was involved in the pilot development of eight modules for data collection: demographic data, the narrative personal history, *emic* explanatory models of mental distress (Eisenbruch & Handelman, 1989), *emic* clinical phenomenology that is phenomenology derived from the constructs of the Cambodians themselves, the Composite International Diagnostic Interview (CIDI; Wittchen et al., 1991), social networks and coping styles and help-seeking steps as connected to mental distress explanatory models. In documenting the cases, care was taken not to assume trauma as a punctuation of life history during the Pol Pot years. Instead, each person mapped their life history, spanning early development, experiences during the civil war, the Pol Pot years, the Vietnamese presence, possibly the period of flight to refugee camps and repatriation to the homeland, and current stressors like poverty, lack of health care, and fear of war or landmines. The villagers defined their problems themselves.

To identify potential roles of traditional as well as Western systems, the explanatory model profiles of the health staff and the traditional healers (*kruu*, monks, mediums, traditional birth attendants), as well as the patient's own explanatory model, were recorded. The explanatory models and clinical symptoms and signs were gathered using vernacular Khmer terms. The clinical phenomenology profiles as recorded by the Western and the traditional sector were compared, revealing the differing diagnostic formulations (Eisenbruch, 1996) and treatment rationales offered by the various healers encountered in an individual's help-seeking career.

Thus the data recorded the matching, or mismatching, between what people believed *caused* posttrauma and distress, and what they *did* about it—who they sought in the local network for help. There was an overview of the healing potential of the different resources already in place. The traditional sector did not claim to treat all mental health problems, but focused on intervention in acute situational crises, marital problems, and the resolution of neighborhood and community disputes. These were often interpreted by all as caused by spirit possession or soul loss, or by magical human intervention, that is, sorcery. Monks tended to focus on advice, calming people's anxieties, and encouraging acceptance. *Kruu*, the trained "vocational" folk healers, provided medication and magical rituals to help rid people of invading spells and spirits and, through the public performance of the ritual, to reintegrate the person into the local community. Mediums, mostly women, interceded with ancestors and in this way acted as remoralizing counselors for women who could not face their future. Traditional birth attendants helped families through difficulties around childbirth and the puerperium.

It became possible to offer focused training to the right resources, and to avoid installing ineffectual skills. Through monitoring of the training and the follow-up of 675 NGO workers, health staff, and villagers, as well as treatment of patients seen in mental health clinics set up in district and provincial hospitals, it was possible to feed back and improve interventions and curricula.

The interventions of the core group had four elements. First, awareness concerning psychosocial and mental health problems was fostered by producing appropriate materials and training local workers in psychoeducation. Second, community rebuilding was supported and the existing sectors strengthened through the right match between problems and resources. Existing resources were better equipped by offering training on the basis of a specially developed manual in English and Khmer (Somasundaram, Kann, van de Put, Eisenbruch, & Thomassen, 1997), to different groups such as teachers, health staff, healers, and NGO community workers, with new resources added at different levels, including mental health clinics at the provincial and district level. Third, villagers were trained in teams, on the basis of monitoring the effectiveness of trainees in the pilot phase, to refer families and provide psychoeducation. Fourth, self-help groups were encouraged, where women and men, even some of the most deeply alienated (for example, drunkards), could sit together on a mat in the village, for example, and acknowledge their shared anguish and suffering.

Discussion

In both of the above case settings the TPO model was adapted to the local circumstances, with exploration and incorporation of local cultural belief systems and an emphasis on local participation. The experience gained reaffirms the reality that refugees undergo a series of potentially traumatizing events as they move from war to border camps, to resettlement, to repatriation, to internal displacement. Resettlement, even though it represents escape from the awful camps, does not necessarily bring relief. The work of the program runs consistent with the findings that refugees do best if they acculturate and at the same time keep a grip on their cultural identity (Berry, 1991; Eisenbruch, 1990). TPO's impressions of culture shock are also consistent with those commonly described. Refugees, even after resettlement, show *cultural* as well as personal losses (Lipson, 1991; Schindler, 1993), and these reactions may be reactivated later in life, all of which has implications for trauma theory as well as for public mental health interventions.

Traditional healers have value as "trauma therapists" in countries recovering from war and TPO's experience, particularly in Cambodia, enhances understanding of the contribution they can make. Contexts vary from closed areas like refugee camps to open situations where the displaced population has more access to its own healing resources. In the "outbreak of peace" after the emergency phase of relief, new problems such as the AIDS epidemic have emerged in counties such as Uganda and Cambodia—here, traditional healers also have a role (Green, 2000).

The TPO program is underpinned by certain assumptions, that traumatic events are dictated by local historical experiences as well as local cultural mediation, and that understanding local idioms of distress unlocks the local clinical symptom profile of psychological and social disorder (Eisenbruch, 1992). The findings add to our understanding that a combination of local resources such as traditional healers, health care, and relief workers can ameliorate psychosocial problems of large groups, not just individuals—compare de Jong (de Jong, 2002).

Three recommendations for cross-cultural public mental health emerge. First, culture and context have to be studied on population and individual levels. Second, one should avoid the sole use of Western quantitative research instruments (to measure PTSD, for example) that are not based on culture-sensitive qualitative data (Eisenbruch, 1991), and may perpetuate the "category fallacy," with indigenous diagnoses overlooked and Western categories imposed where they have no cultural validity (Kleinman & Good, 1985). Third, given major changes among the victims of man-made or natural disaster the intended long-term outcome of programs should not be inflexibly laid down in the original design (de Jong & Van Ommeren, 2002).

As for the balance of power between local staff and expatriate NGOs, TPOs experience underlines the value of engaging and empowering local staff as early and fully as possible so that they are ready to take over.

The TPO model is in evolution. It remains somewhat synchronic and cross-sectional. More attention is now being paid to the effects of cumulative adversity and chronic trauma (Remennick, 2002). Repatriation from border camps can lead from one set of traumas into the next. Prolonged guerrilla war and displacement can force the newly returned into flight once more (Sokhet & Whiteside, 1995), with consequences for their health (Anyinam, 1995). Returnee and the local population may suffer further internal displacement, and they face the constant threat of landmines (McGrath et al., 1993), serious illness, landlessness, and poverty (Davenport, Healy, & Malone, 1995). Returnee settlements are in double jeopardy. Western treatment facilities of the camps are no longer at their disposal and even if healers and religious networks can be traced they may no longer be able to offer comfort to those returning to their villages with changed perceptions after years spent in camps abroad.

It will need to pay greater attention to culturally appropriate trauma therapy for children. Culture mediates the possible range of child responses (Aptekar & Stocklin,

1997). More than half of children exposed to war meet the criteria of PTSD (Allwood, Bell-Dolan, & Husain, 2002), levels of stress were related to war exposure (Smith, Perrin, Yule, Hacam, & Stuvland, 2002), the IES persists after the war (Dyregrov, Gjestad, & Raundalen, 2002), and those who do are at higher risk of comorbid psychiatric diagnosis (Donnelly & Amaya-Jackson, 2002). Over the past 2 years, the TPO model is being adapted in order to deal with these issues (de Jong, 2002).

It needs to vary the starting point for therapy of posttrauma in men and women. Not only are there profound cultural differences in response to trauma (Breslau, 2002), the interactions between culture and gender vary in trauma (Jenkins, 1996). There may be gender differences in underreporting rape, for example—and anecdotal evidence suggests a greater problem in some cultural contexts of rape in men than in women. It needs to refine interventions if they are to deal adequately with the role of torture, compared with other traumas, in generating posttraumatic stress symptoms (Silove, Steel, McGorry, Miles, & Drobny, 2002). It needs to refine the cultural validity of the research instruments used in the model. They also tend to focus on PTSD and may need to be modified to embrace other psychic states often overlooked in trauma research and therapy (Kirmayer, 1996; Manson, 1997; Zur, 1996). It seems to want it both ways, focusing on psychiatric, psychophysiological, and epidemiological aspects of trauma yet claiming to offer a "culturally competent" engagement with traditional views of suffering and its alleviation. It brackets "mental health" and "psychosocial" but it is not always clear whether the interventions are aimed at reduction of "PTSD," "anxiety," and "depression," or at the alleviation of suffering without necessarily improving mental health. More attention is needed on the population-based approach to prevention of PTSD (Sorenson, 2002). The model neither includes any spiritual facet nor does it indicate how quality of life is measured, culturally normed, or used. It starts a program by invitation, but is the TPO model really accepted by the host country, and how does it overcome institutional resistance? At the organizational level, there should be evidence that the TPO program has led to policy changes in departments of health and faculties of health sciences in the host country. At the individual level, it is unclear whether the TPO counselors, even if they seem to perform their "counseling" role, have accepted the TPO model itself. The initial groups are urbanized and naturally eager to absorb Western ways of counseling, but do they truly accept the traditions of their rural countrymen? It needs to clarify whether the counselors, trained to deal with PTSD, will "reinvent" themselves and contribute unwittingly to newer incarnations of posttrauma, such as the AIDS epidemics. How many armies of counselors would one need to vitiate the mass economic and social pathologies in a country such as Cambodia? How can the TPO model answer the new epidemic in which parents sell daughters, children shoot parents, lovers hurl acid, and youth descend into ecstasy? It has to confirm whether the model will work in other post-conflict settings? The examples in this paper are drawn from African and Asian settings. How might the model be useful for responding to postconflict trauma in the context of globalization and international terrorism (Alexander, 2002)?

Five domains for future research can be identified. One focus concerns intervention outcomes and the need for longitudinal or at least repeated measures (Mollica et al., 2001)–the likely time span and longer term attributes of various types of mental distress need to be better understood. Research is also needed to monitor the healing that may occur in the absence of specific intervention. The cultural competence of intervention strategies should be evaluated by a combination of cultural epidemiological and qualitative ethnographic research. Human rights issues should also be included (Silove, Steel, & Mollica, 2001). Finally, research is needed on the long-term benefits for trauma survivors of intervention, and on the sustainability of programs once the Western agencies have departed the scene.

Conclusion

The TPO program attempts to address the problems of target groups of refugees, and beyond that it seeks to be useful for structuring a systematic and integrated public mental health response to large-scale human suffering. The objective of the program is realized through a design in which experiences from diverse fields and disciplines including public health, social science, mental health care, and rural development strategies are combined. A model has been developed integrating qualitative and quantitative research methods resulting in an intervention program applicable in diverse cultural settings.

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