Implementing Collective Approaches to Massive Trauma/Loss in Western Contexts: Implications for Recovery, Peacebuilding and Development

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Introduction

Since the early 1990s there has been a growing critique of the application of western mental health approaches to assisting non-western populations following major natural and human-made catastrophes. This critique is part of a larger discussion that has developed in the international humanitarian field in attempting to clarify guidelines and best practices in psychosocial and mental health response to complex emergencies. Following the terrorist attacks in New York, London, and Madrid, and Hurricane Katrina in the Gulf Coast of the United States, it has become important for many in the trauma field to ask whether western-oriented approaches are best suited even in western contexts. There are emerging conceptual frameworks that seek to integrate individual mental health approaches within a broader population based framework to disasters. However, implementation of such approaches face enormous obstacles. In this chapter, we present the voices of Jack Saul, who worked as a mental health professional, international trainer in trauma response, and resident in Lower Manhattan following the 9/11 World Trade Center attacks, and Saliha Bava who worked to provide community engaged services to the displaced Hurricane Katrina population in Houston, Texas. They write about the challenges on the ground in implementing a "community resilience" approach following massive trauma. They highlight a number of themes they see in common from their respective contexts. They then present a set of principles in applying collective approaches to massive trauma/loss in North America, Europe, and Australia.

I.   Approaches to Massive Trauma and Loss

There have been a number of recent discussions about how to provide mental health and psychosocial services during and in the phase after war, violent conflict, terrorism, and natural disaster. Among international government agencies and non-governmental organisations, part of what has spurred this discussion has been a need to situate western biomedical and psychological models of mental health and trauma response within a larger framework of humanitarian response. The international conversations and attempts at reaching some agreed upon guidelines have emphasised methods and stages of implementation. In the United States and in other western countries, there has been a recent surge of interest and activity the area of collective and community engaged responses to mass trauma and disaster. Recent attempts to conceptualise the role of mental health interventions in catastrophe response and preparedness have stressed the development of conceptual frameworks based on research and theory from the disaster management field. This is leading to new thinking about strategies for promoting community level factors that promote individual and population wellness as well as how to assess such processes. In the following section, we present some of the discussion about the how mental heath and wellness are being approached in non-western and western countries.

Emerging Collective Approaches: Family and Community Resilience

One of the strongest critiques of the implementation of western approaches to trauma recovery in non-Western contexts is their assumption that extremely stressful experiences of war and atrocity not only cause suffering, but the this consequent "traumatisation" relocates phenomena from the social to the biopsychological realm. This may distort a counting of the human costs of war turning the resulting misery and distress into a psychological problem to be solved. Trauma is viewed within this western biomedical and psychological perspective as an individual-centred event in which the singular human being is the basic unit of study and analysis. The emphasis then of this view is on similarity rather than difference and diversity. This perspective is problematic not only in the way it fails to account for the ways in which war and other disasters impact families, communities, and larger populations, but also in the way it privileges the "memories" of singular events in catastrophes rather than on processes that are historic, ongoing, continuous, and evoking different reactions and responses over time (Summerfield, 1999).

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There have been attempts to place psychological programmes in response to massive trauma and loss into a larger social context. Ager (1997) has pointed to the tensions that have existed between approaches that are conceptualised as unique, indigenous and community based and those that are conceptualised as generalisable, technical and targeted, and most trauma programmes are defined by the latter characteristics. He proposed a four phase framework that puts psychological interventions within a larger context: (1) an initial phase in which planned interventions avoid disrupting intact protective factors such as community structures, meanings, and networks; (2) in the second phase, in which social resources that are considered too weak must be actively re-established – family reunification, community development, vocational training, etc.; (3) the third phase in which particularly vulnerable groups may need compensatory support; and (4) only when the other phases have been implemented is there a place for a fourth phase in which there is targeted therapeutic support. What is crucial for the effectiveness and sustainability of such a programme is that the voices of those for whom services are intended contribute to the design, implementation, and evaluation of such assistance (Ager, 1997).

Baron, Jensen and de Jong (2002) have proposed the "inverted pyramid" which delineated levels of mental health and psychosocial intervention ranging from security measures that must be implemented for the entire population (the top of the pyramid) to mid level interventions that support family and community networks to address problems, to the lower and narrowest part of the pyramid that includes the relatively few people who will need psychotherapeutic and psychiatric services after a catastrophe.

The training of local professionals and practitioners in mental health and psychosocial response has been discussed in a set of guidelines developed by the Task Force on International Training of the International Society for Traumatic Stress Studies (Weine, et al., 2002). In 2007, the Interagency Standing Committee of the United Nations published the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) with input from over 200 NGOs. These new guidelines focus on implementation of steps in complex humanitarian emergencies that take into consideration the particular social, political, and cultural context of the recipient populations. These guidelines highlight as core principles: the promotion of human rights and equity, maximising the participation of local populations in humanitarian response, doing no harm, building on available resources and capacities, integrating support systems, and developing a multi-layered set of complimentary supports that meet the needs of

diverse groups.

Collective trauma requires a collective response (Saul, 2006, 2007). "A collusion between therapists and patients, society and survivors, and among family members to avoid speaking about traumatic events may disrupt a sense of historical continuity, and may increase the disconnection of families and communities" (2006, p. 3). A collective response is a paradigmatic shift, which promotes resiliency and wellness.

The recent focus on resiliency in western mental health and trauma response shifts our focus from a perspective of breakdown, pathology, or disorder to one of individual and social strengths and resources accessible to the people impacted by traumatic situations (Bava, 2005, Landau & Saul, 2004; Ungar, 2008; Walsh, 1998, 2003, 2007). Models of resiliency largely focus on individual resiliency or adapt empirically established principles for individual recovery to community application (Hobfall et al, 2008). We believe that family and community resiliency needs its own conceptual framing so as to avoid falling into the trap of individualist thinking. We draw on the works of Norris, Stevens, Pfefferbaum, Wyche and Pfefferbaum, (2008), Hobfoll, (1998), Landau and Saul (2004), Ungar (2008), and Walsh (1998, 2007) to provide such frameworks. We briefly identify the key concepts provided by these various frameworks and in the subsequent section provide a critical analysis of applying the western model in the western context by drawing on narratives of implementing them in the context of 9/11 and Katrina.

Norris et al. (2008) provide a conceptual framework on community resiliency discourse for disaster preparedness in the west. An extensive review of literature is utilised to develop a conceptual framework that draws out Economic Development, Social Capital, Information and Communication, and Community Competence as four primary sets of adaptive capacities that foster community resiliency. These resources are further interfaced with robustness, redundancy, and rapidity for deployment during disasters. They view "resiliency as a process—a positive trajectory of adaptation after a disturbance, stress, or adversity" (Norris & Stevens, 2007, p. 321). Though their paper is presented as a disaster preparedness frame, we believe it may be partially extended to recovery. The authors provide a synthesis of a wide array of research on resiliency from eight disciplines, thus providing the reader with a rich conceptual source. However, due to its scope, the reader is not provided with a road map for operationalising these concepts for implementation in intervention or research. Further, the subtext of the paper assumes a geographically intact and stable community rather than a dislocated and scattered community

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like refugees and internally displaced people. Though the conceptual framework is provided as more a "rotary than a highway" (Norris et al., 2008; Norris & Stevens, 2007) that moves towards a resource rather than a psychopathological paradigm, it fails to highlight the family and relational perspective which is provided by Walsh (2007) and Ungar (2007). Further, though Norris et al. address culture as a caveat, they are limited by their notion of culture as a region or society, an anthropological perspective, which fails to acknowledge culture from a critical theory perspective as a socio-political-economic discourse.

Walsh calls for a multi-systemic, resiliency-oriented approach to recovery. She stresses the contextual factors in practice, by situating the traumatising event in a communal context while attending to the relational networks and practice focussed on "strengthening family and community resources for optimal recovery" (p. 207). She identifies belief systems, organisational patterns and communication as impacting the family and social process in risk and resiliency (Walsh, 2003, 2007). The key processes to facilitate resiliency include: belief systems: the ability to make meaning of the traumatic loss experience; positive outlook and transcendence and spirituality; organisational patterns: flexibility, kin and community connectedness and economic and institutional resources; and communication/problem solving, which includes clear, open emotional expression and collaborative problem solving. While Walsh approaches resiliency as a systemic process from micro (family) to macro (communal), Norris et al. approach it as a macro systemic process. Another distinction between Walsh's and Norris et al.'s frameworks is the former is applicable to the recovery phase of disaster management while the latter is limited to the preparedness phase.

While the above frameworks provide conceptual perspectives on community resiliency, Baron, Jensen & de Jong (2002), Ungar (2007), Landau, Mittal & Wieling (2008) and Landau & Saul (2007) provide frameworks for implementation. Jensen (2002) provides a framework for systemic organisation of interventions: "Within each country, interventions need to be organized. A system of interventions can be developed according to the 6 Cs: Coordination, Collection of Systematic Data, Community Public Health Approach, Clinical Service Development, Capacity Building, and Supervision and Care for the Caretakers".

Ungar (2008) presents five principles of resilience as applied to practice. They are as follows: resilience is nurtured by an ecological, multi-levelled approach to intervention; resiliency shifts our focus to the strengths of individuals and communities; resiliency research

shows that multi-finality, or many routes to many good ends, is characteristic of populations of children who succeed; resiliency studies show that focus on social justice is foundational to successful development; and resiliency research focuses on cultural and contextual heterogeneity related to children's thriving (2008). He defines resilience as:

> First, resilience is the capacity of individuals to navigate their way to resources that sustain well-being;
>
> Second, resilience is the capacity of individuals' physical and social ecologies to provide these resources; and
>
> Third, resilience is the capacity of individuals and their families and communities to negotiate culturally meaningful ways for resources to be shared (p. 22-23).

His definition emphasises the individual, family, and community while contextualising the constructive nature (meaningfulness) of how the resources are utilised. His research is focussed on pathways to resiliency and on children and youth. He approaches resiliency as a multi-level ecological intervention and moves from a micro to macro perspective of accessibility and resource availability.

Landau and Saul define community resilience as "a community's capacity, hope and faith to withstand major trauma and loss, overcome adversity, and to prevail, usually with increased resources, competence and connectedness" (Landau, 2001; Saul, 2002, p.). Landau (1991, 2002) presents the Linking Human Systems (LINC) model which applies resiliency theory to individuals, families, and communities facing crisis, trauma and disaster. The goal of this approach is "to engage the extended social support systems that can help empower and inspire individuals, families, and communities to reconnect and identify resources for healing" (Landau et al., 2008, p. 196). She identifies the central component of the approach as 1. recruiting family and/or community members as agents of change, 2. assessing practical aspects of resiliency using transitional genograms, field maps, multi-systemic level map and strategic polarisation maps (detailed in Landau et al., 2008); and 3. implementing the designed interventions. The principles of the LINC Community Resilience Model (Landau-Stanton, 1986; Landau, 1991; Landau & Saul 2004) are

> 1. Ensure that we have an invitation, authority, permission and commitment from the community; 2. Engage the entire system of the community, including representation of individuals and subsystems from each cultural and ethnic group, all economic, cultural, and

status strata; 3. Identify scripts, themes and patterns across generations and community history; 4. Maintain sensitivity to issues of culture, gender, and spirituality; 5. Encourage access to all natural and ancillary resources (bio-psychosocial, cultural, ecological); 6. Build an effective prevention/management context by collaborating across all systems; 7. Foster a balance of agency and communion across the community; 8. Build on existing resources; 9. Relate programme needs to goals, future directions and best interests of the community; 10. Utilise resources, turn goals into realistic tasks, and those into practical projects; 11. We provide the process, the community takes responsibility for the content and goals; 12. Encourage community links (natural change agents) to become leaders in their communities; 13. The more peripheral we are, the more successful are the program and the community; and 14. Success of the project belongs to the community (p. 300).

Landau & Saul (2004) identify factors that were in interplay during the process of disaster recovery in the Lower Manhattan Communities project and the Buenos Aires project. These factors can be categorised into 1. disruption (family and community systems: process, function, structure, and organisation); 2. stressors (transition, catastrophic event, unresolved grief, and loss); 3. multi-systemic impact levels (loss of ability to contextualise, family dynamics, bonding patterns and communication patterns, social and community levels) and 4. transitions (emergence of resilience and transitional pathways).

Common to all these frameworks is the relational responsiveness or "joint action" (Shotter, 1984, 2007) to traumatic events. According to Shotter joint action refers to "mutually responsive, dialogically-structured relations with the others and othernesses around us…[we] enter into a dynamic inter-involvement with them" (2007). This promotes connectedness and contextualising which are bedrocks for the trauma recovery, development, and peacebuilding processes (see Public Conversations Project; Weingartern, 2003). Connectedness or relational responsiveness is crucial to collective approaches. By collective approaches we mean community resiliency and wellness practices and processes that are connected to the local people and context; promoting of cultural, social and emotional well-being; and respectful of the historical, cultural, social, communal, familial, and relational-identity discourses. Such processes, which embody relational responsibility (McNamee & Gergen, 1999) are both community-engaged and community-based in practice. Community-engaged practices are participatory activities that are designed, delivered, evaluated, and sustained by and with the

local people's voice and experience. Such activities not only draw on the local population's resources and capacity but will also pull outside resources with the local input. Ungar identifies resource and capacity as hallmarks of resiliency building processes (personal communication, June 2008). Community-based is defined as services located within access to community members (see Boss et al., 2003; Pulleyblank-Coffey, Griffith, & Ulaj, 2006). Community-based services are more likely to succeed if they are based on community assessments and engagement. Such services may be designed by outside resources and located within a geographical community. Typically in practice, community-engaged and community-based services are used interchangeably.

Emerging Collective Approaches: Performative and Narrative Perspectives

Disasters are the disruptions of structures and functionality. Resilient disaster recovery is the process of returning to some aspects of functioning that existed pre-disaster and developing new ways of functioning to adapt to the newly emerging structures. The performance of disaster recovery is the process of moving through the spaces of transformation and transition. Such transformational and transitional performances occur in the "liminal phase" of what Turner, Abrahams, and Harris (1995) refer to as "anti-structure" It is the phase in which one passes from one stage (pre-disaster) to another (post disaster) through social processes of reflection, dialogue and action. These processes of a resilient response are performed collaboratively for creating collective structures which in turn promotes social relational processes.

Performance is a perspective, process and approach that "can provide a space for communities that have endured calamities to come together to share experiences and engage in public discourse" (Saul, 2006). Performance of trauma and healing practices can be understood as enactments that may be symbolic, an entity and/or a ritual (Schechner, 2002). Such enactments within the liminal space allows for the creation of spaces for action and reflection which furthers transition. These processes invite multiple collaborations for making sense of the disaster and for creating post-disaster collective structures. Following the performance of these collaborations, within the liminal spaces are specific actions or series of action that are initiated and accomplished. And each of the performative actions takes on significance in excesses of the liminal performance of collaborative actions (Schechner, 2002).

We create different forms of collective responsive performances to collective trauma. These collective responses include theatre, public spaces, community action, community dialogue, etc. Public spaces are convening and conversational spaces. Convening allows for values and identity to be performed. Conversation allows for respect of differences, construction of meaning, and community action. Convening people for conversation and dialogue involves invitation, inclusiveness, building trust, developing ways of negotiation, and leading to instrumental action, meaning, narrative and embodiment of the new process. Such liminal spaces post-disaster that allow for community building and action are illustrated below in the performance of "Ground Zero Initiative" which led to the formation of community forums that consequently led to the performative development of the "Downtown Community Resource Center" . Performance affirms agency and embodiment. Performance can be improvisations and/or structured. The Downtown Community Resource Center's Video Archive Group's project is a narrative and performative action of collective response that represents structured improvisations.

An important part of the communal healing process is having one's story validated and made a part of the collective story that emerges after a complex and horrible tragedy. This affirmation by the community at large is often described by those who survive major disasters as a crucial step in recovering their sense of well-being. As we have seen in New York City post-September 11, the emerging story after such events needs to respect and be broad enough to encompass the stories experienced by many different people—those who have lost family and friends, those who have lost their homes, those who were far away from the Ground Zero but still were deeply affected, those who were confused, and those who suffered discrimination and injustice as a result of the events. It can be problematic when the dominant narrative is narrow, rigid or marginalises some segments of the population. This has particularly been the case for the Arab speaking and Muslim communities in which many members faced harassment, detention, and deportation. Often it is those people who do not have a voice in society that may be further victimised or exploited after a collective tragedy as illustrated by Saul, Breindel, Margolies, et al. (2004).

We have observed in our work across cultures and communities that the western notion of the linear verbal narrative is one among many versions of how individuals and groups arrive at a sense of meaning and coherence after tragedy. These experiences may take years to

comprehend as people draw on past stories of vulnerability and/or strength to frame their current experience.

As a result of work with community narrative and liminal performances, we have been interested in the way that meaning-making is both an active and dialogic process and is enacted in the social dramas of families and communities. Overwhelming experiences of stress and loss are carried as "embodied knowledge" (Taylor, 2003), and thus through the body and action meanings are performed and re-performed over time. This collective process of meaning-making is important especially, but not only, for people who have experienced tragedy together. There has been a recent worldwide proliferation of theatrical, ritual and other communal performance practices in response to massive trauma (Agger & Jensen, 1990; Fullilove, 2002; Reisner, 1998, 2003; Taylor, 2003; van der Kok, 2006). We need to better understand how these practices promote individual and collective resilience and wellness. In the subsequent section we explore such collective responses and the challenges in implementation.

II.   Implementing Collective Approaches to Massive Trauma in Western Contexts

In the following section we describe challenges and obstacles to implementing community-engaged programmes following the World Trade Centre Attacks in Lower Manhattan and those following Hurricane Katrina with the displaced population in Houston, Texas.

Community Resilience Responses to the World Trade Center Attacks in Lower Manhattan

In the days that followed the terrorist attacks on September 11, 2001, the International Trauma Studies Program (ITSP) at New York University mobilised itself to respond to the need for training in disaster and community response to trauma and loss in New York City. The ITSP, based in the Department of Psychiatry at NYU School of Medicine had been providing postgraduate training in international trauma response since 1998, with guest faculty from post-conflict situations in Europe and Africa presenting on large-scale responses to massive trauma. ITSP had been a co-sponsor of the Kosovo Family Professional Education Collaborative (Griffith, et al., 2005; Pulleyblank-Coffey, Griffith, & Ulaj, 2006; Weine, Agani, & Rolland,

2001), which helped train and develop family and community-based mental health services following the recent war in Kosovo. ITSP was also a sponsor of Refuge, a treatment programme for survivors of torture and political violence living in New York City, which utilised a family and community resilience approach. It fell within our mission to work with the survivors of the terrorist attacks, which took place in the neighbourhood where most of our faculty lived and worked. These communities of Lower Manhattan comprised children, teachers, parents, residents, and workers who had experienced the greatest physical exposure to the events of 9/11: the deaths of friends and family members, direct threats to their own lives, emergency evacuations from workplaces and schools, physical danger from the debris storms, displacement from their home and businesses, and environmental contamination. With all of New Yorkers, they also faced a series of subsequent events, including the plane crash in the borough of Queens, going to war in Afghanistan and Iraq, the anthrax contamination, and numerous threats accompanied by heightened terrorist alerts.

I (JS) had three roles in my work in my response to the terrorist attacks – as a member of the downtown community where my family lived and my children attended school; as a local New York City psychologist with an expertise in trauma therapy; and as an educator (ITSP at NYU) with experience working in international psychosocial response to catastrophes.

Building Capacity. I anticipated with my colleagues at the ITSP at NYU that the professional response to the psychosocial needs of the tens of thousands of residents living in Lower Manhattan would focus primarily on individual counselling and therapy. Thus we decided to focus instead on best practices we had recognised in international psychosocial response to massive trauma, which included family and community level interventions. Since most of the initial mental health funds for training after 9/11 were directed towards assessing and treating PTSD, we established an ongoing disaster response training programme in which visiting faculty in our postgraduate programme in International Trauma Studies either donated or offered low-fee training. This programme sustained itself on tuition payments and offered monthly workshops for two years on individual, family, and community responses to trauma and disaster and was attended by more than 3,000 New York-based mental health professionals. These workshops included interchanges with internationally based professionals from former Yugoslavia, Africa, Israel, and Palestine who were experienced in working with large populations in their own

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countries dealing with mass trauma.

We taught an eco-systemic approach to trauma and disaster response. In the eco-systems approach, "treatment" is directed at rebuilding the strength of social groups, including families, school communities, neighbourhoods, and the city and region as a whole. The medicalised focus on PTSD with the promise of effective evidence-based treatment, i.e. cognitive-behavioural therapy, dominated the mental health discourse in New York after 9/11 and overshadowed family and community approaches which many of us knew to be effective in disaster contexts. The critique of how a pathologising perspective can undermine local capacity in international contexts was applicable in the New York City context as well. The proximity and enormous amount of potential funding for recovery created an environment in which there was a great deal of competition among researchers and practitioners from around the city and country who aggressively pursued agendas that often had very little to do with the needs of the population. Large-scale surveys of the mental health needs of adults and children focussed primarily on individual symptoms, rarely on the challenges people faced at work, in their families, communities, and in their physical environment or on the adaptive resources that could have been supported. It was not uncommon for treatment programmes with a research component to exclude those who did not meet the strict criteria for PTSD or who presented simultaneously with other mental health difficulties. From my perspective as a community member, many researchers seemed oblivious to the needs of populations in Lower Manhattan, pursuing their own research agendas instead. In my psychotherapy practice, I found that often clients sought help because of the changes in their workplace due to loss of fellow workers, role change, and displacement to different offices. But human resource departments focussed on stress related to experiences on 9/11 rather than on the felt loss and/or the ongoing organisational stress due to the changes taking place. Although a great deal of funding ultimately went into training mental health professionals in Cognitive Behavioural Therapy (CBT), relatively few therapists who received this training utilised it with trauma survivors. Many New Yorkers who did seek psychotherapeutic treatment went to therapists they had seen prior to 9/11.

A number of New York based mental health practitioners did come together at the Department of Health and Mental Hygiene under the leadership of Deputy Director Martha Sullivan for a conference on community-oriented approaches and how they might be funded by the Federal Emergency Management Agency (FEMA) and its New York mental health

programme "Project Liberty." The outcome of this meeting was a commitment to continue to support community approaches and a conference for community leaders sponsored by NYC RECOVERS. The central thesis of NYC RECOVERS was that the wisdom of recovery lay in organisations. Organisations, which were integral to the myriad communities that comprised the regional ecosystem, had the ability to assess the needs of their constituents, and institute appropriate remedies. Furthermore, organisations had the capacity to form linkages with other organisations, thus recreating the social and organisational framework that had been damaged by 9/11 (Fullilove & Saul, 2006). The conference was called *Together We Heal: Community Mobilization for Trauma Recovery*. It brought together 200 people from organisations of all kinds. The concept of community mobilisation was presented and its application to planning for the anniversary of 9/11 was discussed. Out of the conference emerged the concept of "September Wellness", an effort to embed the anniversary in a larger period of healing mind, body, and spirit through wellness activities (Fullilove & Saul, 2006).

Ground Zero Initiative. People living in Lower Manhattan bore the immediate brunt of exposure to the attack and its aftermath. As a psychologist with a long professional commitment to trauma recovery, I found myself in the role of recipient of services rather than "helper". I realised that among my friends and neighbours, there was the raw talent for doing what was needed to help the community cope with the impact of the terrorist attacks. It was off-putting that people were arriving in droves from outside the neighbourhood to "care for" the residents of the area.

The initial approach of the New York City Board of Education followed in the same vein, with a focus on screening children for PTSD and offering therapeutic services to those who were identified as having difficulties. Not only was very little attention paid to the impact of these events on teachers and parents, but also, neither group had been engaged in giving input into the evaluation process of the children. While the mental health of children became the focus of the school system's efforts, there were no places for parents to discuss their concerns as a group. In response, we joined together to create family support committees that developed community forums for parents, teachers, and school staff from the downtown elementary schools.

Under the rubric of the "Ground Zero Initiative", we worked, first and foremost, with the school community. These schools were within a few blocks of Ground Zero, the site of World

Trade Center Destruction. Teachers, students and administrators had experienced the immediate horror of running from the collapsing Towers, as well as the longer-term stress of being displaced from their school building. One school of 600 children was offered a vacant school as a temporary measure. In one weekend the parents came together and cleaned, painted and moved furniture into the school, making it usable for the children to attend the following week. The sense of togetherness and of taking action in the context of practical activities were repeated numerous times during the year and were seen by many parents as some of the greatest contributors to returning to sense of well-being. By doing for their children, the parents were able to reassert their own agency and thereby regain some sense of power and control.

In January 2002, with the plan to return the children to their home schools, many parents were feeling distressed about going back for the first time to the place where they had experienced the horror four months earlier. Other families had already moved back into their homes near Ground Zero, and others were still displaced from their homes. Some people were more ready than others to have their children return to the school, and the differences among people's feelings about the safety of the environment and the visibility of the destruction were topics that caused tension in the community. To address these issues, a community forum was organised to give parents and teachers an opportunity to talk about the issues that were on their minds.

The family support group invited Dr. Claude Chemtob, a child psychologist and disaster specialist from Hawaii, to facilitate the meeting. As part of introducing a concept of community recovery, Dr. Chemtob presented a framework to orient participants to stages through which a community might pass through following a disaster: (1) an initial stage of shock and then coming together, sharing, and letting one's guard down, called the "united we stand" stage; (2) as people start to get tired and irritable, stresses accumulate and tempers flare, and people retreat into groups within which they feel safer, referred to as the stage of "molasses and minefields" and there were things people could do to reduce tensions and work better together; and (3) a stage in which communities come together to create a positive vision of recovery . Thus, Dr. Chemtob introduced the idea that recovery was not a passive process, but a consequence of the community actively coming together for a common purpose.

During the meeting the parents broke up into small groups to discuss their concerns and to consider how they might increase their skills as parents and teachers. This included a

collective conversation about how parents and teachers could take care of themselves and support each other as well. A community needs assessment was conducted with the approximately 100 participants of the meeting. The community forum thus accomplished several goals: it deepened participants' understanding of the process of disaster recovery, it offered an opportunity to talk through concerns, and it collected data on community needs. The forum, at one and the same time, served for healing, problem-solving, and needs assessment.

Creating a Community Resource Center. The above mentioned needs assessment prompted community members to join forces and develop the Downtown Community Resource Center for Lower Manhattan. The needs expressed by community members fell into four general categories: (1) Monitor environmental safety and respond to risks that may arise; (2) Monitor and respond to emotional needs and reactions in children and adults; (3) Promote social cohesion, establish a public space for activities, discussion, and play; and (4) Provide clear and useful information on emotional reactions and recovery skills. The needs assessment at three months after September 11 highlights the emerging needs of community members related to shifting concerns about particular events and stressors. There was a strong focus on recovering a sense of agency and decision-making. A core group sought a public space where community members could come together and share ideas, projects, resources, and their combined creativity. They articulated the following goals of their community resilience approach:

- To recognise and strengthen existing skills, resources, and resilience in the community;
- To enhance connectedness in families, neighbourhoods, organisations, and occupational groups;
- To promote mental and physical wellness in youth, adults and families; and
- To create forums for public discourse and the expression of the multiplicity of community voices, viewpoints, and histories.

Through the Center, community members were able to engage other residents and workers to develop a number of active projects.

One of the greatest challenges in setting up a community resilience project was securing enough funding to prevent the core group of active community members from getting fatigued and burned out. We fortunately received initial funding from a private foundation to sustain the programme while we worked to develop a contract with Project Liberty for FEMA funding.

This, however, required help from advocates of our work to make the case for collective community interventions, a concept that was so logical to community members, but a different paradigm from the more individualised mental health focus of funders. It was fortunate that some of the community members that worked in our project were documentary film makers and were able to make a short video piece that vividly portrayed the usefulness of bringing parents and teachers and school staff to address the practical and emotional needs of the children and caretakers (Saul & Ray, 2002). We entered into discussion with representatives from Project Liberty during the months following 9/11 and were able to develop a contract after nine months of responding to the changes that were being made in the request for proposals at the city and state levels.   We received funding in March of 2003 and then were told with 80 other organisations five weeks later that we only had until the end of August 2003 to carry out the work. This was a long and frustrating involvement, and upon later reflection many community members involved with setting up the project felt that had they known that it would take so long to negotiate a contract and then to be funded for only six months, they would have used their private funding and focussed energies on the community work. In other words, this involvement with grant negotiations was felt as depleting resources that could have been utilised for better purposes. There has yet to be an assessment of the enormous cost to the 80 programmes that had a similar experience.

Another challenge was finding an affordable and accessible public space for a resource centre and for community programming in the urban setting was very difficult. There were no accessible public spaces in Lower Manhattan that could be used flexibly for community meetings and programmes. Though there were some schools and businesses that offered their space free of charge, space was still at a premium in the months after 9/11. Despite the delays in funding and the lack of space, the Center ran as a virtual programme facilitating programmes around the downtown neighbourhoods.   The community members chose two types of programmes which they thought would be useful for community members – those that focussed on peer and family support and those that developed public sites for narrating and hosting public conversations about the community's experience, concerns, and the meaning of what they had and were experiencing.

Peer Support Programmes.   Following the community forums in the school, the guidance

counsellors, psychologists, and special education teachers continued to hold regular meetings with parents to discuss ongoing concerns about their children. These meetings were held weekly through two school years until June, 2003. One peer support programme that was facilitated by DCRC was *The Artist Studio Tours of Lower Manhattan:*

> While the epicentre of 9/11 was the symbol of financial power, the World Trade Center, the events of that day impacted a major arts community living in the same area. The images created by those artists are crucial in shaping and reflecting our society's view of this crisis and its aftermath. To encourage this discourse within the artist community, the Downtown Community Resource Center sponsored the *Artist Studio Tours of Lower Manhattan.* Nearly 200 artists have participated in these studio visits, many of them attending the entire series of tours.

The project was an example of how a peer–support network developed in the language and preferred activities of this occupational sub-culture, then opened to the community at large. One of the challenges of the mental health response in New York was the many diverse cultures – ethnic, neighbourhood, organisational, occupational, etc. By supporting "community links" or change agents within these groups and providing some economic and administrative support, the group developed its already existing support network which sustained itself many months after the work of the DCRC finished (Landau & Saul, 2004). Other peer support groups initiated were with parents, teachers, children's arts groups, journalists who had covered 9/11, and a tenants' organisation that documented its experience responding to the needs of the disabled and elderly members of their housing project (Independence Plaza Tenants' Association, 2003).

Narrating and performing the community's experience. The Downtown Community Resource Center Video Archive Group, another community-driven project initiated by the Center, recognised that it was in a unique position to create a narrative archive from the ground, from the streets and homes of Lower Manhattan. They decided to use their resources to speak with their neighbours, create a community dialogue, and publicly share the stories of community attachment and resilience. This project may be unique to oral history archiving projects in that it was initiated by community members not long after a disaster and with the goal of promoting collective narration to strengthen community recovery. The members of the archive group were not outside experts, but local people who went through the same progression of experiences as

the people interviewed. In being members of the community they had access to interviewees through their social networks and a shared sensitivity to the ongoing shifts in community sentiment and concerns.   The group was able to get training in oral history methodology and with a videographer conducted a series of interviews, which were then edited to 15 minute pieces in collaboration with the interviewees.   The interviews were shown in public spaces in the community as well as put on the web (Saul, Breindel, Margolies, et al, 2004). The project was called *Stories from the Ground*. The Archive group also wrote a paper on the project, which was presented at the International Oral History Association Meeting in Rome, Italy in the summer of 2003.

One of the more ambitious projects of the centre was the Downtown Community Center Theatre Project in which a theatre ensemble was formed, interviewed a cross section of community members, worked improvisationally to create scenes from people's stories, and presented them back to the interviewees who then participated in further development of the piece. The full theatre piece was performed in the community, followed by talk back sessions with community members and others who had come to see the performance.   New stories emerged which were integrated into subsequent performances. This theatre of witness in Lower Manhattan was entitled " Everything's Back to Normal in New York City."   The following is a description of the theatre work by the Director, Abigail Gampel:

> *"Everything's Back to Normal in New York City"… are the exact words said by one of our interviewees, he almost laughed as he spoke. For many years he had lived 3 blocks from the World Trade Center and this phrase was commenting on the fact that after surviving the horrors of 9/11, he and all of the tenants he was fighting for in his neighborhood - the downtown community - though very much alive, still had no electricity- the air they were breathing was toxic as was the water they had available- they had no access to the simple comforts folks uptown in Manhattan had and yet, as he said, the mayor was parading around Ground Zero exclaiming "Everything's Back to Normal in New York City".*

> *The contrast of realities that group of words painted against the destroyed backdrop of lower Manhattan- brought forth a section of the theatre piece called "Surrealism" where all of the actors flew about the stage growing more and more frenzied. The many points*

of view that can be easily construed about things political, racial, the surreal quality that fear can generate and how terror can be embellished- all of these morphed together into a powerful theatrical statement.

We began the creative process of building this piece of theatre, by putting together an ensemble of 8 actors who would wear the hats of anthropologist, archaeologist, psychologist, performer, auteur and philosopher – all storytellers.

As a group, our ensemble interviewed people who lived or worked in lower Manhattan about their experiences around the subject of 9/11. From each interview we sought what resonated the most deeply, found repetitions of themes, and worked at distilling theatrical truth. Many of the interviews were transcribed verbatim from tapes, we wanted to use the language intact. We also used our own experiences as New Yorker's and 9/11 survivors in telling the stories. The Ensemble then wrote scenes, monologues, poetry, stream of consciousness prose, selected interview segments, all of which became the sinew of this piece of theatre.

How to achieve the pulse of this topic. The after effects of 9/11 on residents of lower Manhattan. We discovered that the boundaries of lower Manhattan blur into countless neighborhoods, bridging the boroughs of New York, America and the world. As we work further on this piece, our challenge is to allow the act of witnessing to reveal and untangle the many tendrils of connection. It is a day that many we spoke to initially would prefer to brush off, as if it were a part of the past. But as more questions were asked it became apparent that even with all of the television shows, books and political agendas, the hurt and individual experience around 9/11 has not gone away. The core of its staying power being the fact that we can clean up the debris- but human beings don't clean up so easily! We are filled with hidden places that haphazardly store away confusion and the pain of loss. Here we are 2 years later and "Everything's Back to Normal in New York City" except for the fact that Ground Zero is a looking glass into the past and the future.

Both the Archive and Theater Project gained momentum during their six months of operation

and reached many people across the community, creating opportunities for public conversation and a process of collectively narrating what they were experiencing as a community. It was unfortunate these projects which take an immense amount of time and energy in their first phase of three to four months had to end when the funding from Project Liberty was curtailed, as previously mentioned. Both of these projects created safe and non-stigmatising sites in the community where people had opportunities to be together and discuss what was of greatest concern for them. Both projects have tremendous potential to promote community action and cohesion, and not just in times of crisis.

Houston Responses to Hurricane Katrina and Displaced Populations

Locating the Katrina Disaster. Hurricane Katrina is a not just a natural disaster. It is a euphemism that captures the disasters caused not only by nature but also by human and recovery efforts. The way Katrina is constructed creates challenges and possibilities to understand and respond to such a mass trauma. Katrina framed as "hurricane" potentially de-contextualises the disaster by stripping the historical reference to slavery in America. Also, it fails to acknowledge the pre-existing and ongoing social location issues, such as familial, race, geography, regional politics, and economic. Norris et al.'s (2008, p. 131) label of Hurricane Katrina as an environmental disruption is based on the conceptualisation of the duration. I believe that the duration persisted in the form of ongoing disaster due to the lack of recovery plans, political and economic gaming, FEMA's lack of resource mobilisation and attendant failure to rapidly deploy these resources. Furthermore, there was a lack of critical thinking in developing recovery plans for the nation's largest dislocation. Relying on short-term disaster recovery models created ongoing-disasters for displaced people such as having to re-register three to four times to continue to qualify for FEMA assistance including housing benefits. The rebuilding recovery efforts are focussed on homeowners, and do not take into account intergenerational housing and the renter situation. Internally displaced persons' (IDPs) experience of Katrina is not very different from the people who seek refuge due to mass violence or civil war. Baron, Jensen and de Jong (2002) describe this state for refugees as:

> Most often, after years in exile, the cumulative effects of the stress of their
> ongoing living situation seem to outweigh the memories of the initial traumatisation. Van

der Veer (1995) writes that traumatisation is usually not a specific traumatic event in the sense of an isolated incident or a set of events that have left painful scars for refugees. More often, it is an enduring, cumulative process that continues during exile because of distinct new events, in the native county and in the country of exile. It includes a chain of traumatic stressful experiences that confront the refugee with utter helplessness and interfere with personal development over an extended period of time.

Similarly, IDPs refer to their experiences of flooding, and the journey from New Orleans to Houston as a distant past compared to the adjustment to Houston and accessing their rights to quality of life or to move towards wellness. It is the chain of traumatic events that prolongs this disaster, creating helplessness, hopelessness, and fear for the future that continues like the after shocks of an earthquake.

We refer to this disaster as *Katrina* to emphasise the intersectionalities of a hurricane, features of disaster, forced migration, and acts/processes of injustice and human rights violations. Accordingly, long term recovery systems and implementation designs need to be adapted from experiences of recovery effort of mass traumas—grief, loss and bereavement and resiliency interventions; refugee resettlement; and political action and empowerment processes.

Katrina Population. The psychosocial issues related to the lives of these IDPs began with historic trauma, and the lack of immediate rescue efforts, along with survival efforts through the rising waters of the breeched leeves. The process of bussing them to Houston from the Astrodome acted as both a trigger and a relief for the IDPs. The psychosocial issues were further complicated not only by the broken kinships and social networks, but also in adjusting to the Houston culture. Many of our new neighbours reported being overwhelmed by the city, afraid to drive on the highways (if they had a car), unable to use mass transit (if they didn't). Houston is about three times the geographic size of New Orleans, and the population is about four times the size of New Orleans. Further, Houston population in Poverty (1999) is 19%, with a median household income of $36,616, as compared to New Orleans population in Poverty (1999) is 28%, with a median household income of $27,133. Another significant difference is that many had never moved far beyond their intergenerational family and communal networks. For instance in Houston the non-native born (non-Texan) was 26%, while in New Orleans the non-native born (not from Louisiana) was four percent (Bava & Levin, 2007b).

After relocation, many have been unable to find long-term employment thus leading to poor economic conditions. This stress is added to other pre-existing conditions and environmental stressors such as alcohol and drug abuse, crime, domestic violence, and depression. Many of them still think they will "go home". Unfortunately, many of these individuals did not own homes, but rather rented. Local news reports indicate that little if any work is being done to replace low income rental property in New Orleans.

The Zogby survey of the IDPs residing in Houston, solicited by United Way in February 2007, reported on the demographics of 803 evacuees who were randomly selected from a list of 12,000 households that were receiving rental (FEMA) assistance. This is a good representation of the community that we served. They are predominately African-American (91.4%), and 57% with a high school education or less. The average household size is three persons, with one adult and two children. Of this group, 70% were employed prior to the evacuation, and 70% of those had annual incomes under $15,000. At the point in survey, 38% are employed, but only two thirds had full-time employment. The household income for over 60% of the surveyed group was under $12,000.

Respondents were asked about their general emotional outlook, at that time, and 37% reported that they were "unusually depressed", as opposed to 55% that reported that they were "more positive." Similarly, only 37% of those surveyed indicated that they felt confident in their ability to support themselves and their families in the near future.

Immediate Response at a Mega-Shelter. On August 29, 2005 I (SB) was activated as a volunteer member of the City of Houston's Disaster Mental Health Crisis Response Team. I was charged with directing the mental health services for the second largest mega shelter set-up in Houston at the George R. Brown Convention (GRB) Center to serve evacuees from Louisiana, particularly from Superdome, the local football stadium. We housed 7,000 people and over 30,000 registrations passed through the shelter facilities in three weeks. The mental health services, which were set up under the medical branch of the Incident Command Structure, included a health clinic and psychosocial services offered in the "living" (community) area of the shelter. This charge was fulfilled in the spirit of collaboration which is central to my home institution the Houston Galveston Institute (HGI). I set up a collaborative leadership team consisting of members from across the various mental health disciplines and key onsite service

organisations. This leadership, which met daily, was critical to the collective spirit that was created in design and delivery of the on-site services and later informed other community services for recovery. Drawing on collaborative (Anderson, 1997; Anderson & Gehart, 2007) and performative perspectives (Bava, 2005), the GRB story is described in the American Family Therapy Academy monograph on *Systemic Response to Disaster* (Bava & Levin, 2007a).

HGI, a private non-profit organisation founded in 1978, is dedicated to innovations in mental health theory and practice through direct service, training, and research. HGI is the home for Collaborative Therapy (Collaborative Language Systems) (Anderson 1997, 2007) and one of the premier institutions in the development of the family therapy field (cf. Anderson & Goolishian, 1988). We attribute much of this success to our collaborative approach that fosters partnerships not only with clients—individuals, families and community organisations -- but also with larger systems such as public service agencies—Harris County Children's Protective Services, Harris County Community Youth Services, and Office of the Attorney General of Texas.

HGI stepped forward in the aftermath of Hurricanes Katrina and Rita to respond to the mental health needs of people affected by disaster. We have developed a number of programmes ranging from clinical services to community-based (Rolling Conversations Project- a mobile mental health unit project) and community-engaged services (Filling the Gap project, Community Partnership for Resiliency and Social Engagement projects) as part of our recovery efforts. Below, I (SB) describe some of the pertinent programmes that locate the challenges of implementing community resiliency practices.

School Collaborations. HGI received funding to provide "clinical services" to over 400 people affected by the hurricanes through the NOW (New Orleans West) School, Goose Creek Independent School District, and Galena Park Independent School District. HGI was also contracted by Communities in Schools to serve students affected by the hurricanes in the Alief and Aldine School Districts. We approached each school as a community and spoke to the key stakeholders to inquire about their perspective of how the services needed to be designed and delivered. One of our central questions was how to engage the parents of these children and what types of services for the teachers and administrative staff should be offered.

Though Houston was an intact community, the parents were living in a state of

uncertainty with the constant sense of the sand shifting under their feet. There was no clear communication from Louisiana State and federal public authorities on when and how to return to one's home. In the initial few months there was no knowledge about the extent of damage to their homes. Coming from large kinship networks, parents were still in the process of finding and reuniting with their missing relatives. All this was co-occurring while they were trying to navigate Houston, a new city for most people. Thus the challenges were on how to engage parents while respecting their needs to focus their energy and resources on creating stability. This was also impacted by the dearth of accessible public transportation.

Project Resiliency. The various mental/behavioural health organisations were charged by officials from the City of Houston and Harris County with the task of developing a comprehensive and collaborative mental health response to Hurricanes Katrina and Rita. This led to the formation of Project Resiliency which had nine active partners funded by the United Way of the Houston Gulf Coast and The Houston Katrina/Rita Fund. Six of the nine partners received financial support through the joint funding effort. Two partners'—city and county—activities were funded through their respective public funding sources and were not included in the reporting requirements. HGI's Community Partnership for Resiliency programme, part of Project Resiliency, was funded to address collective trauma by helping organisations with mental health linkages and understanding of community resiliency to strengthen existing social supports and create new ones.

"An early operating principle of the Project Resiliency partners was to address distress and grief. Although there were number of individuals dealing with mental illness, a far larger percentage of the displaced persons were dealing with significant-to-profound life destabilization, grief and loss" (Project Resiliency Report, 2008, p. 10). The focus on mental health was a dimension of wellness since traditionally organisations active during disaster approach mental health services from a screening for PTSD and medical model perspective. The Collaborative's focus, on the other hand, "considered personal experiences to response and recovery as a process that would continue over a period of months and perhaps years….Resiliency and post-traumatic growth were seen as an important aspect of the work in all

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* The terms behavioural health and mental health are used interchangeably throughout the document to address the scope of issues addressed by the project partners.

areas. While providing services in the midst of the ongoing disaster, it was important to remember the pre-existing perspective of the audience. Providers worked to frame the wellness model in ways in which people were accustomed." (Project Resiliency Report, 2008 p. 11)

The result of these practices was the *Houston Model*, a continuum of activities provided by a diverse group of behavioural health providers to effectively respond to the behavioural health needs of people in the midst of disaster. The outcomes and effects of the collaborative efforts were described in a report (2008) as follows:

Capacity Building – increased the ability of organizations to respond effectively during emergencies or natural disasters by providing training for social service personnel; behavioral health professionals; primary care providers; ministers; lay clergy; volunteers; teachers; and other school personnel.

Community Resiliency – increased the ability of a community to positively adapt and become stronger despite experiencing significant adversity by promoting community as a healing place; forging partnerships between organisations and individuals; public information campaigns; public awareness workshops; and support groups.

Clinical Services – expanded the safety net for people who needed more intensive mental health services through screening and outreach; short-term individual counseling; short-term group crisis counseling; education/information/referrals; and the development of a *pro bono* behavioral health referral network. (p. 11).

Constructing the Design: In December 2005 and January 2006, while we were planning the design of "Community Resiliency" we learned, from a trial presentation with the funders, that they expected a definite response plan. Our expertise informed us to stay flexible; to take the position of "not-knowing" (Anderson, 1997), thereby learning with our participants and from our community. I found myself challenged to write our proposal so that it gave clarity of intention but maintained flexibility with the process in the implementation of the intention. As much as I was driven by the principles of disaster response-flexibility and improvisation, I was also working with funders that were looking for a specific direction that a familiar mental health framework could provide.

On January 13, 2006 we collectively presented our proposal which was a collaborative process unprecedented for the mental health community in Houston. Each partner organisation

worked with an openness and flexibility to share its expertise, ideas and budget preparation with the other partners. The funders exhibited flexibility in meeting with us to give feedback on our proposal was another unprecedented event. Our expectation was to advise them on how we think the trauma services needed to be conceptualised, designed and implemented to enhance emotional wellness rather than utilising an illness approach to disaster mental health.

Each of the partner agencies presented on what services they would be offering. Even though we had discussed the continuum of services that informed our proposals, the lesson we learned was that we needed to be more specific with respect to our target population and focus more on the types of services. The group revised its presentation material and came back for a second round of presentations after which the funding was approved—though some administrative expenses were not funded and some partners were asked to redesign their services since not all the requested amounts were allocated, which is not uncommon in non-profit funding. Some critical elements that were not funded were public service announcements for communicating emotional wellness messages. Yet we were informed that a certain amount of monies were being held for later allocation for clinical services, should a need arise. The retention of money for clinical services was indicative of an ongoing tension throughout the project between what the local community desired in terms of services and what projects the funders wished to underwrite.

Challenges: Project Resiliency's report (2008) details the challenges of implementation as ranging from community and provider groups to programme plans. The challenges attributed to community and provider groups included compassion fatigue and burnout among Houstonians; the overlapping role of the service providers who were also service recipients; educating providers about the difference between mental illness and grief and loss response; and the challenges of the population we were serving, who experienced continuous disruption "The primary focus of all evacuees was to create a sustainable livelihood in a new environment while dealing with circumstances that included adjusting to a new community, a new lifestyle, a new way of earning income and a difficult public transportation system" (Project Resiliency, p. 13). The challenges of the programme plans were: the internal structure of Project Resiliency, funding for the project, documenting the need for mental health services, education and training, and explaining the model.

In retrospect, some of the community approaches were community-based rather than

community-engaged services depending on the target population. The design and delivery of the capacity building services were community-based. Some of the community resiliency services such as support groups attempted to build on principle of community engagement but were not met with much success. According to the project partner, "[a]lthough specific reasons for the lack of participation and interest in the support groups were unknown, possible reasons included: dependence upon an unpaid volunteer to lead support groups; lack of transportation among the prospective clients; and perhaps, most important, competing priorities" (Project Resiliency, 2008, p. 13), all of which are very characteristic of a displaced group. Meeting basic needs and survival needs were critical to emotional wellness. So this raises the question as to what degree does a community-based programme need to be community-engaged? Based on our experience, no programme is successful without community engagement but there are different degrees of community engagement. It ranges from partnership to cooperation to collaboration. Some engagements are at the levels of organisations while others include more citizen participation.

Community Partnership for Resiliency. Project *Community Partnership for Resiliency (CPR)*, a component of Project Resiliency, was aimed at the enhancement and development of the public-private partnership in the area of wellness to promote community resiliency. The CPR proposal aimed at planned and intentional efforts of collaboration towards community resiliency. "Community resiliency", was defined as the ability of a community not only to deal with adversity, but also to become stronger in spite of such adversity (Brown & Kulig, 1996/97; Kulig, 1996; Kulig & Hanson, 1996). CPR's focus was on non-behavioural health responders among the following communities: higher education, community organisations, research, cultural arts, event planners, and corporations. School-based, behavioural health, disaster case management, media, and medical responders, etc. were to be covered by the other PR partners' proposals.

The proposed CPR project focussed on creating awareness of psychological wellness and enhancing resiliency by conducting the following activities:

- Outreach to organisations within the community to enhance community resiliency
- Hosting community round tables
- Facilitating cross fertilisation of ideas to enhance community resiliency
- Identifying, documenting, and promoting best practices of resiliency-building within and

across individual communities

- Identifying behavioural health strengths and needs within each community
- Linking organisations to resources for enhancing community resiliency
- Developing a process document and curriculum for replicating this process with other communities

The working assumption was that "[c]ollective trauma is often less 'visible' to mental health clinicians trained to work with individuals. However, people would find it difficult, if not impossible, to heal from the effects of individual trauma while the community around them remains in shreds and a supportive community setting does not exist. Thus, community-based interventions such as outreach, support groups, community organization, consultation, and training of gatekeepers and community caretakers are essential to rebuilding and strengthening social ties" (Myers, 1994).

Process: Upon receipt of funding approval, CPR in May 2006 launched its meetings with the various identified groups. HGI provided linkages to promote resiliency and behavioural health resources through community events organized by other organisations such as: Interfaith Ministries, Houston Area Urban League, and local apartment complexes' health fairs. HGI and PIP collaborated with the City of Houston's Focused Care programme to design anniversary community plans for August 2006. In the mean time, we were identifying contacts or entry points in research and higher education communities to work together to gather best practices information. We also worked with Houston Association for Marriage and Family Therapists (HAMFT) to conduct a panel discussion on the lessons learned from Katrina/Rita and the next steps to be taken by their members. HAMFT also consulted on their efforts regarding behavioural health disaster preparedness and response. We were also invited to a number of community events as resources consultants. As we provided linkages to organisations as well as the IDPs, we conducted a gap analysis of the then current mental health system delivery. We learned that most of the mental health services offered to people were screening for trauma symptoms and information and referrals. Upon reflection, we were also serving in the capacity of information and referral but our focus was on the social service providers. We consulted on mental health service design and how to interface individual counselling. I found myself responding to organisational requests for how to provide individual counselling, how to refer, when to refer, and who to refer to, but was challenged when we offered consultation on efforts to

promote resiliency initiatives. The cultural discourse of mental health services was so strongly embedded to imply one-on-one, face-to-face services that it left no room for other types of service discourse. Though our intent was to create community action resulting from community engagement as mental health services, we found ourselves responding to our partners, in the spirit of collaboration, with clinical services, which were needed as well. For instance, a difficult cases consultation group was set up within the Houston Long Term Recovery team, in which our role was to be available on hand for consultation on mental illness issues. We found our role was more in support to the service providers, who were reassured to have a mental health consultant on hand.

There was a constant discussion about the tremendous need for mental health services aka PTSD treatment and yet the community health clinics that were being monitored for referrals reported no higher utilisation of their services. Through these various interactions, we decided to shift our focus from having round table discussion within communities as initially proposed, to having dialogues on what was mental health. We organised roundtable discussion for 30 people from various public and private agencies representing social services for this conversation. We created an advisory group of mental health and social service providers to plan this event. Ten days before the event we found that we were getting more people interested in joining the dialogue. The numbers slowly rose from 30 to 80. We finally had over 110 people attend *Houston's Long Term Mental Health Response to Katrina/Rita: Reflections & Actions*. We stated our objectives as:

- To share our stories
- To explore emerging needs & challenges
- To inform the design of "What is next?"
- To learn about funding perspectives and opportunities for disaster mental health services

A year and a half later as I write about this, people still refer to this event as one of the most helpful events since it brought providers and IDPs to the table to share *their* ideas of what was working and what was needed to address mental health. Since then we have not had any large scale community dialogue on mental health in Houston. In spite of the need the funders turned down such requests since the direct relationship to an individual's mental health like clinical service was not present. The lack of the familiar, i.e. individualised clinical services, was

seen as being too different.

Challenges: By October 2006, five months into the project, we were getting feedback from our funders that they were not satisfied with the performance measures of Project Resiliency and consequently CPR. By December the funding was stopped for most of the partners. Each individual organisation did not receive any ongoing feedback, thus such a move was perceived as being rather abrupt and disrespectful of challenges identified below. The list of project challenges, identified by partner organisations for a mid-term report, included, project population factors (includes service providers and recipients), administrative issues, and contextual factors such as transportation and mobility.

In retrospect, the funders were expecting the service providers to show results in terms of identified outputs in spite of the challenges mentioned above and in spite of the partner's efforts to develop programme materials and engage the community as course correction to these challenges. For instance with CPR we had outputs throughout the service months yet they were baby steps towards the community roundtables. Thus the process of community engagement was not factored as part of programme development. We sensed that the funders were also unclear about what they were requesting. According to our Project Coordinator, who was the liaison between our project and the funders, they had paid for community services but were expecting clinical services. As mentioned previously, this tension between community-based or community-engaged services and clinical services was a recurring theme throughout our project.

In this context, the definition of community becomes very blurred. One notion of community was the Houston community defined in terms of its geographical area. It also included localities or sections of Houston where the evacuees were primarily residing. Another notion of community was the evacuees that were located all over Houston with limited or no transportation access. Many people did not have very reliable communication systems either. Thus, a number of evacuees found themselves isolated—either self-imposed or otherwise— as a result of their present context. And then there was the community of service providers. Those who were part of the long-term recovery team (optional) had an opportunity to share experiences and learn from each other. The various social service providers organised themselves as a team, thus implicitly using the notion of a learning community and community action framework. They were self organising and were able to stay organised due to the investment of the resources in leadership and space from one of the key local funders. From within this community emerged the

unmet needs team that provided fiscal oversight of the money that was directly distributed as aid to families to rebuild their lives. This was one of the most organised communities following the initial organisation by the Mayor of Houston and the Harris county judge. Both opened their arms and provided city and county resources for an organised response to shelter people as they were bussed from the Superdome, to the Astrodome, and then onto George R Brown, the largest mega-shelters in Houston. There were other organisations that were not social service providers that set-up programmes that provided opportunities for the IDPs to connect with each other, e.g The Contemporary Arts Museum, and an oral history project entitled, "Surviving Katrina and Rita in Houston", both of which are wonderful examples of community programmes that promoted mental health or emotional wellness using art and oral history.

Building Community Resiliency Project. A national funder put forth a call for proposals in Houston for "Community Resiliency" in February 2008. Some of the language was very much in keeping with the discourse of promoting community resiliency. One of their funding priorities for proposed project services and activities was stated as "special initiatives recommended that meet the eligibility criteria outlined below, *and address our evolving understanding of the mental health and resilience needs and most effective ways of addressing them for long-term recovery*". Our group was excited to apply for this grant as it seemed to be in-line with what our mental health and service community was requesting. Under the HGI's auspices we drafted a three component request to promote community resiliency building practices in Houston. The three components included: 1. Community-based services using a mobile mental health unit (known as the Rolling Conversations Project), 2. a social engagement model to further therapeutic services in conjunction with community activities (quilting, scrap booking, etc.) which brought community members together. 3. Participatory community action based on local and reflexive learning among the providers and recipients as to what promotes community resiliency in Houston so that it furthers our ongoing recovery effort.

      Challenges: All but the last component were funded in spite of community need and support. The reasoning we were given was that it did not fit within the funder's priorities. One of the challenges was in grasping the equivalent role of the facilitators of community resiliency as social service providers. The other challenge was the request for payment to participants who were identified as local experts of the recovery process for their time and expertise on

community resiliency. Lastly, the challenge was that this service was not directly touching the lives of evacuees, though no acknowledgement was given to the fact that service providers are also part of an affected community. Most of these service providers (some of whom were also IDPs) at the point of the proposed intervention (community action) would have been involved for nearly three years in the recovery process.

III.   Emerging Themes in Implementing Collective Approaches

Across the two major mass traumas in the United States of America we find the following interconnected common themes in implementing collective approaches for community resiliency:

1. **Tensions in Clinical and Community Approaches:** The clinical approach can be distinguished from an ecosystems or community approach in a number of ways. The clinical approach focusses almost exclusively on the individual as the client, and particularly in a post-disaster context this approach is easily stigmatising, as people do not necessarily want to be identified as having a mental health problem. It also usually offers a limited range of possibilities for healing. Frequently, clinical services are not oriented to the stated needs of clients, but to the services the clinicians are interested in providing. The clinical perspective emphasises enhancing the expertise of the providers and little attention is paid to enhancing the competence of clients to recognise and find solutions or to the lack of attention to the communal nature of their difficulties.

    The most common form of clinical service offered during disasters is crisis counselling. Such programmes are designed to be short term and in Houston involved door to door canvassing using a psycho-educational component along with information and referral for services. Though Norris (2007) reports that such services were wide reaching after Hurricane Katrina (1.3 million counselling encounters), their utility was largely questioned in Houston by both service recipients and other social service providers. Due to the lack of an integration of mental health and other disaster recovery services, there was a gap that went unbridged even though referral numbers were provided. As stated in the IASC report "do not separate out mental health or psychosocial support" services (p. 14). Typical crisis counselling programs are not well coordinated with other social support services. This was one of the bridges that I (SB) was attempting through my efforts with the CPR project. By mapping the

gaps created by lack of interfacing and coordination between these services and convening the various key players in the recovery effort, I was focusing on increasing community capacity.

In the ecosystems, or community approach, the client is the social environment and the focus is on strengths, resources, and continuity. One of the most important assumptions of this approach is that communities have the capacity to heal themselves and that the greatest resources for recovery are community members. The activities supported by such an approach are often those that community members are already engaged in and thus non-stigmatising. In coming together around practical concerns, the connections between people may be enhanced, and as we have recognised both internationally and in New York, these become the sites for sharing information, expressing emotion, and providing mutual support (Fullilove & Saul, 2006).

One of the common themes we both noted in our work was that we continuously had to explain the collective/community perspective to mental health practitioners, city agencies, funding organisations, and to the media. Though in the years following 9/11 there appeared to be greater acceptance of community approaches, as well as an emphasis on promoting strengths and resources, the changes seemed to be more in language than in conceptual understanding and knowledge of implementation. There is currently a greater willingness to explore how individual clinical approaches, both pathology and resilience oriented, can be implemented in the context of broader social interventions that highlight engagement and collective resiliency. We are now seeing the greater utilisation of approaches after major trauma and disaster that address mental health needs in the context of family and community interventions, (see Walsh, 2007; Boss, 2004; and Fraenkel, 2007).

2. **Inside/Outside Expertise and Competing Agendas:** The IASC committee recognises that an "affected community can be overwhelmed by outsiders, and local contributions to mental health and psychosocial support are easily marginalised or undermined" (2007, p. 33). A community resiliency approach requires the systematic identification of the various adaptive capacities of the various members within the affected communities. There is a need to focus and improvise an organisational focus where one can determine which one of these adaptive capacities are most important and which ones will be more challenging to access. Such

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systemic identification and focus becomes very difficult due to the chaos and the continuous structural and organisational shifts that happen on the ground. The challenge lies in recognising one's strengths and how to express that communally rather than the organisation with the largest resource or voice setting the agenda for the community.

I (JS) was a community member, local mental health professional, and a trauma specialist running academic and community programmes prior to 9/11. Some communities such as mine might have the various expertise needed while others such as the community of the displaced people in Houston might have some expertise but not all the various resources as explicated in the Norris et al.'s networked adaptive framework due to dislocation and other social location factors such as race, economics, politics, etc. So it raises the question of power discourse: how is expertise identified? Who identifies it? How is such capacity tapped into before there is an import of expertise? The process of recognising the local expertise furthers the resiliency of the locals during disasters. Who takes this perspective is critical, because such a perspective is a critical perspective and sensitive to community organising. Norris et al.'s framework provides a preparation frame which can further such activation to be triggered in spite of the chaos. We believe that it is important to develop similar frameworks for displacement and disenfranchised communities that are further rendered voiceless as a result of the break-up of their social network due to displacement. Further, it is crucial to acknowledge that we have multiple competing agendas. So who gets positioned to keep an eye on the big picture of what's needed by the impacted community? While the political process of access and network exits that influences the negotiation of outside and inside resources, such negotiations are also shaped by political agendas as seen in Katrina. Landau's framework provides for an alternative that is not any one entity but the community as a whole that keeps the political agenda accountable to the people. In her model all parts of the community have to be there. But again such a model is challenged in Katrina as the community doesn't exist in one geographical location. Who will bring all those people in? Such a practice is both resource- and time-consuming, especially in the aftermath of dislocation and in the midst of response when the individual family agenda might trump the community agenda. A core group of people will bring people together, which in Katrina has happened a number of times. However, this process has been received with scepticism by a number of other local groups, since it has been viewed as a political process that aims at

building the economic resources of those with means, and not of those who lack such economic clout, thus raising a number of human right issues. However, even in communities with means, as described about Lower Manhattan, a community with social, political, and economic resources, outside forces can potentially render it invisible or voiceless.

3. **Cultural Silence**: How do we play out the various challenging discourses? Often in a community when something is spoken, something else goes unspoken. However, unspoken is not the same as silenced. Some discourses, however, promote silence while others promote the notion of transparency. For instance, a culture of silence was created with the rhetoric of "unpatriotic" when people wanted to protest the war on Iraq. At a community level, organisations' need to compete for funds and to position themselves as having ran successful programmes to acquire further funding creates a cultural silence and thus no lessons learned that can bring about systemic shift might be identified. So we are likely to maintain the status quo by focussing on social service rather than social change.

4. **Political and Economic Parameters:** As discussed above, political and economic performances are always present and operate in the foreground and background. However, when they are not discussed openly and do not become part of the conversation of the design they not only create the culture of silence but also maintain the status quo. Politically, though we may privilege the collaborative structure but economically, we create remunerations systems that focus on certain positions weighted with privilege. This is because we privilege the expertise that represents knowledge and authority but not expertise that draws on life experience. Such western models of funding affect implementation. Funders speak the language of collective and community resiliency approaches but may not publicly acknowledge their uncertainty on how to implement innovative local ideas that have not yet been "tested".

The lack of transparency makes it difficult to find ways to develop community-engagement programmes. Dialogues are needed to address these parameters. For instance, not being funded for administrative processes or for planning (the liminal space of community engagement) are economic factors that fail to acknowledge the types of efforts required in community resiliency. We need more dialogue between the implementers,

recipients and funders from the outset. Rather than having economics dominate the conversation in the planning process as the primary resource, it is crucial to acknowledge the other adaptive communal resources at the table. Thus, funders have to join hands with community members to mitigate the hierarchy created by the resources they bring to the table.

5. **Flexibility and Improvisation:** Recovery is an emergent process and one has to plan to have no plan (Norris et al., 2008). One has to have a flexible and improvisational approach (Bava & Levin, 2007) wherein one is willing to make mistakes. But coming from a fear and blame perspective the notion of mistakes is in it of itself an expensive prospect. Improvisation includes flexibility in funding and access to resources, especially after the honeymoon phase of recovery when exhaustion and hopelessness are more likely to take hold. Creative, flexible and communal thinking and action are enactments of adaptive resources and perform as protective factors from burnout. However keeping blame and fear, which can kill creativity and flexibility, at bay is an enormous challenge. Creating a context with servant leadership and courage become critical at this juncture.

6. **Leadership:** Most leadership models are drawn from corporate rather than social sector. Both corporate leadership and social entrepreneurship require similar notions of leading a team, but the latter is much more value-focused. Such a model of leadership is in the service of a social cause rather than in service of economic gain. One such model of leadership is the Servant Leadership (Greenleaf, 1991). The City of Houston's mayor Bill White showed such remarkable leadership in his call of responding to Katrina by developing and facilitating a recovery system for the IDPs arriving in Houston. Such a leadership requires vision, goals, courage, and humility. To implement this, one needs collaboration, community engagement, and improvisation. The leader is a gatekeeper, a community builder, a visionary, a process facilitator, a task master, a mentor, a problem solver, a path maker, a person who makes mistakes, a course corrector, an inspiration, a motivator, a listener, a faith keeper, a hope builder, a resource leveraging actor who continuously blends these and many more roles.

    Community engagement invites two forms of leadership: individual and team. My (SB) role on the CPR project illustrates the individual leadership form while the GRB project of

directing mental health services illustrates team leadership. There is more resistance to team leadership model but it is a greater fit for collaborative practices. The elements that make it successful are time, patience and relational resources. However, if the relationships are in place, it is easier to implement such a model as experienced at GRB. Though there is a point person, the decision-making is a shared process (Walsh, 2007). Each model of leadership has different implications for task, pace, process and time and consequently, it impacts output and prioritisation of tasks, in turn impacting each others expectations. Common to both models is partnership, as there is no leader without a team.

7. **Collaboration and Partnership:** The IASC (2007) states that "effective mental health and psychosocial support (MHPSS) programming requires intersectoral coordination among diverse actors, as all participants in the humanitarian response have responsibilities to promote mental health and psychosocial well-being" (p. 33). In addition to coordination and collaboration, partnerships and relationships at each level are what make for successful implementation. Effective partnership emerges from the various people engaged in dialogue to connect, collaborate and construct a mutual endeavour towards the possibility (Anderson, 1997) of development, recovery, and rebuilding. Conversations and relationships go hand in hand. Harlene Anderson, originator of Collaborative Therapy (1997, 2007), states that the type of conversations form and inform the type of relations we form, and the relationships we have form and inform the conversations. For effective collaboration and partnerships, conversations (dialogue) and relationships are central for action. For instance, in conversation and in relationships the Lower Manhattan area developed *community fora*. The fora developed the Downtown Community Resource Center, which in turn led to the action of The Artist Studio Tours of Lower Manhattan. Thus through collaboration and relationships, dialogical space was created for meetings which led to collective action and community building. Such dialogical space becomes praxis that furthers community resiliency through collective practices.

8. **Resilience as Metaphor and Process:** Resilience as a metaphor from physics may have its limitations when applied to relational process, but has been a concept that inspires hope and optimism after massive trauma. As we have stressed in this article, this process by which

individuals and groups gain access to what they need in order to recover from crises, takes place on all systemic levels. Individuals are resilient to the extent that they are sustained by resilient families and communities. Unger (2008) makes the point that the concept of resilience is a social construction (Anderson, 1997; Gergen, 1999) that is shaped by culture and many situational contexts. If resilience has to do with accessing available and potential resources, then what people define as meaningful resources is critical to the process. Many resources may be available but not meaningful and considered worth pursuing. As Ungar states, the notion of meaningfulness is also socially negotiated and thus resiliency is metaphorical as it will vary by each community's meaning-making system. Collaborations that are intended to promote resilience must engage in a process that will identify meaningful resources, perhaps discover new untapped resources, and develop strategies that will attain them.

After major trauma, dislocation, and further victimisation that often unravel the social fabric, and in which cultural leaders may no longer be present, the foundation for promoting resilience may be fragile. As we have seen in our work with refugee communities, the re-weaving of social connections and the recovery of social and cultural resources, historical continuity and identity, may be a very long journey. The process of adaptation of populations that have endured massive trauma, such as the survivors of the Nazi Holocaust, takes decades and includes many practices that promote resilience that are quite unique and culturally specific.

9. **How and What to Count?:** So how does one measure practices that promote resilience that are quite unique and culturally specific? Measures of success for community resiliency are still being identified while the need for statistics and numbers as way to justify the sources for funding and seeking more funds creates tension. The former is a measure of impact that is not always immediately discernable in a process oriented approach such as community resiliency building. The latter is measure of outputs usually reportable in numbers. Using the measure of head counts is good for accounting quantity but not quality. Head count is a good measure for reporting turnout at a community event but should not be confused as impact of community resiliency.

Thus, another challenge is what counts as measures of success? To apply only head

counts as measures of success is to revert to an individualised model, thus discounting community resiliency. The increasing western notion of effective practice driven by evidenced-based practices that are not tested in the real world but driven by methodological conservatism (Kvale, 2008) increases the use of clinical models under the guise of community resiliency. Such models might have no input from the local community in which it is to be applied. Every mass trauma is a new learning experience due to the number of social location factors, not just a new context to apply a tested model. Further, mass traumas are opportunities for transformation and social change. Thus, we need measures of social transformation change and not just measure of social service.

We are failing to acknowledge that we are still learning what works within a dynamic context while the discourses of accountability and evidence-based practices are on the rise. The culture of accountability intended to create ethical practise though is creating a reductionist reporting culture based on economic accounting principles. The notion of accountability is both social and economic. It is both ethical (doing the right thing) and spending the right way. However the latter is in service of the former. "Accountability stems from late Latin *accomptare* (to account), a prefixed form of *computare* (to calculate), which in turn derived from *putare* (to reckon)" (Oxford English Dictionary). As we understand and develop accountability principles and practices we are turning to the most common ways and literal sources of accountability, those defined by economic principles which form the basis for accounting. Using accounting measures for accountability is using an economic model for measuring social and communal practices. Economic accounting is only one of the ways of identifying the "right thing". Such a practice then uses the "bottom line" attitude of commerce to measure emotional wellness. This in turn leads providers to do head counts and promotes practices like screening for community resiliency, which again individualises recovery practices rather than promote collective processes. This creates a vicious cycle that is self-defeating.

10. **Community Engagement and Measurement:** At the risk of creating an artificial distinction between community engagement and "programme" rollout, we speak to the challenges of measurement in community action. A community resiliency programme includes the phases of design and delivery, programme implementation and ongoing programme evaluation

(continuous learning). Though community engagement is part of all the phases, it is especially critical in the initial phase. However, most funding is for programme implementation thus discounting community engagement and thus creating artificial distinction between the "design" and the "implementation." Consequently discounting the impacts of convening people for community action which in turn is community resiliency building. Here the statistics need to include the number of meetings, the opening and challenges identified, the types of strategies discussed, the number of people attending, the new linkages created, the local perspective gained, the networks tapped or built, etc.

Community engagement is a much harder concept to grasp given the various meanings of community (Norris et al., 2008). Further, within a transient community or a re-forming community the notion of "community" is not present as a geographical unit but has been transformed into a virtual group of people who are now identified as internally displaced, dislocated, and/or a diasporic community such as the Katrina impacted citizens. Thus engagement of such a community involves different strategies from a geographically "intact" community like New York. Mapping of community resources for engagement of a geographically "intact" may include tools such as developed by Landau et al. (2008), or asset mapping (Kretzmann & McKnight, 1993), or community mapping (Kirschenbaum & Russ, 2002) etc. Yet mapping of virtual communities is possible and important as learned from internet communities. We need to learn and advance such methods for practical applications to IDPs impacted by mass trauma. The staging and purpose of such mapping for community engagement is crucial for people to have the experience of genuine involvement rather than their participation being experienced as the need to access their identity (ID) numbers for headcounts to secure or maintain grants (personal communication with IDP, 2008). To do so, once again reduces people to numbers and they are left feeling that their voice does not count, but their ID number counts.

We need methodologies and procedures that measure communal factors that promote community resiliency. We need various social relationship and perception indicators to measure community engagement rather than individual measures of mental health. Measures of emotional wellness are more appropriate than the current measures of mental health, which are typically an epidemiological perspective of mental disorders. We are not ruling out the occurrence of mental disorders and PTSD post disaster. Rather we are speaking to the

issue of validity. Are we measuring what we say will be different when community engagement and resiliency is promoted? Rather than measure the incident rate of illness we need incident rates of health. We need various measures of social relationships and social capital to measure community engagement. "Social relationships are described using various terms and measures—among them, relationships and connections to people, levels of interpersonal trust and mutual aid, social cohesion and collective efficacy, social support, group membership, mutual respect, and social power or the ability to work together to achieve desired ends" (Policylink, 2008). The Greenlining Institute defines social capital as relationships and connections between people that creates feelings of trust, reciprocity, and cooperation (2002). Norris et al. identify social capital as one of the primary sets of networked capacities of community resiliency. They identify social capital as encompassing social support-perceived and received, social embeddedness, organisational linkages, citizen participation including leadership, sense of community and attachment to a place. These components are potential entry points for community engagement but can also serve as measures of community engagement.

11. **Human Rights:** In United States, the federal organisation that is activated in the face of an event causing mass trauma is Federal Emergency Management Agency (FEMA). It "coordinates the federal government's role in preparing for, preventing, mitigating the effects of, responding to, and recovering from all domestic disasters, whether natural or man-made, including acts of terror" (FEMA, 2008, para. 1). A number of Congressional Acts have shaped the formation and function of FEMA. One of the major acts that has implications from a human rights perspective is the Robert T. Stafford Disaster Relief and Emergency Assistance Act, signed into law on November 23, 1988. This Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programmes. The Advocates for Environmental Human Rights (AEHR), a New Orleans advocate organisation that critically reviewed the Stafford Act states that, "for years, the US Government has recognized the *Guiding Principles on Internal Displacement* as an important tool for dealing with situations of internal displacement, and welcomed the fact that an increasing number of countries are applying them as a standard" (2008). According to AEHR (2008), "although the U.S. government promotes human rights standards for displaced people in foreign countries, it has failed to apply these standards to protect

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American citizens who are struggling to rebuild their lives and communities on the Gulf Coast." The reason is that disaster recovery is federally coordinated by FEMA whose standards are different from the above guidelines. They state these standards are not a *right* but rather a *promise*, thus stripping from the local people a *right to disaster recovery*.

The way larger systems are structured in their response mandate impacts the local community response as has been discussed. From our perspective it is not enough to view access to mental health as human rights; rather it is critical to view that protection of one's human rights is promotion of mental health. Thus, protection of one's human rights takes on the value similar to meeting one's basic physiological needs. Meeting basic needs is to physical health what meeting human rights is to emotional or mental health, community health, and socio-cultural health. Such a position is in keeping with the IASC guidelines to "apply a human rights framework through mental health and psychosocial support" (p. 31).

Conclusion[2]

While there is an increasing consensus on approaching mass trauma recovery and rebuilding from a community engagement and resiliency perspective, there still remain a number of challenges. These have to do with the types of disruptions, transitions and challenges to rebuilding in the aftermath of a mass traumatic event faced by particular communities. However, the way in which preparedness and recovery efforts can help with a resilient recovery process or could harm or hinder the locally occurring cultural process is based on how we as a field shape these discourses. As conceptual models of community resiliency that honour local practices and resources and promoting of well being are put forth, it is equally important to understand these frameworks in the context of practice and implementation. Drawing on our experiences of 9/11 and Katrina, we present the challenges and the principles of collective approaches. The critical challenges in implementing collective approaches in the west are dominated by a medicalised paradigm that promotes clinical approaches (disease model) rather than community approaches that enhance health and well-being. This is further complicated by the competing agendas introduced by the inside and outside expertise and political and economic discourses. During

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[2] We are interested in your response. Please contact Jack Saul at jacksaul@mac.com and Saliha Bava at drbava@gmail.com.

such complex processes there is increased possibility for creating a culture of silence and limiting flexibility and improvisation (creativity), which are critical to promoting resiliency. One of the factors that potentially limits creativity is the interplay of political and economic discourses in terms of "what counts" as effective or successful and accountable practice? The response to such challenges are the action principles for collective approaches which embody leadership, collaboration and partnership, and measurable community engagement practices that promote resiliency as a metaphor and process using local narratives and performatives practices while honouring our universal human rights.

Some of the practical implications of such an approach are:

- Protecting physical and enhancing virtual space for convening communal activities;
- Preventing the redirection of funding from resource poor neighbourhoods and protecting post-disaster communities from political and economic exploitation;
- Training mental health professionals in collective, relational, and contextual thinking in disaster situations;
- Increased research funding to develop community-engaged methodologies;
- The need to further develop thinking about families and extended families' response and how to strengthen them, reduce stress, and promote their wellness;
- Applying collective approaches to other groups suffering from the long-term effects of massive trauma - for example refugees, other displaced groups, and immigrants;
- Promoting a relational and wellness perspective with families and communities and better understand and prevent the stresses that may lead to conflict and resource loss;
- Exploring how to prevent burn out and fatigue with affected community members in order to sustain the spirit of altruism and interdependence after a catastrophe.

These suggestions raise a number of questions that as a community of mental health and psychosocial practitioners we need to keep dialoguing such that we develop reflexive practices. Further it is important to recognise that conceptualisation, funding, programme design, evaluation, research and administration, are all *forms of practice.* Without this much needed critical and reflexive view of all our practices we are at the risk of colonising the world with the models such as the "diseasing of America". A preventive approach that is relational and dialogical is more likely to promote peace and development.

References

Advocates for Environmental Human Rights (2008). *Protecting the Human Right to Return with Dignity & Justice After Hurricane Katrina.* Retrieved from http://www.ehumanrights.org/ourwork_residents_HRRGRD.html

Ager, A. (1997). Tensions in the psychosocial discourse: Implications for the planning of interventions with war-affected populations. *Development in practice, 7:* 402-407

Agger, I. and Jensen, S. (1990). Testimony as Ritual and Evidence in Psychotherapy for Political Refugees, *Journal of Traumatic Stress* 3 (1): 115-30.

Anderson, H. (1997) *Conversation, Language and Possibility: A Postmodern Approach to Therapy.* New York: Basic Books.

Anderson, H. & Gehart, D. (2007). *Collaborative Therapy: Relationships and Conversations that Make a Difference.* New York: Routledge.

Anderson, H. & Goolishian, H. (1988) Human systems as language systems: Evolving ideas about the implications for theory and practice. *Family Process*, 27, 371-93.

Baron, N., Jensen, S. B., & de Jong, J. T. V. M. (2002). Mental health of refugees and internally displaced people. In J. Fairbanks, M. Friedman, J. de Jong, B. Green, & S. Solomon. (Eds.). *Guidelines for psychosocial policy and practice in social and humanitarian crises* (pp. 243-270) New York: Report to the United Nations.

Bava, S. (2005a). Community resiliency: Behavioral health and wellness process. *The Nexus, 1 (8)*: 1-2.

Bava, S. (2005b). Performance Methodology: Constructing Discourses and Discursive Practices in Family Therapy Research. In D. Sprenkle & F. Piercy (Eds.), *Research Methods in Family Therapy* (2nd Ed.). Guilford Press.

Bava, S. & Levin, S. (2007a). Collaborative disaster response: Setting-up mental health services in a Mega-shelter. *AFTA Monograph Series: Systemic Responses to Disaster: Stories of the Aftermath of Hurricane Katrina.* DC: American Family Therapy Academy.

Bava, S. & Levin, S. (2007b). *Building bridges: MFTs as agents of hope during disaster.* Presented at American Association for Marriage and Family Therapy Annual Conference. Long Beach, CA.

Boss, P. (1999). *Ambiguous loss*. Cambridge, MA: Harvard University Press.

Boss, P., Beaulieu, L., Wieling, E., Turner, W., & LaCruz, S. (2003). Healing loss, ambiguity, and trauma: A community-based intervention with families of union workers missing after the 9/11 attack in New York City. *Journal of Marital and Family Therapy, 29*(4), 455-467.

Brown, D. & Kulig, J. (1997). The Concept of Resiliency: Theoretical Lessons from Community Research.

FEMA (2008). FEMA history. Retrieved August 20, 2008 from http://www.fema.gov/about/history.shtm

Fraenkel, P. (2007) Engaging families as experts: collaborative family program development. *Family Process* 45:237–257, 2006

Fullilove, M. (2002, April). Together we heal: Community mobilization for trauma recovery. Paper presented at a meeting of Columbia University School of Public Health. New York.

Fullilove, M., & Saul, J. (2006). Rebuilding communities post-disaster: Lessons from 9/11. In Y. Neria, R. Gross, R. Marshall, & E. Susser. (Eds.). *September 11, 2001: Treatment, research and public mental health in the wake of a terrorist attack* (pp. 164–177). Cambridge: Cambridge University Press.

Gergen, K. J. (1999) *An invitation to social construction.* Thousands Oaks, CA: Sage Publications, Inc.

Greenleaf, R. K. (1991). *The servant as leader.* Westfield, IN: The Greenleaf Center for Servant Leadership.

Griffith, J.L., Agani, F., Weine, S., Ukshini, S. Pulleyblank-Coffey, E. Ulaj, J. Rolland, J., Blyta, A., & Kallaba, M. (2005). A Family-Based Mental Health Program of Recovery from State Terror in Kosova. *Behavioral Sciences and the Law, 23*: 547–558.

Independence Plaza Tenants' Association, (2003) Neighbor to neighbor --the downtown solution: IPNTA's guide to community healing. Downloaded from website August 15, 2008 http://ipnta.org/book/index.html

Inter-Agency Standing Committee (2007). *IASC Guidelines on mental health and psychosocial support in emergency settings.* Geneva: IASC.

Kirschenbaum, J & Russ, L. (2002). Community mapping: Using geographical data for neighborhood revitalization. Available at: http://www.policylink.org/pdfs/Mapping.pdf

Kretzmann, John P. and McKnight, John L (1993). *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets.* Evanston, IL: Institute for Policy Research.

Kulig, J. (1996). Surviving and Thriving: Resiliency in the Crowsnest Pass, Lethbridge, Alberta: Regional Centre for Health Promotion and Community Studies.

Kulig, J. & Hanson, L. (1996). Discussion and Expansion of the Concept of Resiliency: Summary of a Think Tank. Regional Centre for Health Promotion and Community Studies, University of Lethbridge. Lethbridge, Alberta.

Kvale, S. (2008). Qualitative inquiry between scientistic evidentialism, ethical subjectivism and the free market. *International Review of Qualitative Research, 1(1):* 5-18.

Landau, J. (2001, November) Enhancing family and community resilience in the face of trauma: community outreach and organization. Presentation at the International Conference of the International Family Therapy Association. Brazil, Nov. 2001.

Landau, J. (2007). Enhancing resilience: Families and communities as agents for change. *Family Process, 46*(3), 351–365.

Landau-Stanton, J. (1986). Competence, impermanence, and transitional mapping: A model for systems consultation. In L. C. Wynne, S. McDaniel, & T. Weber (Eds.), *Systems consultations-- A new perspective for family therapy* (pp. 253). New York: Guilford Press.

Landau, J., Wieling. E., & Mittal, M. (in press). Linking Human Systems: Strengthening individuals, families, and communities in the wake of mass trauma. *Journal of Marital and Family Therapy.*

Landau, J., & Saul, J. (2004). Facilitating family and community resilience in response to major disaster. In F. Walsh & M. McGoldrick. (Eds.). *Living beyond loss.* New York: Norton.

McNamee, S. & Gergen, K. J. (1999) *Relational Responsibility: Resources for Sustainable Dialogue.* Thousand Oaks, CA: Sage Publications, Inc.

Norris, F. H. and Stevens, S P. (2007). Community resilience and the principles of mass trauma intervention. Commentary on "Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence" by Hobfoll, Watson et al. Psychiatry 70(4): 320-328.

Norris, F., Stevens, S., Pfefferbaum, B., Wyche, K.,&Pfefferbaum, R. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology 41:* 127-150.

Project Resiliency (2008). *Project Resiliency Report. The Role of Behavioral Health and Behavioral Health Providers: A Retrospective View of the Disaster Response to Hurricanes Katrina and Rita 2005-2007.* Houston, TX. Available at: Sage Associates.

Policylink. Neighborhood influences on health: Social relationships. Available at: http://www.policylink.org/CHB/SocialRelationships/default.html

Pulleyblank-Coffey, E., Griffith, J, & Ulaj, J. (2006). The first community mental health center in Kosovo. In A. Lightburn & P. Session. (Eds.), *Handbook of community-based clinical practice* (pp. 514–528). New York: Oxford University Press.

Reisner, Steven. (1998). Theater Arts Against Political Violence. *International Trauma Studies Program Website.*

Reisner, S. (2003). *Private trauma/public drama: Theater as a response to international political violence, In* The Scholar and Feminist Online, 2.1. Available at: http://www.barnard.columbia.edu/sfonline/ps/reisner.htm?

Saul, J. (1999). Working with survivors of torture and political violence in New York City. *Zeitschrift fur Politische Psychologie, 7*(1–2), 221–232.

Saul, J., Breindel, H., Margolies, L, Hamilton, L., Jacobs, N. (2004) Stories from the Ground: A community initiated narrative archive in lower Manhattan post 9/11. Proceeds of the International Oral History Association World Congress, Rome.

Saul, J. (2006). *Trauma and performance: constructing meaning after tragedy, theater of witness in lower Manhattan post 9/11.* Presented at Trauma and Research Net, Hamburg Institute for Social Research, St. Mortiz.

Saul, J. (2007). Promoting community resilience in lower Manhattan after September 11, 2001 [monograph]. *American Family Therapy Academy: Systemic Responses to Disaster; Stories of the Aftermath of Hurricane Katrina,* Winter 2007, 69–75.

Saul, J. (Producer), and Gampel, A. (Director). (2003) *Everything's back to normal in New York City: Below Canal, a work in progress.* New York: Downtown Community Resource Center, International Trauma Studies Program, New York University.

Saul, J. (Producer), and Ray, J (Director). (2002) *A partnership for kids: post 9/11 coping*

strategies for the school community. [Video] New York: International Trauma Studies Program, New York University.

Saul, J., Ukshini, S., Blyta, A., & Statovci, S. (2003). Strength-based treatment of trauma in the aging: An Albanian Kosovar case study. In J. Ronch & J. Goldfield. (Eds.).*Mental wellness in aging: Strength based approaches* (pp. 299–314). London: Health Professions Press.

Schechner, R. (2002). *Performance studies: An introduction*. New York: Routledge.

Shotter, J. (1984) *Social accountability and selfhood*. Oxford: Blackwell.

Shotter, J. (2007) *Getting it: 'Withness'-Thinking and the Dialogical... in Practice.* Available from: http://pubpages.unh.edu/~jds/bookpage.htm

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48:* 1449-1462.

Summerfield, D. and Toser, L. (1991). "Low intensity" war and mental trauma in Nicaragua: A study in a rural community. *Medicine and War, 7:* 84-99.

Taylor, D. (2003). *The Archive and the Repertoire: Performing Cultural Memory in the Americas*. Durham: Duke University Press.

Turner, V., Abrahams, R., and Harris, A. (1995). *The ritual process: Structure and anti-structure.* Aldine Transaction

Ungar, M. (2008). Putting resilience theory into action: Five principles for intervention. In Liebenberg and M. Ungar (Eds.). *Resilience in Action.* Toronto: Univerity of Toronto Press.

van der Kolk, B. (2006). Trauma, Memory and Cognition. Presentation at the International Trauma Studies Program, New York.

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford Press

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42(1),* 1-18.

Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process, 46*(2): 207-227.

Weine, S., Agani, F., & Rolland, J. (2001). The Kosovar Family Professional Education Collaborative. Symposium presented at the Annual Meeting of the International Society for Traumatic Stress Studies. San Antonio, TX.

Weine, S.M., Danieli, Y., Silove, D., van Ommeren, M., Fairbank, J., & Saul, J. (2002). Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings. *Psychiatry*, *65*(2), 156–164.

Weingartern, K. (2003) *Common shock: Witnessing violence everyday.* New York: Dutton