Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE TWENTY-NINTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Displaced in America: Finding Hope in Community

Recent hurricanes, tsunamis, earthquakes, and conflicts have reminded us of the age-old problem of displaced persons and refugees. These are life crises that affect individuals, families, communities, and societies. How do refugee individuals and groups help themselves? How do the surrounding community and government help? What is the public health approach to preventing and preparing for catastrophe affecting populations? This is an issue of community mental, physical, and social health now and in the future. We will explore adaptive responses.

Speakers

Westy Egmont, DMin, Chairman, Massachusetts Governor's Advisory Council on Immigrants and Refugees; working with the U.S. Committee on Refugees and Immigrants, and Cultural Survival; Past President of the International Institute of Boston, Lowell, and New Hampshire

Lisa Gurland, RN, PsyD, Director of Behavioral Health Planning and Development, Massachusetts Department of Public Health

Lorna McKenzie-Pollock, MA, LICSW, Doctoral studies in anthropology; Director, International Counseling; Assistant Clinical Professor of Social Work, Boston University School of Social Work; clincal practice specializing in immigrants, refugees, and others with limited English language; past social worker, Indochinese Psychiatry Clinic, Brighton Marine Public Health Center; Past Associate Director, Cambodian Community Clinic, Metropolitan Boston Asian Mental Health Collaborative

Jody Ranck, DrPH, Director, Health Practice, Institute for the Future

Moderator

David G. Satin, MD, LFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, April 7, 2006, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD

Displaced people, whether refugees or people who have relocated voluntarily, have been a part of society since time immemorial. Populations migrate for better living conditions, flee from famine or natural catastrophe, are driven out by war or conquest, or search for new settlement out of curiosity and love of adventure. Their needs, their demands, and their gifts have posed questions and problems.

It's hard to say whether these phenomena are more or less now than In past eras. Certainly we hear more about them and take more responsibility for them in today's closer-knit world. We hear—somewhat In the abstract—about displacement by war and famine of huge populations in Africa, and of ethnic sub-populations in the Balkans and the middle east. The flood displacement of practically the whole city of New Orleans certainly brought this issue home to United State society.

This certainly is an issue of community mental health, public health, and social policy. Erich Lindemann was interested in the life stress affecting individuals moving to a new community in Wellesley, Massachusetts, the mental and physical health consequences on a community of forced urban relocation in the West End of Boston, and public policy in general as it affects community structure.

Today our speakers will address this issue from four different perspectives:

- the experience of displaced persons and how they care for themselves
- professional services meeting the needs of displaced persons
- the care that communities and society provides to displaced populations
- advanced planning to prevent and cope with displacement of populations

Westy Egmont, DMin

Chairman, Massachusetts Governor's Advisory Council on Immigrants and Refugees; working with the U.S. Committee on Refugees and Immigrants, and Cultural Suvival; Past President of the International Institute of Boston, Lowell, and New Hampshire; develops rsources for minorityand disadvantaged communities

Recent news about the super heated immigration debates of Congress and street rallies from a few thousand on Boston Common to a half million in Los Angeles enables many citizens to experience the outcry of undocumented residents. Caught in the choices of powerless poverty in Mexico or powerless marginal existence in the United States, they have accepted the life of being outside the law and willing to risk what little they in order to pursue any life better than that from which they fled. For many, the choice is as simple as $3.50 per day or $70 per day in earnings, but within these economic terms are the frustrated lives of many who have been denied self-determination and often suffered abuse in the context of political oppression or sustained and unyielding poverty. Without safe water, the question of mental health seems like a luxury. Without basic food, self-care takes on primal qualities.

The politics of immigration come in the door with those immigrants who seek behavior health services and present for mental health counseling. The context of their lives is inescapable. Beyond the undocumented fleeing the consequences of struggling states are those from failed states. A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return due to persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. We are familiar with some of the stories such as the 25% of the entire population of Afghanistan fleeing to surrounding states to escape the Russian army, the Taliban or U.S. bombing in the pursuit of Al Qaeda. Life's stabilizers- community, extended family, house of worship, work- were sacrificed in hope of avoiding death, finding education, relative safety, and tentative sleep.

The Lost Boys of the Sudan, who repeatedly reminded us that they were not boys or lost, were young adults orphaned between the ages of 8- and 10-years-old who had fled across the dessert and the river to Ethiopia and then been pushed back by armies. They had fled again to Kenya and in their epic journey had found each other, the fellow survivors. The former Yugoslavia imploded and ethnic hatred fed by nationalism turned European cities into the site of massacres and war crimes, dividing families and neighbors in forced loyalties and fearful decisions. As recently as this week, gubernatorial candidate Deval Patrick drew attention to the reality in New Orleans saying, "Our failure to those we have seen on the roof tops with outstretched arms began long before Hurricane Katrina." America's "refugees" or internally displaced people bare

similarity to those fleeing war and famine around the world, except that they have a wealth of choices relatively soon after the disaster and though woefully inadequate, they are not without public sector action on their behalf.

What happens to the survivors? Is there a lesson from baring witness to these oppressed people in professional roles as they resettle and act upon choices they could not have imagined? Taking a brief look at just two aspects of recovery for survivors, we might focus on community and facilitation. By community, the focus is on group identification. Somali women who departed their home land, crossed barren dessert to find purported safety in the two major refugee camps of Kenya, Dadaab and Kakuma. Approximately 80% of the population are women and children. From 1991 to 1993, approximately 300,000 Somalis fled across the 800-mile Kenyan-Somali border. Most refugees walked miles over Somalia's desolate savanna into Kenya's North Eastern Province, others risked their lives in makeshift boats to reach Kenya's coastline further south. As of this writing, most of the refugees continue to remain in camps in Kenya, some temporary cities numbering over 80,000 refugees. Many were the victims of violence, including rape, as they fled war-torn Somalia. They went to Kenya to escape these dangers, only to face similar abuse upon arrival. The UNHCR has documented rape among 300 Somali women, 100 in Somalia and 200 after reaching Kenya. The absence of stigma among the women, in relative terms, and the collective nature of community life allow traumatic events to be absorbed in the context of acceptance.

One strong element in interviewing the women is the pattern of collective self-understanding, "We were assaulted," "We were attacked by the soldier who was sent with food." Perceiving themselves as part of the whole, the dominant "we" is inescapable to the Western ear. Victimization is of the people- the clan- and there is little individual attachment to the elements that in the U.S. might be associated with personal blame or responsibility. This corporate sense of violation lifts individuals from certain elements of psychic distress as they naturally assume a shared lot, common grief and mutual assistance. We would be wrong to dismiss the individual elements, but the collective context and strength of survivors is often overlooked.

When populations come to the developed world, an early instinct is the creation of a formal community. The U.S. recognizes this need and encouraged practiced organizing by giving dollars to these new entities, which are appropriately named Mutual Assistance Associations. Often their potential is hindered by the rise of old world agendas of class, religion, or clan but the formation usually proceeds until a surviving organization or organizations can fulfill a leadership role. Within a short time the Vietnamese had formed groups in Boston. Since the population arrived in three waves and the experience of those who left at the fall of Saigon was markedly different from those who lived through re-education camps and a new government, the community formed different

associations with leadership appropriate to the differentiating experience and yet willing to bridge the divides with the total community of 20,000.

Yet another example is in Northern New England where the refugee population shifted from Asians to Africans coming from Liberia, Somalia, Sudan, Sierra Leon, and Eritrea. With little in common- not language, food, religion or music- the Africans formed a group for themselves, recognizing their common bond in arrival, loss, and color within the whitest of states, and within the perception of Americans who know nothing of their cultures. Systems replacing some of the lost family support developed rapidly as families shared child care, goods, job leads, holidays and social events.

Having run schools, churches, and poverty agencies over decades, opportunity came to lead the International Institute of Boston, an agency at the time committed to refugee resettlement. An admitted plus of this work was a stately ambassadorial facility in the Back Bay on Commonwealth Avenue. After assuming office, the challenges of the building became evident. Most of the refugee services were in the former laundry and boiler room below the street level. Relegated to the worst space, staff worked in the mahogany bedrooms and in the tooled leather dining room. One might ask, “What is the best environment for community mental health work with a traumatized population?” and “How do we create space in which we facilitate recovery?”

During my training in pastoral counseling I served for a semester at the now decommissioned Danvers State Hospital. Its mammoth granite walls and fortress like elements were very Alfred Hitchcock and caused residents and staff to relate in prescribed ways. During that time the work of Maxwell Jones and the concepts of the therapeutic community became a source of seeing alternatives to this work environment. The sociopolitical influences that permeated the psychiatric world, the concept of the therapeutic community and its attenuated form- the therapeutic milieu- caught on in Britain and the United States and dominated the field of inpatient psychiatry throughout the 1960’s. The most striking characteristic of the therapeutic milieu was that the community itself, as well as all the individuals who constituted it, were the most powerful influence on treatment. Unlike other settings, many of the values that formed the underpinnings for every milieu were clearly articulated- egalitarianism, permissiveness, honesty, openness, trust (Almond 1974; Leeman 1986; Leeman and Audio 1978; Rapoport 1960).

All therapeutic communities rest on several assumptions including; patients should be responsible for much of their own treatment, the running of the unit should be more democratic than authoritarian, patients are capable of helping each other, treatment should be voluntary whenever possible, restraints should be kept to a minimum, and psychological methods of treatment are preferable to physical methods of control. Psychotherapy, individual therapy, and various forms of group therapy were used

routinely and were usually psychoanalytically informed (Almond 1974; Cumming and Cumming 1962; Wilmer 1981). Tucker and Maxmen (1973) described the treatment milieu as a "laboratory wherein the patient may safely experiment with newly acquired adaptive skills." The aim of a modified therapeutic community was to "promote a corrective emotional experience, enhance personal understanding, and maximize healthy ego growth."

Applying the simple principles of Jones' work, we designed a new facility. Staff and client spaces were mixed on each floor with great emphasis on having the brightest, most appealing spaces dedicated to clients. Simple elements like water coolers and coffee service were added to encourage lingering and gathering spots. As the need arose with increased Muslim refugees, East-facing corners were designated for prayer. Old traditions were reinvented and processes like distribution of supplies were tied into End of Eid parties. Even the colors were chosen for client comfort, taking natural dye colors familiar to developing nations, were used on the wall and in the carpet. A healing community starts at the door and is expressed by all staff and in all gatherings. Though security, contract requirements and confidentiality all intruded on the environment, the underlying assumptions of equality and client directed and encouraged mutual assistance survived. A facilitated community was formed and the integrated service delivery model which served thousands of clients well was using these insights.

Staff working in these environments report their sustaining will to be derived from their clients. As bleak as are the tragic events of history, our contemporary events, so evident is the human character that demonstrates a will to live and an indomitable determination to affirm life. Within this environment could be nurtured specialty programs to assist victims of human trafficking, labor and the sex trade both being active sources, and torture survivors. Bi-cultural staff play a pronounced role in this model. There is evident identification with providers who share language ability and even more with those who come from similar backgrounds. While risking retraumatization, former refugees among the staff played leadership roles in addressing the most critical aspects of trust, communication, and role models. At the same time, these services by a mixed team, including U.S. born staff, allowed a shared burden and mix of expertise that further enhanced the client work. The institutional impact of bi-cultural workers was evident in their need for mentoring as they worked in a new culture and the increase or decrease of clients based on the primary language capacity of staff. When an Ethiopian staff member left without having other staff member of the same background, within a short time all Amharic and Tigrinian speakers were gone from the client list. Within the community, identified helpers who have access to support and larger resources are essential.

The U.S. Refugee Program, which consists of 10 national agencies working with 300 local chapters or sites, currently resettles about 50,000 refugees each year, which is down from a high of over 200,000. The work is relatively invisible, but is powerful evidence of community health delivery and democratic values. Each client is processed abroad by the United Nations and CIS. They are welcomed by non-profit staff who arrange housing, orientation, first foods, and enrollment in services and benefits. Serving daily arrivals is daunting, in their variety and needs. However, staff is selected for the job that requires a run to the airport at midnight, after moving pots and groceries and even mattresses during the day. Hours will be spent at Social Security in neighborhood schools but in this process, the most vulnerable of the arrivals to the 'land of liberty' find something we all seek, hope.

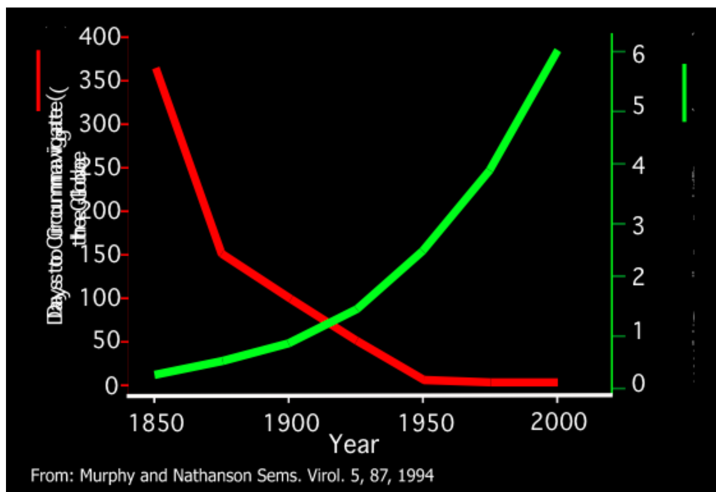
Good resettlement agencies, those who value clients and bring psycho-social understanding and service along with protection and education demonstrate the power of addressing the displaced with integrated service and building an environment that sustains the displaced as they rediscover their own strength and resolution. Hope is a resurrected feeling. It suffers in the inferno of human cruelty and wallows out of sight in the dark passages through loss but it can be found again. Vaclav Havel, a poet and politican once stated, "Hope is not the conviction that something will turn out well, but the certainty that something makes sense regardless of how it turns out."

We determine, in partnership with newcomer's communities, the speed of recovery and the transfer of hope from us to them. The burden of life falls to each of us alone, but the creation of new communities falls to us all.

Lisa Gurland, LCSW, RN, PsyD

Director of Behavioral Health Planning and Development, Massachusetts Department of Public Health; consultant for behavioral health disaster response as part of comprehensive emergency response planning

Behavioral Health Emergency Preparedness



- The worldwide population growth combined with speed of travel.
- The general thinking among Americans up to the early part of the 1800's was that disease was an incident in a drama of moral choice and spiritual salvation. Cholera, which was a huge problem in Europe was not going to be problem in the U.S., or so Americans desperately believed. By the time cholera hit U.S. shores in the 1860's, disease in general had become a consequence of human interaction with the environment. Disease went from being a moral dilemma in the early 1800's to a social problem a few decades later. Think about the parallel in our present situation. Many people believed that as Americans were protected from many of the problems endured by other parts of the world. Terrorism, certain diseases, biological agents escaping from laboratories, etc.
- 1918 Flu pandemic

Definition of Behavioral Health

- Behavioral health addresses the ability to function as individuals, families, institutions and communities.
- The purpose of a Behavioral Health Response is to mitigate the consequences of a disaster through prevention and intervention.

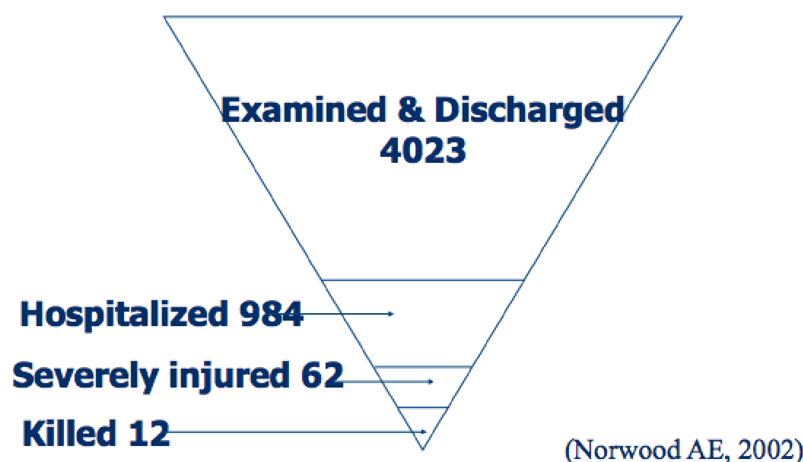
Purpose of Behavioral Health Intervention

- Builds resiliency in communities before a disaster in order to reduce the behavioral consequences post-disaster
- Assists individuals, families, and communities during crisis
- Prevents or reduces future problems for individual, family, or community
- Reduces inappropriate use of medical and first responder resources
- Supports the rebuilding of an affected community

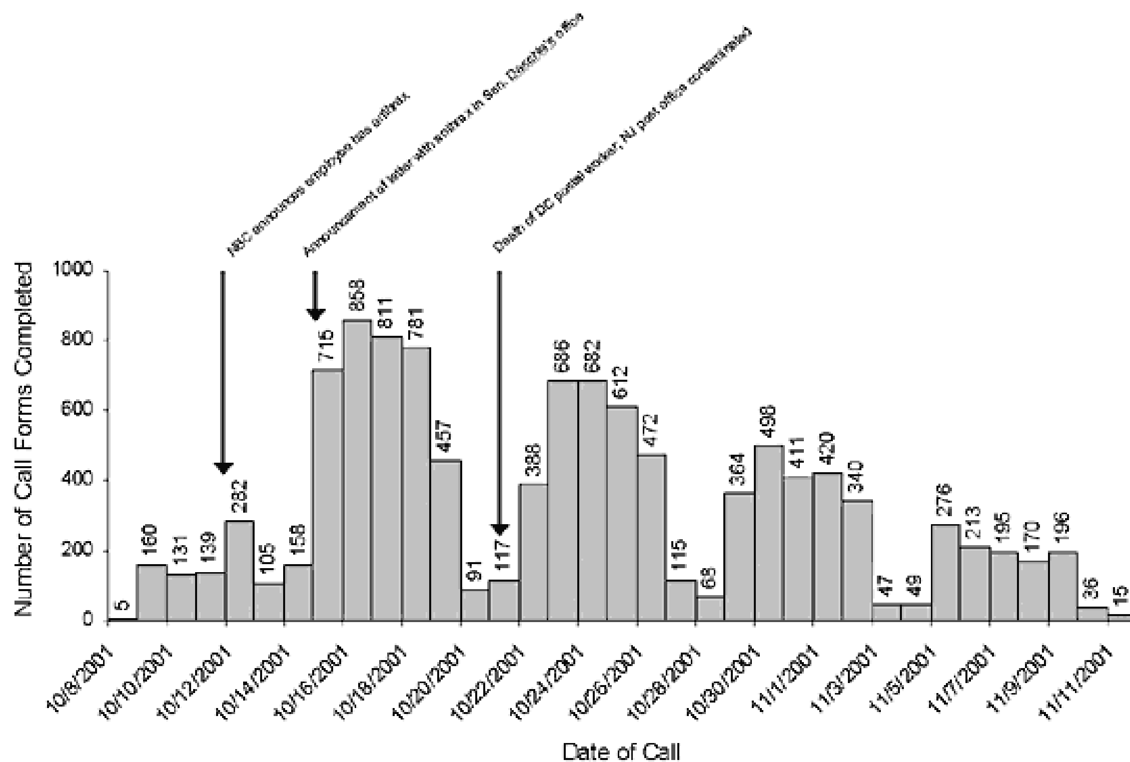
Behavioral Health Emergency Preparedness Principles

- No one who experiences a disaster is untouched by it.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- This means that besides the people who are directly affected by the illness, acts of terrorism, or flooding, there are all of the others- the friends, family, and community of those affected, the caregivers, first responders, medical community, the social service agencies, etc.

Sarin Attack on Tokyo Subways



(Norwood AE, 2002)



Vulnerable Populations

- Refugees and other newcomer groups, especially those with a history of trauma exposure
- Any child or adult with prior trauma exposure
- The elderly and disabled
- Disenfranchised or fragile individuals and communities
- MDPH works with communities to help identify those who will be most vulnerable in the community. Vulnerability will vary depending on the emergency and responders and providers may fall into the vulnerable category as well. CDC has algorithms and formulas that are easy to use to estimate the extent of the emergency for geographical areas. For example, if the flu pandemic first hits in the Berkshires, then we would expect to have up to 40% of the workforce out because of their own illness or the illness of a household member. What does that mean for the fire department, police department, truckers who bring the food to the supermarket, etc.

Chinese Proverb

- *You can't prevent the birds of sorrow from flying over your head, but you can prevent them from building nests in your hair*

The Rationale for Behavioral Health Intervention

- People experience common emotional and psychological reactions to disasters- disaster stress.
- These reactions subside with time for most people.
- A behavioral intervention (psychological first aid, crisis counseling, etc.) helps people understand the experience as well as build supports and coping skills.
- Appropriate interventions can prevent long term problems by returning people to their pre-disaster level of functioning as quickly as possible.
- Many refugees (as individuals and as communities) have amazing coping skills. Somali Bantu's originally settled in Atlanta, GA, New York, and cities in Ohio, but they moved in mass to Lewiston, Maine to spare their children the effects of urban temptations and social ills- this is how they coped.
- The largest Cambodian population is in Long Beach, California, and after an earthquake as well as the Stockton School shooting a large group moved to Lowell, MA.

Behavioral Health Response

- How people respond to an emergency has life changing ramifications.
- If behavior can support optimal functioning, then one's sense of well-being will increase and stress will decrease.
- Optimal Behavioral Health supports the healthy functioning of all community members.
- Disruption of Behavioral Health leads to coping problems within families, neighborhoods, and institutions (health care agencies, schools, government, religious institutions, etc.).
- Prevent people from doing what is not in their best interest, such as substance abuse, panic, family discord or disruption.
- The R and I program at MDPH has developed a list of key words that will be important to understand in a communicable disease emergency. For example, immunization vs. treatment, treatment vs. cure, and bacteria vs. virus. We are working on having these words translated and described in numerous languages to be used by the local community press to educate their constituency either before or during an emergency.

What We Know About Disasters

- It causes significant disruption of family dynamics
- It causes significant disruption of natural support systems

- It causes changes in school configurations
- It creates disruption of community infrastructure

Unanticipated Effects of Disasters

- Significant influx of outsiders
- Interface with large & complex bureaucracies
- Impact of new social patterns
- Impact on marginalized groups

Facts About PTSD

- Everyone exposed to disaster experiences stress, but stress isn't necessarily considered a *disorder*.
- PTSD = no appraisal mechanism, either hypervigilant and aroused or avoidant (fight or flight)
- The best way to prevent PTSD is to recognize and deal with stress reactions *before* they become a disorder.
- Appraisal keeps you in the present. One can only appraise a situation accurately, if one is present-focused.

Self-Care

- Self-care is an essential component of disaster planning for all responders.
- There is a direct relationship between how well responders take care of themselves and each other as well as the quality of care provided to people affected by the emergency event.
- Responders should have the following;
  - Self Care Plan
  - Family care plan
  - Team Care Plan
  - Robust and redundant communication patterns and networks

The 2003 SARS Outbreak in a Teaching Hospital: The immediate psychological and occupational impact

Maunder, Robert et al.
Canadian Medical Association Journal
May 13, 2003; 168(10)

Building Resiliency

- Members of the Public
- Community Institutions and Agencies
- Disaster Response Teams

"We don't have to become heroes overnight, just a step at a time, meeting each thing that comes up, seeing it as not as dreadful as it appears, discovering that we have the strength to stare it down."— Eleanor Roosevelt

Jody Ranck, DrPH

Director, Health Practice, Institute for the Future

From Crisis to Hope: Making Humanitarian Practices for Refugees more Humane

I've been asked to speak about the predicament of refugees post-Rwanda and Katrina and how we might prevent refugee situations and respond to refugee crises in the future. The concept of prevention is viewed as central to how we think about resiliency and reconstruction in the aftermath of disasters. But in order to give this issue the rightful attention it deserves I think a brief introduction to the historical context of "the refugee condition" and of the political context of disasters should be our starting point in order to think about what form of "prevention" may be most effective. In order to talk about prevention in the first place we have to think through the political conditions of vulnerability that put some communities at greater risk of disaster than others. I want to avoid a framing of "prevention" that looks at the issue in a purely technological sense, or merely a matter of the use of public health planning devoid of historical and political context as they relate to the refugee condition(s)- for there is nothing 'natural' about who suffers in a disaster.

The reason why I am taking this approach is that there is very little that is "natural" in the effects of so-called natural disasters. Histories of discrimination, policies of neglect and, frequently, criminalization of minorities both shape the way infrastructures are put into place, or not, and the response in the wake of disaster. A cursory glance of recent disasters across the globe shows that the numbers of individuals affected keeps growing so we should begin to ask why. Long before the debacle of Hurricane Katrina the discourse of humanitarianism was experiencing a profound crisis. What I mean by humanitarian discourse is the assemblage of practices, ideologies and organizations that create this thing called "humanitarianism." The crisis I'm referring to is one that should seem obvious by now- 50,000 refugees dying in the camps in the Congo in 1994 and the conflict that grew out of this refugee crisis to create Africa's first "World War" from 1996 to the present (killing nearly 3.5 million to date). The abysmal failings of famine interventions in Ethiopia in the 1980's, the failure of the crisis in Darfur at the present, just to name a few, all point to a failure to confront the political failings of humanitarianism. While shocking to the American public, we must now recognize that events such as Hurricane Katrina are just the latest installment in a long history of negligence and maltreatment of those affected by both manmade and natural disasters and a failure of local, state and global institutions to address the needs of the poor and disenfranchised. Therefore it is high time we begin to open up a serious conversation on the politics of humanitarianism post-disaster and the links to the broader political order

of societies prior to disaster in order to think the future of disaster relief. However, the task of criticizing humanitarianism is not easy, the very use of the word "humanitarian" places humanitarian practices all to frequently above criticism. But I would argue that to think critically about this discourse is the first step in making humanitarian practices more humane.

Recently the philosopher Giorgio Agamben (1998) has extended Hannah Arendt's examination of the limits of human rights to look at the camp through the prism of what he terms "bare life," that is "life that can be killed but not sacrificed." Bare life, or *zoe* for the Greeks, was life that is common to all beings. Zoe is juxtaposed to *bios*, or life that has a politically qualified existence. Bare life is a particularly appropriate way to describe the refugee existence in the camps, that is one without political subjectivity or reduced to the most basic needs that humanitarian organizations are obliged to offer aid in the form of a "gift." Agamben makes this distinction in order to illustrate the relationship of politics to humanitarianism:

> "The separation between humanitarianism and politics that we are experiencing today is the extreme phase of the separation of the rights of man from the rights of the citizen. In the final analysis, however, humanitarian organizations…can only grasp human life in the figure of bare, or sacred life, and therefore, despite themselves, maintain a secret solidarity with the very powers they ought to fight."

Agamben wants to direct our attention to how we deprive refugees or recipients of aid of any politically qualified, or particular form of existence that we would grant most other categories of beings. Our media are often complicit, representing the refugees through the voices of aid workers, as such they become what Liisa Malkki (1996) has referred to as "speechless emissaries" of suffering. This way of constructing the refugee puts her at a distinct disadvantage in concrete terms. An excellent example of both Agamben's point and the inferior relationship of refugees in this gift relationship can be found in Barbara Bush's observations of refugees in Houston on September 5, 2005[1]:

> "This is working very well for them…Everyone is so overwhelmed by the hospitality…And so many of the people in the arena here, you know, were underprivileged anyway, so this—this (she says laughingly) is working very well for them."

[1] http://www.commondreams.org/headlines05/0906-01.htm

While startling crass to an American audience this view of refugees is surprisingly common if one takes a look at refugee testimonies and the institutional context of humanitarian aid to refugees in places like Rwanda, Burundi and Uganda.

The gift relationship (Harrell-Bond 2002) sets the refugee up for a wide range of institutional relationships that all too often work to the disadvantage of the refugees as I will discuss below. But first, to illustrate my point on the political origins of suffering, I would like to offer some historical context of disasters that rest in our historical memories and can shed some light on the current problem. Remember the Irish Potato Famine of 1845-49? This was not simply a matter of potato blight or a "natural disaster" causing 500,000 to 1,000,000 deaths, but was the historical outcome of colonial policies that prohibited Catholics from owning land or having secure economic positions. Absentee landlordism and a free market ideology that blocked action until it was too late were all responsible for the tremendous death and suffering that occurred. When the British finally opened workhouses the material conditions were so terrible that it is estimated that 200,000 died in these workhouses alone. The Ethiopian famines of the 1980's that mobilized a generation of pop stars through Band-Aid (note the irony in the name) to confront this so-called "natural disaster" understood as a drought was. As Alex de Waal and others have shown, a war by other means where depriving communities of food was a mode of warfare. Sudan is the same and while focusing our attention on Darfur at the moment it might also be useful to investigate the entire history of famine and war in the region and the vital role that humanitarian aid has played in sustaining the conflict (Keen 1994). While many lives are saved by humanitarian interventions we also see many more lives lost as humanitarian aid has sustained conflicts in places such as Southern Sudan. While the media frequently speak of the lack of political will to address these conflicts and refugee situations we rarely see critical engagement with humanitarian practices themselves, at least in any sustainable way.

In the U.S. post-Katrina, we have witnessed a tremendous amount of criticism aimed at the political elites who have been seen as incompetent in their handling of the Katrina crisis. For a very brief moment we actually even heard murmurs of a discussion on poverty and race in the U.S. and how race and class played important roles in the structure of suffering during the crisis. This was brought home through direct images of suffering and harrowing stories of sheriff deputies from neighboring counties representing primarily middle class white constituencies and how they blocked the evacuation of African-American refugees trying to exit the city. Yet, we also saw many examples of politics as normal and mediatic attempts to stigmatize the victims of the hurricane or justification of neglect and social discrimination. Congressman Richard Baker's (LA) illustrates the callousness of much thinking on the right through his observation that "We finally cleaned up public housing in New Orleans. We couldn't do

it, but God did!” Baker’s statement highlights the close connection between libertarian values and the Christian right-wing and how these discourses have merged to structure a great deal of the anti-poverty thinking in this country over the past 20 years or more. It is political discourses such as these that must be redressed in order to think about prevention of disasters in the first place.

But we should not be surprised at the magnitude of the suffering during Hurricane Katrina. In the wake of 9/11 the response to disasters in the U.S. has increasingly been framed through the prism of “readiness.” Now, “readiness” marks a direct departure from the idea of “prevention” that the discipline of public health has promoted for the past century. “Readiness” draws more directly on military metaphors and preparation and an attention to the probability of an “emergency situation,” rather than an ongoing engagement with population-based approaches to health and poverty that may be far more effective in both preventing disasters or high casualties as well as building more resilient communities. Readiness also is much easier to implement from a policy perspective in that politicians do not have to confront the complex issue of poverty. It is much easier to mobilize vast sums for military budgets to protect the “homeland” than to give “handouts” to “Cadillac driving welfare mothers,” as Reagan would have it, and virtually any entitlement will undoubtedly be treated in the public sphere today. In the U.S. we have witnessed a great deal of rhetoric about the social collectivity in the wake of 9/11, but there is a stark disjuncture with our response to 9/11 through the discourse of readiness that remains silent at best on the issue of the structural conditions of poverty that structure vulnerability to disasters.

This tension is built into the current structure of DHS and FEMA and many within the emergency management quarters recognized this problem long before Hurricane Katrina struck. This may also be a barrier to finding anyone willing to take the job of heading FEMA at the moment as the *New York Times* recently documented the failure to get any of the first eight nominees to the position to accept the job. While many have mocked the color coded alert system used by DHS, much less attention has been given to those who have focused on the rapid acceleration of the destruction of the infrastructure that could help prevent crises or allow us to respond in a more effective manner. Otherwise the development of the wetlands off the coast of Louisiana and the dramatic reduction of the Army Corps of Engineers budget by 80% would have become a far greater political issue since both would have played a major role in preventing the destruction that we all witnessed. Prior to the disaster of Katrina, Louisiana ranked 48th in support for public health and 49th for infant mortality rates according to the United Health Foundation (Sirkin 2006). Others have noted the anti-urban bias in the Bush Administration, which to be fair, has a long history in the U.S. even prior to this administration, that has dramatically reduced public works for cities. Already we see the

Republican response to the need for aid post-Katrina is one based largely on depriving the poor in developing country of funds and assistance they may have received through the Global Fund for AIDS, TB and Malaria.

What Katrina did was open up the eyes of a media that had long sought entertainment value in the plight of America's poor through reality shows such as Cops, Cheaters, and a never ending stream of infotainment. Yet according to the U.S. government's estimates, at least 37 million Americans fall beneath the poverty line (a line that is constructed in rather stingy terms to avoid even greater government assistance to more "unworthy recipients"). Why were they so invisible? The effect of New Orleans was to shine a very bright light on the poverty situation in the U.S. and reveal who suffers the most when disaster strikes. However, some members of the media were late to draw attention to this reality- when Yahoo displayed two AP photos of a white couple carrying goods vs. a two black men carrying goods through the floodwaters startling different captions were utilized. Whites were "survivors" while blacks were configured as "looters." The reality that nearly 100,000 New Orleansians lacked the means of transportation to exit the city was lost on much of the media. Nearly 3 out of 5 black families lacked vehicles alone. "Readiness" meant that you were responsible for your own evacuation. Al Sharpton was one of the few to recognize the dynamics of poverty in New Orleans through his observation that the poor lack bank accounts and the payment of public support at the end of the month meant most stayed home hoping that they could get their checks and then be able to *afford* to evacuate.

In the post-Reagan America of hyper neo-liberalism you must find, or is that *fund*, your own way out of the disaster. What we have witnessed through several decades of neoliberalism is a shift from sharing risk as a collectivity to the individualization of risk and responsibility that lies at the heart of much of the suffering we have seen post-Katrina. From health insurance to disaster evacuation, your survival depends on your own capacity to escape and we should never have expected much from FEMA in the first place. The question is- at what point will this way of thinking "readiness" create a tipping point where its political effects outweigh the effects of the disaster? Already by 1995 the U.S. had encountered a similar "quiet" disaster when the Chicago heat wave killed nearly 750 people, mostly those elderly lacking social supports and the ability to afford air conditioners (Klinenberg 2002). Social supports and the social ecologies of urban life matter- while this case is not a refugee story it illustrates how social ecologies structure the outcomes of disasters. In this case we also saw how a city let its citizens down and emergency humanitarian measures fell far short and the consequences were deadly. As we think of new technologies and interventions to assist us in disaster contexts we must not lose sight of these socio-political dimensions to life and expect the technologies to come to our rescue.

My own experience in Rwanda further confirms the globalization of this trend in how we think about humanitarianism and development in developing countries. From this experience I learned how the genocide was built on the wreckage of a dying colonial discourse of race that had been utilized in indirect rule in Rwanda. When the IMF/World Bank structural reforms in Rwanda (a country that had been viewed as the Switzerland of Africa in the eyes of donors) produced periodic famines and contributed to a dramatic increase in social suffering, this dying colonial discourse was appropriated to fuel the political genocide to a stunning degree. Only in the aftermath of the genocide did we see anything resembling a humanitarian response emerge since thousands of dying Africans were not worth the risks that a few thousand U.N. peacekeepers and allies might encounter. Yet, the quality of the humanitarian response was dismal. Knowledge of the political culture of Rwandese and the many difference among them was virtually non-existent. A homogeneous, guilty population of Hutus was met with great suspicion by humanitarians and the legacy of this period continues into the present as the Rwandan body politic attempts to "heal" itself.

The anthropologist Liisa Malkki (1995) has studied this "architecture of silence" that presides over many a humanitarian intervention and how forgetfulness descends over each successive crisis in a "regime of strategic invisibility" that denies refugees any singular, political subjectivity. Rwandans were viewed as a collectivity, denied of any particular food cultures in the distribution of food aid, denied of any political differences that made all Hutus, regardless of political affiliation, guilty by association. Aid and the gift economy worked hand in hand to degrade refugees who were frequently offered food considered animal feed from the hands of humanitarians, as Johann Pottier observed (Pottier 2002). As is typical of most refugee camps, and this is supported in the literature, an environment of distrust descended over all Hutu refugees regardless of guilt or innocence. As the camps became full, the recognition that many refugees have skills and assets that could enhance their survival and existence was considered almost unfathomable. *Refugees as bare life become unusable*. The state of emergency always requires a top-down approach. Refugees do not think. I may sound harsh here but the debacle of the first 50,000 who died in the camps of Goma became the next disaster of 100,000 who seemingly disappeared in 1996 at the hands of the RPF…became the 3.5 million Congolese who have been killed either directly or indirectly since the Congolese civil war broke out. These events are connected in the politics of the region.

One event in my experience that brought home this inhumane politics of humanitarianism is the experience I had in 1997. I spent a day at the International Criminal Tribunal for Rwanda's offices in Kigali watching documentary footage taken during the genocide and observed a particular harrowing set of images of Tutsis clamouring before the French Embassy, the home of the declaration of the rights of man,

attempting to find refuge and transit out of Rwanda to avoid the assured execution that awaited Tutsis. With gates slammed in their faces, many of these individuals, some employees of Western humanitarian agencies, awaited impending execution. The next day I was leaving a U.N. compound and noticed the plaque with the names of Tutsi employees who had been murdered during the genocide. This juxtaposition brought home the brutal shortcomings of our humanitarian discourse. As these events unfolded we even heard of Westerners planning evacuations of the Silver Back Gorillas in Northern Rwanda.

I spent nearly 5 years working on post-genocide Rwanda. I frequently interviewed survivors and former refugees from the 1994 genocide or previous pogroms that occurred in the 1960's and 1970's. Many had fled Rwanda, some through the French "safe haven" or the Zone turquoise. In these so-called "safe zones" the women were raped repeatedly and held hostage. Others had been displaced and encountered humanitarian organizations attempting to care for their needs. While I do not wish to paint all humanitarians as oblivious to the suffering around them, I do believe we need to address the task of critical thinking in order to think through how we might otherwise treat refugees. I interviewed trauma counselors for UNICEF claiming to provide "culturally sensitive" approaches to trauma who scoffed at the mention of *ngoma* or spirit possession. These indigenous institutions have a long history in Rwanda despite attempts by the Catholic Church to deny them legitimacy. In the run up to the genocide many hillsides were rife with acts of sorcery. So, if spirits played a role in stoking the genocide they could most certainly play a role in re-working selves and societies in the wake of the genocide. Trauma resides in the body and the possessed body can become an important vehicle for re-working the experience of genocide and rape. These Rwandan counselors, entrusted with the skills of culturally competency, responded with "Ça c'est sauvage et incivilise," when asked if they engaged with traditional healers.

Other organizations working with widows of the genocide received Western training in trauma management yet recognized that Rwandan women would go into the banana groves in the secrecy of the night and utilize these other spiritual practices and *umupfumu* (witch doctors), since the source of illness in the traditional cosmology rests in the social body that was based on a concept of the flow of fluids. Social disharmony produces blockages which lie at the heart of illness. This is why barricades were so symbolic during the genocide, blockages are signs of disharmony and every Rwandan knew what was going to happen when roadblocks emerged in the hours following the shooting down of President Habyarimana's plane. Yet these signals and signs of distress are rarely taken seriously by those who come to the aid of refugees and survivors.

Another problematic area was the question of justice. When the international community established the International Criminal Tribunal for Rwanda (ICTR) out of

the statute that created the ICTY the decision was taken to have the trials in Tanzania. Rwanda, it was argued, was too insecure to guarantee effective prosecution of war criminals. Yet for the Rwandans I interviewed, this created a disjuncture where justice was rather abstract and far removed from their everyday lives. Throughout the 1990's and early part of the millennium the pursuit of justice was characterized by many missteps ranging from lack of credible witness protection, to an initial reluctance to pursue rape as a war crime until the landmark case of Jean-Paul Akayesu who was the first to be convicted of rape as a war crime in 1998, to an inability to execute a social welfare fund that donors had established for the survivors. There was also a notorious case where the ICTR's own judges laughed at a female witness who was recounting her experience of being raped.

The frustrations that Rwandans felt was also a symbol of their anger at the international community for allowing the genocide to happen in the first place. The international community's legitimacy to carry out justice when they were viewed as complicit in the genocide has been a serious barrier to implementing anything resembling justice in a constructive way in the wake of the genocide. The injustice of justice was further brought home when we entered the age of anti-retroviral treatment in Africa. Convicted perpetrators of the genocide who are HIV positive now receive HAART therapy while many of the women who were raped will die before their perpetrators due to lack of access to ARVs. How justice takes on a life, or not, in local worlds is an extremely important point often missed by those espousing the universality of globalized notions of justice.

Perhaps the root of the problem with justice is even more philosophical however. Our modern form of justice is an administrative-bureaucratic affair detached from any sort of embodied ethics and for crimes of this magnitude can we really expect individuals and communities to feel some sort of redemption from punishing the guilty? I am not arguing for any type of rejection of the pursuit of justice, rather we may have to adjust our expectations and open our eyes to other ways of thinking justice in more life affirming ways. Trauma and genocide involve a tremendous loss that will never be repaired. Absence and loss are terribly difficult to address through a legal discourse. This is a profound philosophical question that every survivor of genocide and torture faces- how to relate to the experience of loss without being subsumed by it.

In the case of Rwanda we are dealing with a century of colonialism, genocide, and basic questions of how to reconstitute a society in a way *other* than what has been constituted through generations of violence. The trauma is not merely the trauma of 1994, but nearly a century of extreme violence by pre-colonial, colonial, and post-colonial forms of violence and power. Justice in the administrative sense is a very blunt and, in my opinion, weak pedagogical tool to accomplish the task that violence of this

sort demands. Justice has becomed separated from ethics in the late modernity in which we now live. While researching this issue many years ago I came across this quote from Jean Rhys' *Wide Sargasso Sea* that reflected the experience of modern justice that many of my informants seemed to articulate[2]:

> "'Justice,' she said, 'I've heard that word. It's a cold word. I tried it out,' she said, still speaking in a low voice. 'I wrote it down. I wrote it down several times and always it looked like a damn cold lie to me. There is no justice.'"

After thinking about these lines it came to me that the process of how "we" must come to think about our responsibilities to what remains in the wake of genocide and war is an important question to ask in understanding how societies respond to disasters. How the victim of violence acquires her voice, or subjectivity in the wake of disaster is an important philosophical and practical question. This was something that was hard to grasp when armed purely with the liberal discourse of human rights. It is just assumed that something called reconciliation will emerge from tribunals. But do we really want to reconcile forms of subjectivity produced through decades of state violence? The human rights approach is too individualistic and apolitical to capture the challenge at hand. My realization was aided by an encounter with a genocide survivors' organization that resisted Western funded trauma programs and appeared quite aloof from human rights organizations but struggled to create a space where women could articulate their experiences. The name of the group was Mbira Ndumva, or "Speak, I'm Listening," was telling. The challenge of creating a space where women could articulate their suffering and actively engage with the other was central to their success in alleviating suffering.

In some cases, these women welcomed Hutu women who had returned from the Congo under a great deal of suspicion. But the recognition that Hutu women had experienced rape and murder as well was part of this active forgetting and listening that could form the basis of a community to come. These acts created the ethical space for the re-constitution of society that is necessary but is a long, difficult and flawed struggle in a militarized context as Rwanda. Nevertheless, if we are to discuss the issue of *hope* in the wake of the disaster we must resist the melancholic tendency to look to the past with resentment. Justice must be the critical questioning of the present and a position of remaining unreconciled with the past and the way "we" have been constituted through violence and exclusion of the other. Another justice is one that opens up the possibility of addressing exclusions and refusing the push to reconcile identities that have become naturalized and produced through modern violence. There is no point in reconciling the

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[2] I am indebted in Thomas Keenan (1997), Fables of Responsibility. Aberrations and Predicaments in Ethics and Politics. Stanford University Press, Stanford.

categories of “Hutu” and “Tutsi” for Rwandans are far more than what these tainted categories can possess. Decolonizing the social imagination that has produced these categories is fundamental and fortunately we do see examples of this in the everyday lives of the women I interviewed who remain marginalized from the state apparatus of memory and reconciliation that dominates the media and official memory. Memory as a social praxis resists a desire for origins and authenticity and searches for other forms of belonging. It is my feeling that issues such as these may inform the way we think about humanitarianism in the future to produce something more humane and worthy of the term humanitarianism.

As we look ahead we will see many new technologies and public health practices that can play an important role in prevention and aiding humanitarian situations. From GIS to RFID, advanced communications devices, new technologies for water and sanitation are going to play a role in enhancing service delivery in the time of disaster. We may find more advanced surveillance technologies to guard against terrorism and more sophisticated atmospheric and weather forecasting models to give more warning before storms. These are all very important and I applaud those who are trying to think in creative ways on how we can deploy the technologies at hand to reduce suffering. But, we will need to have a much more sophisticated and intellectually honest approach to thinking through the politics of humanitarianism, prevention, human rights, and citizenship to allow communities to respond in a more life affirming (in the Nietzchean sense) manner in the future. New technological developments must be accompanied or produced through corresponding developments in social technologies capable of reconfiguring the politics of prevention and response in order to have the effects we might desire.

Our current political atmosphere is not encouraging however. Our overriding concern with security in the wake of 9/11 will undoubtedly play an important role in producing new conflicts and refugee situations as security trumps poverty alleviation and human rights both at home and abroad. Already we have seen numerous cases where human rights have been subsumed to security needs thus laying the ground for future conflicts and suffering. We live in the new Cold War, one characterized by readiness rather than a commitment to address poverty and the historical roots of these conflicts. Let’s not forget that in 2003 our budget for Iraq was 20 billion dollars- a sum coming to more than 1.5 times the entire international development budget. Israel, a technologically advanced and quite wealty nation by global standards, is still by far the largest recipient of U.S. “development assistance.” In the U.S. we have only seen further cuts in social services, education, and urban infrastructure that could make low-income neighborhoods more resilient. We have traveled this road before to disastrous consequences and we must think about prevention as the right to the conditions that

produce good health. This is a far more ethical and politically focused way of thinking about prevention.

We might think of more creative responses to refugee flows than camps that allow for the rapid spread of infectious diseases or better shelter and water programs but, and I must emphasize, we might try to work with those fleeing violence and disasters to recognize that they do have political rights and particular forms of existence and living that are worthy. The tasks ahead are difficult and demand creative thinking for cooperative paradigms that think security beyond the state and allow for a space for those who fall between the boundaries of states, and we must struggle through the hard work of creating spaces to give voice to trauma as well as open up new ways of thinking about inclusive democracies and how we can become ethical selves in relation to others who have experienced loss will be the challenge of the future. Or, the work of memory and mourning. This is where the true rebuilding post-Rwanda and Katrina where hope can emerge.

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