"To do no harm," Spiritual Care and Ethnomedical Competence: Four cases of Psychosocial Trauma Recovery for the 2004 Tsunami and 2005 Earthquake in South Asia

Adapted from a book chapter in *Creating Spiritual and Psychological Resilience: Integrating Care in Disaster Relief Work*

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> Indeed there was a near melee of activity from the large number of agencies who rushed to the region, albeit most of them without any previous experience of a country like Sri Lanka, its culture and background problems. Many came specifically to provide mental health assistance to the 'traumatised victims' of the tsunami. But the question is: were such communities seeking mental health and psychosocial assistance framed in this way? The impressions gained from field level discussions are that they were not. They did not want counselling, instead pointing to their shattered homes and livelihoods. The children were observed to be sad, and a few with nightmares, but well functioning and keen to have their schools rebuilt.
>
> (Jayawickrama, 2006)

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INTRODUCTION

How can spiritual care be appropriately and safely integrated into psychosocial trauma recovery work? What constitutes "appropriateness" vis-à-vis the diversity of psycho-, social-, and medical tasks that need to be accomplished in global disaster relief? In order to respond to such questions, this chapter will present a framework involving re-fashioned categories and new terminology in hopes of bringing to life the pitfalls and potential solutions of global trauma work. Such pitfalls and a review of past recommendations will be outlined. Next, four case studies of collaboration from South Asia will be discussed through fieldwork vignettes and interview material. The chapter's synthesis will involve methods and support for applying health. "Appropriateness" will be discussed by maintaining that there is spiritual care techniques in ways that offer healing in diverse domains of a cost-benefit determination that takes into account psychosocial benefits at the lowest cost (including cultural costs) to the disaster-affected society. The chapter will end on its message that collaborations happen best within democratic and symmetric relationships of stakeholders innovating optimal interventions.

From a category standpoint, spiritual care techniques are among the many ethnomedical techniques within the larger domain of **integrative medicine** that -- when blended with the domains of public health and group psychology -- make up integrative psychosocial resilience [IPR, figure 1].

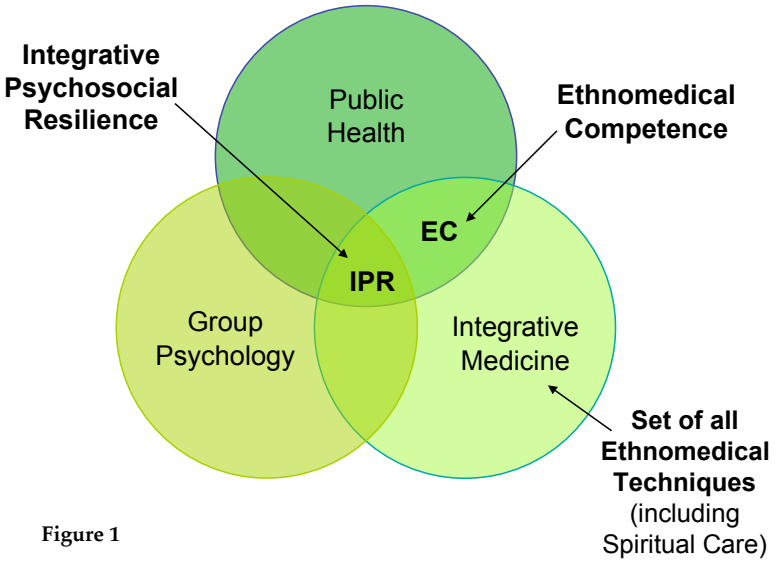

Figure 1

IPR brackets our attention on healing the psychosocial wounds of disaster (and excludes other important relief functions such as food, water, sanitation, disease prevention, structural repair, communications,

security). The designation "ethnomedical" incorporates the view that all healing practices are configured by the context in which they were created and the context in which they are currently being applied. **Ethnomedical competence** [EC] is the capacity to discern appropriate blends of techniques that meet public health needs for particular situations. Appropriate blends are ones which deliver substantial benefits while doing minimal harm (including minimization of costs). While maintaining an evidence-informed stance on effectiveness and safety, EC views Western and non-Western techniques as equally respected partners.

Box 1: Cultivating Ethnomedical Competence

1. Utilize literature review, anthropology and related disciplines in order to arrive at a more accurate view of affected persons, preliminary therapeutic goals and list of possible interventions.
2. With the community, learn about local idioms of distress, negotiate mutually agreeable goals and prepare to exercise maximal flexibility consistent with those goals. Balance cultural power so that all parties collaborate in democratic and symmetrical learning environments. Consider utilizing a consultant with ethnomedical experience to provide perspective and cultural skill sets.
3. Study applicable culturally-embedded, local healing interventions. Ascertain how culturally embedded interventions are (or are not) being utilized.
4. Take a step back to view the entire field of possible interventions (Western, local and non-local/non-Western) and choose a set of interventions on the basis of feasibility, efficacy, "doing no harm," and cost.
5. Work within a plan of integrated services. Expand program monitoring/evaluation terms and outcome studies so that the measured parameters take local signs of distress into account.

Why even bother to create so many categories with new terminology? These categories aspire to take into account the increasing academic critique (Jayawickrama 2006; Shah, 2006; Shah, 2007a; Summerfield, 2005) against the individual-focused pathology-oriented, psychological protocols that are applied by outsiders coming to Asian disasters with the intent of doing good. Many Asian-centric relief authorities prefer *psychosocial* conceptualizations of trauma intervention in order to respect the dynamic relationship between psychological states and social realities – recognizing that strengths and vulnerabilities in either will co-influence the other. Psychosocial programs show "commitment to non-medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach" (Ommeren, Saxena, & Saraceno, 2005).

BACKGROUND: OBSTACLES AND CHALLENGES

In order to prevent an overly biopsychiatric approach, IPR is a framework that accommodates the blending of psychosocial interventions. Still, psychosocial interventions can be ill-fitting if local interventions are ignored or Western interventions are not culturally adapted. Epistemologically, it makes a world of difference that widely accepted interventions and protocols are developed largely by those in Western settings, validated through randomized control trials with Anglo-European populations seeking generalizability, and configured by the philosophical underpinnings of modernism, positivism, and logocentrism. Part of the cultural cost to a non-Westernized person who avails herself to a Western intervention is that a survivor must do work (and possibly lose parts of herself) to adopt a self-concept that fits the intervention's terms of reference. Operationally, these interventions are then superimposed (taken "off the shelf") or lightly adapted for use cross-culturally and trans-nationally with the hope that they bring benefit (and they often do) without considering a wider palette of interventions that would better take into account the local population (as possibly bring substantially more benefit). With a view toward mitigating these challenges, warnings from leaders in the field include:

Box 2: Challenges to Cross-cultural and Trans-national Trauma Interventions

A. A World Health Organization [WHO] bulletin: "We need to remember that the Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal" (Summerfield, 2005).

B. "Off the shelf" intervention materials are difficult to use in diverse settings because they are unknowingly embedded with cultural expectations and unsubstantiated assumptions (Norris & Alegría, 2006; Vega, 1992).

C. "Attempts from outside Aceh to 'train' various community leaders in how they might respond to widespread psychological distress at a community level, using western constructs of community reconstruction and development, may be misguided and will probably be unwelcome." (WHO, 2005)

D. "Standardized instruments are useful for evaluating outcomes in relation to standard psychosocial interventions, but they may not encompass local constructions of mental distress, reasons for seeking traditional healing, or definitions of successful treatment, which may be grounded in spiritual cosmologies" (Patel, Kirkwood, & Weiss, 2005).

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E. A Sri Lankan academic, Janaka Jayawickrama (2006), offers this analysis: "…unplanned and uncoordinated humanitarian assistance without a clear vision may create as much distress as the disaster. To categorise affected communities as 'traumatised' and in need of psychological or psychosocial support – and on the basis of assumptions that owe nothing to the voices of the people themselves – is to miss important opportunities to provide humanitarian assistance that will be valued by recipients."

Clearly, spiritual care interventions are vulnerable to the above pitfalls, *especially if the field of spiritual care pursues generalizability and protocol-driven interventions.* If, however, spiritual care aligns itself appropriately with local traditions, evolving practice norms, and holistic healers, it can stimulate highly relevant IPR while minimizing harm. With this in mind, what follows are relevant recommendations from different sources:

Box 3: Recommendations for Utilizing Religious, Spiritual, and Traditional Views in Disaster

A. The religious construction of meaning surrounding the disaster may mean that efforts to deal with psychological and social consequences of the disaster in ways that are not consonant with such religious and cultural values and beliefs (e.g. trauma-focused counselling, psychiatric approaches) will be both ineffective and unacceptable. (WHO, 2005)

B. Authors M. Carballo, B. Heal, and M. Hernandez (2005) observed improved resilience in tsunami-affected populations utilizing spiritual grounding and religious leaders. They suggest the following: "Some of those affected by the Tsunami may react poorly to alien approaches …external (as well as internal) groups must always pay careful attention to local cultures, religions and traditional ways of coping with incidents such as the Tsunami."

C. "Traditional healers are culturally and linguistically similar to their clients, share the cosmology of their clients, and generally have a holistic approach to healing especially useful to conflict-affected populations who may suffer a variety of traumatic impacts and symptoms, including emotional, psychological, physical/somatic, social and spiritual ones" (de Jong, 2007).

D. "From a public health perspective traditional healers often have the advantage that they are easily accessible from a cultural and geographic point of view" (de Jong, 2007).

Appropriately applied (i.e. ethnomedically competent) spiritual care and pre-existing rituals re-tooled (or re-traditioned) to fit disaster contexts, therefore, have great IPR scope. As the primary mechanism (under UN resolutions 46/182 and 48/57) for inter-agency coordination of humanitarian assistance, the Inter-Agency Standing Committee (IASC) has laid out important guidelines for psychosocial best practices:

Box 4: The Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* encourages relief workers to interface with appropriate spiritual practices and local healers. Relevant warnings and recommendations from IASC's Guidelines include:

A. Engaging with local religion or culture often challenges non-local relief workers to consider world views very different from their own. Because some local practices cause harm (for example, in contexts where spirituality and religion are politicised), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights. (IASC Action Sheet 5.3, 2007)

B. Ignoring such healing practices, on the other hand, can prolong distress and potentially cause harm by marginalising helpful cultural ways of coping. In many contexts, working with religious leaders and resources is an essential part of emergency psychosocial support. (IASC Action Sheet 5.3, 2007)

C. Blending therapies in order to arrive at ethnomedically competent integrative psychosocial resilience is encouraged in Action Sheet 5.3 as well: "Accept existing mixed practices (e.g. local and Westernised) where appropriate."

D. Even when allopathic health services are available, local populations may prefer to turn to local and traditional help for mental and physical health issues. Such help may be cheaper, more accessible, more socially acceptable and less stigmatizing and, in some cases, may be potentially effective. (IASC Action Sheet 6.4, 2007)

E. Before supporting or collaborating with traditional cleansing or healing practices, it is essential to determine what those practices involve and whether they are potentially beneficial, harmful or neutral. (IASC Action Sheet 6.4, 2007)

When attempting to offer sustainable disaster work in South Asia, I have learned the power of engaging experienced non-governmental

organizations ("international" iNGOs or "national" NGOs) in mediating collaborations:

1) They often have the trust of the people because staff has taken the time to learn local realities
2) They form a cadre of barefoot counselors providing psychosocial first aid and making referrals
3) They provide feedback on the merits and demerits of outsiders providing services

A proactive stance for outsiders is to recognize that some degree of "pushback" is inherent to aid relationships (Shah, 2007a) and that pushback can be magnified in cross-cultural encounters. Furthermore, beyond simply anticipating pushback, mechanisms of communication and feedback must be put in place to solicit dissatisfaction from the field as well as HQ/donor commitments to repair and adapt operations so that a program evolves with real-time, real-life concerns.

From a trauma research standpoint, Hobfall (1998) and Draguns (2004) both conclude that a review of past studies suggests the effectiveness of viewing all individuals through the lenses of broader familial, interpersonal, and social contexts. Going one step further than the *de facto* practice of cultural competence (Shah, 2007a), EC affirms that not only must we take into account multiple contexts to understand the traumatized self-concept, but that once we see the traumatized self-concept through many lenses, it is important to develop IPR (a blend of appropriate techniques from a wide palette to achieve optimal results). Within South Asian populations, spiritual care techniques tend to be prevalent and well-received. In the next section, I will present four cases of blending spiritual care within IPR delivery in South Asian disasters.

CASES: VICARIOUS TRAUMA PREVENTION IN NATIONAL STAFF

[one case removed for this abridged version]

Tsunami in India (acute phase)

Entering tsunami relief efforts, I [SAS, the author] was facilitated by pre-existing relationships. In this context, "pre-existing" could signify any of the following in varying degrees: confidence, empathy, faith and positive expectations. On the day of the tsunami, December 26, 2004, I contacted a handful of NGOs that knew me, and I let them know what I could offer. Given my capabilities and sense of what I could achieve alone, I was ready to provide consultancy to relief agencies on psychosocial first aid (PFA) and neuropsychoeducation[1] of vicarious trauma and self-care (hereafter "VT/SC education"[2]).

[1] Classical psychoeducation (teachings to deal with a psychological condition) plus education on the neurobiology of stress/distress/trauma/anxiety/depression. Neuropsychoeducation is taught in the spirit of democratizing health by teaching cognitive mastery and behavioral regulation.

[2] Vicarious trauma is also known "secondary traumatic stress" in the academic literature. Education on vicarious trauma involving self-care and resilience also aids in the prevention of burnout, which is a related phenomenon of exhaustion occurring as a result of harsh working conditions.

On the subject of anything psychosocial, I was prepared to get responses such as "We cannot stop our acute rescue operations for anything mental health right now." Regarding VT/SC education, I was prepared for, "We cannot see the priority of taking care of unaffected rescue workers when so many affected people need aid." However, after two NGOs heard my description, they stated that they recognized the VT phenomenon in their midst. They had a sense of urgency for which I was unprepared, saying, "We cannot afford not to have such training" and "We have college student volunteers working who have never encountered such tragedy, and they have pained eyes as they work."

On December 30, four days after the tsunami, I arrived in Chennai. Through interviews with fieldwork supervisors, I made an assessment of first responder work exhaustion and current self-care protocols. In one organization, Association for India's Development (AID), college students had arrived by busloads to help clear dead bodies and clean debris. One supervisor was visibly worried that many of the fieldworkers were working without breaks and close to exhaustion because "the devastation was so great and there was too much to do." From what I could gather, aside from AID workers being told that they should rest, there were no formal self-care protocols.

On December 31, I conducted a half-day training for AID fieldwork supervisors and upper management in its Chennai headquarters. The training covered the following:

a. VT/SC education (Bride, 2004; Jayawickrama, 2007; Pearlman & Caringi, in press; Rothschild, 2006; Shah, 2007b; Young, Ford, & Wilson, 2008)
b. Reviewing individuals' currently used relaxation and expressive techniques; inquiring what other techniques would be culturally compatible.
c. Simple mind-body relaxation techniques and leading practice sessions on systematic relaxation (e.g. breathing techniques)
d. Discussion on initiating/maintaining simple SC practices in the field (e.g. buddy system, reminders to breathe for relaxation)

Early in our training, one manager shared with the group how daily morning yoga, even during these days of crisis, was a factor in her resilience. From my point of view, this was an important revelation because it reinforced a link between disaster resilience and a common, non-foreign self-care practice. We explored what it would be like to do yoga postures with the explicit intention of preventing VT. I led a segment in which we practiced Nadi Shuddhi (a yoga practice of alternate nostril breathing) as a method for de-toxifying especially emotional moments. Similarly, I presented other ways to link disaster resilience and common practices, such as "What would it be like to have a peaceful meal (and any preceding prayer) infused with the explicit intention of building resilience vis-à-vis a disaster?" In teaching systematic, intentional relaxation, I suggested that people adopt a regular activity/technique that has resilience as its central purpose. This is in contrast to practices like "vegging" in front of a television or exercising or napping that are passively relaxing for some people.

In the villages of Nagapattinam, I was asked repeatedly whether I wanted to get groups of survivors together in order to discuss what happened during the tsunami. In my assessment, this was a problematic way to proceed. First, this would resemble a Critical Incident Stress De-briefing (CISD), and although CISD may be beneficial for first

responders such as firefighters who have been trained to use CISD after tragedies, the research evidence shows that convening CISD-naïve groups of survivors to discuss a tragedy in the acute phase of horror is likely to be non-beneficial or harmful (Gist & Devilly, 2002; Rose, Bisson, & Wessely, 2006; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Second, in the villages to which I would have exposure, survivors were milling about or parts of fluid groups; any group that we wished to repeat the next day would be made up of different people. Thus the stability of the group composition would be compromised, and I as an outsider "swooping in" for a few sessions and "swooping out" may add another layer of disruption, abandonment and "disaster tourism."[3]

Earthquake in Pakistan (sub-acute phase)

Two months after the earthquake, I [SAS, the author] led a team of psychotherapists to teach PFA, EC and VT/SC education to nearly two hundred relief workers in Islamabad, Mansehra, and Muzaffarabad. Through the coordination of an educational NGO, Idara-e-Taleem-o-Agahi, these trainings brought together national staff workers from governmental agencies (Government of Pakistan), NGOs (ITA, Rozan), iNGOs (World Vision, Save the Children), and UNICEF.

Before arrival in Pakistan, I asked Khalida Sheikh, our team's Pakistani-British psychotherapist, what Muslims may do spiritually to bring comfort in times of tragedy. She replied that a Muslim may repeat silently the *Darood Sharif* (or, *Durood Shareef*), a spiritual formula well known to orthodox Muslims linking a person to Allah and inducing peace. Furthermore, she informed me of a mystical practice using imagery and meditation called *Muraqba.*

We adapted and piloted a 12 minute script of vocal instructions (Sheikh & Shah, 2005). Our pilot subject found the script agreeable and suggested some word changes for superior results. Our trainees and their beneficiaries were predominantly Muslim; still, we inquired whether a relaxation technique using Darood Sharif and Muraqba would be welcome. Even though the individuals had varying degrees of religiosity and types of spiritual practice, everyone agreed to try the Noor Meditation.

Box 5: "Noor" Muraqba Meditation

a) Two minutes of progressive relaxation coordinated with inhalation and exhalation

b) Two minutes of reciting a spiritual formula such as *Darood Sharif*; or a repeating a phrase like "Allah Hoo" coordinated with inhalation and exhalation

[3] Disaster tourism is driven by curiosity and not any relief objective. Swooping in/out has a relief objective, but with a transitory quality. Swooping in/out may bring benefits, but it must be counterbalanced with any harm accrued by disaster victims having to repeat their stories and grieve the loss of a caring presence. As disaster-related phenomenon that well-intentioned people participate in, disaster tourism and swooping in/out have not been adequately discussed in the literature. The ethics (dilemmas, line-drawing, harms, recommendations) of such phenomena require deeper treatment elsewhere.

c) Five minutes of Muraqba guided imagery involving *Noor* (Divine Light) making its way over each portion of the body and then gently interpenetrating muscles, organs, and "spirit." *Noor* is a prevalent positive symbol in Islamic mythology. Participants are told that this Divine Light is healing and that contact with it gives a sense of peace and deep comfort.

Throughout the PFA, EC and VT/SC education modules, we attempted to work the boundary across different care provision traditions -- bringing in useful Western views while leveraging and respecting local customs.

Those who gave verbal feedback expressed that being in touch with one's own spirituality was itself a therapeutic tool in their inner healing. The following are other subjective feedback transcribed from evaluation forms:

- *"I get very tired easily and feel mentally fatigued. Today's sessions have made me realise that to become an effective caregiver, I need to take care of my own mental psychological and emotional needs. I found learning breathing techniques and muraqba exercises very useful."*
- *"I wish that these sessions were offered soon after the Earthquake to all the relief workers"*
- *"The skills I learned today I will pass them on to other people in the community who suffered a great deal due to the Earthquake."*
- *"Relaxation exercises should be produced on C.D. and computer so everyone could learn how to relax."*
- *"The session on alternative healing methods was very useful. The discussions we had and the exercises we shared were very simple and beneficial."*

Tsunami in Sri Lanka (Chronic, in between, phase)

In 2005, one year after the Indian Ocean tsunami, a spiritual teacher invited me [SAS, the author] to teach Laughter Yoga during the day-long training for tsunami relief workers to whom he intended teach meditation, physical activities and group reflection. My hope was to provide an intervention that would be consistent with the recommendation (Norris & Alegría, 2006) that culturally based rituals and traditions can be re-tooled as the basis for innovative interventions.

Laughter Yoga involves three major components that I have adapted for use in disaster resiliency for workers:

1. Instructions to laugh in various ways (e.g. milkshake, cell phone, lion, electric) so that the physiological act of laughing, through a neurological feedback loop, induces a psychological state of wellbeing and joy.
2. Interactive group activities that stimulate further laughter through being socially contagious; some interactions ask that people act out social "values" (e.g. handshake, shyness, appreciation).
3. Breathing activities from yoga traditions. In addition to the other deep breathing techniques taught during a Laughter Yoga

session, laughter itself spontaneously induces breathing in a way that lengthens the exhalation. Prolonging exhalation engages the vagus nerve and parasympathetic nervous system enough to reduce heart rate and bring about a subjective feeling of calm (Hobfoll et al., 2007; Sakakibara & Hayano, 1996; van Dixhoorn, 1998).

Our sessions of Laughter Yoga were loud, enthusiastic, and sometimes challenging. Laughter activities appeared to reinforce playfulness and interconnectedness in a novel way that was linked to yoga traditions. Participants reported that the activities helped them to reclaim laughter in a setting where crisis, grief and tragedy had suppressed joy, humor and laughter for many months.

SYNTHESIS

Box 6: Integrative Psychosocial Resilience -- Seven Project Steps

1. **Inventory of team capacities and determining optimal scope of work**
2. **Communicate with networks; Build collaborations; Delineate scope of work**
3. **On-site assessment; Development of ethnomedically competent services; Exit strategy determination**
4. **Service provision**
5. **Monitoring/Outcomes measurement; Monitoring team for burnout/vicarious trauma**
6. **Returning to and refining Steps 1, 2, 3, 4, 5 as appropriate**
7. **Closing work processes; Exit**

In the midst of multiple lists of multiple recommendations, it is crucial to remember that our goal is empowering individuals for a sense of control over their lives and fostering resiliency, which includes helping individuals to enhance functioning and helping communities to identify and mobilize their natural resources (Hobfoll et al., 2007; Norris & Alegría, 2006; Solomon, 2003).

Academic and fieldwork support for IPR approaches as outlined above are increasing. Examples include Transcultural Psychosocial Organization's methodology as described by Eisenbruch, de Jong, and van de Put (2004) integrating "as far as possible traditional, local, and Western healing methods." Compared to medically-oriented programs, open-minded spiritual care programs may have more liberty or comfort or more access in applying ethnomedical techniques such as breathing relaxation, spiritual formulae, or "self-dialogue through the repetition of a word or verse" (de Jong, 2002). In one of the most authoritative reviews of what empirically helps in mass trauma, Hobfoll et al. (2007) cited multiple articles in the literature giving support to diverse ethnomedical techniques; for example: "Yoga also calms individuals and

lowers their anxiety when facing traumatic circumstances, while muscle relaxation and mindfulness treatments that help people gain control over their anxiety are being applied that draw from Asian culture and meditation."

CONCLUSION

Two questions came at the beginning of this chapter. How can spiritual care be appropriately and safely integrated into psychosocial trauma recovery work? The Seven Project Steps (Box 6), four IPR cases in South Asia and the overall IPR framework are responses to this first question. What constitutes "appropriateness" vis-à-vis the diversity of psycho-, social-, and medical tasks that need to be accomplished in disaster relief? Box numbers 1, 2, 3, 4 and *7 [removed in this abridged version]* are responses to this second question.

Among the ethnomedical components of integrative medicine, spiritual care is no less valid than modern psychiatry – it only needs to be deployed in a way that ensures EC. While spiritual care practitioners may find it more natural to draw from local culture and idiom, this is not true *a priori.* Mental health practitioners who work within the psychosocial model are increasingly looking to local culture for clues and strengths for appropriate blends. And often, spiritual care and mental health are housed in the same practitioner or program. Such integration frequently gives rise to important hybrids of practice that will be exceedingly relevant to EC and IPR.

There are both good indicators and unclear signs regarding spiritual care and re-tooling religious traditions. In Sri Lanka, in conjunction with an NGO named Sarvodaya, a US-based colleague (Logan, 2008) evaluated subjective outcomes among a group of women who had participated in "Psycho-Spiritual Healing Project," which included therapeutic play, physical activity, group discussion, experientials, and meditation. The consensus was that meditation had been "the most useful and most calming." In the Pakistani and Indian cases above, I solicited feedback from trainees and most people gave the trainings glowing reviews. From a scientific evidence point-of-view, post-hoc analysis of such feedback will not go very far. In my cases, even with great urging, no one provided negative feedback -- a skew that may be a function of the goodwill created between trainers and trainees.

The "appropriateness" question may be solved by a complicated cost-benefit calculation that recognizes intangibles and involves diverse stakeholders. Experience shows that an overly biopsychiatric approach predicated on generalizability misses important cultural specificity and angers some stakeholders. Experience also shows that psychosocial interventions with multiple therapeutic mechanisms given by well-meaning cultural relativists tend to produce positive feedback and no scientifically convincing measurements of effectiveness. Improving our knowledge on both sides of this equation is crucial. Collaborations with disaster-affected stakeholders and disinterested researchers together will advance our field of work. Gradual approximations with EC will help to unpack the many layers of complexities involved with people's trauma and the interventions that we develop to support recovery.

In closing, I want to express my gratitude to the people of South Asia for their willingness to teach me expanded notions of psychosocial resilience. Drawing from this chapter's opening excerpt from

Jayawickrama, there may be situations in which 'traumatised victims' [deemed traumatized by outsiders] warrant neither mental health interventions nor spiritual care interventions. Some of these 'victims' may simply want restoration of tangible conditions (livelihood, schools) so that they can control their destinies and address their inner lives in collaboration with the people of their choice.

For those circumstances, however, that do warrant psychosocial assistance from outsiders, I will propose we work according to one last guideline: Planetarity.[4] While not congruent with our current notions of 'globalization,' the flattening of the Earth, or being green, Planetarity is an ethical call for how different people/nations relate to one another, and when necessary, help one another in times of crisis. With regard to psychosocial trauma, Planetarity stimulates opportunities for democratic and symmetric relationships of stakeholders innovating optimal interventions. New species of interventions -- ones that no one can imagine just yet – may arise in response to such calls as long as we have open minds, non-domineering work processes and curious spirits.

[4] From Gayatri Chakravorty Spivak: a sociohistorical call for people to be ethically responsible for each other.

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