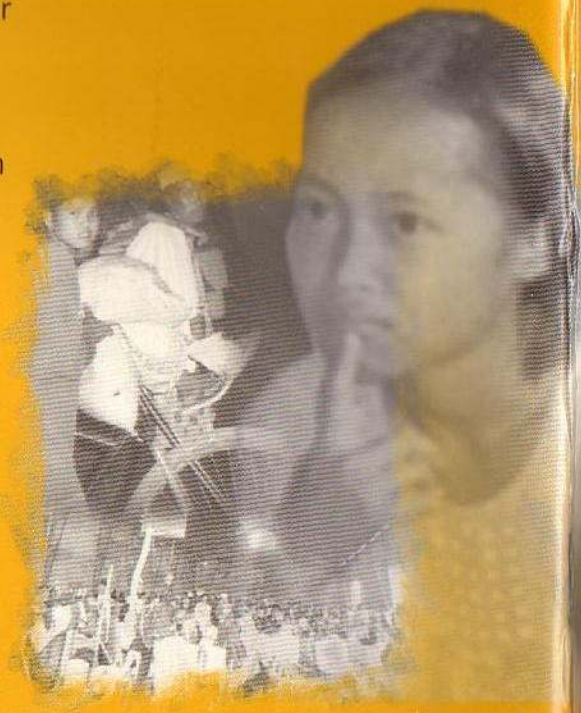
BALAY

Balay Rehabilitation Center is a non-profit organization that offers psychosocial development response to individuals, groups and communities affected by torture and organized violence. The population that it serves includes civilians displaced by armed conflict and those deprived of their liberty due to political circumstances and social violence. It advocates for peace, justice, and human rights. It supports social healing, multi-cultural dialogue, community empowerment and social transformation.



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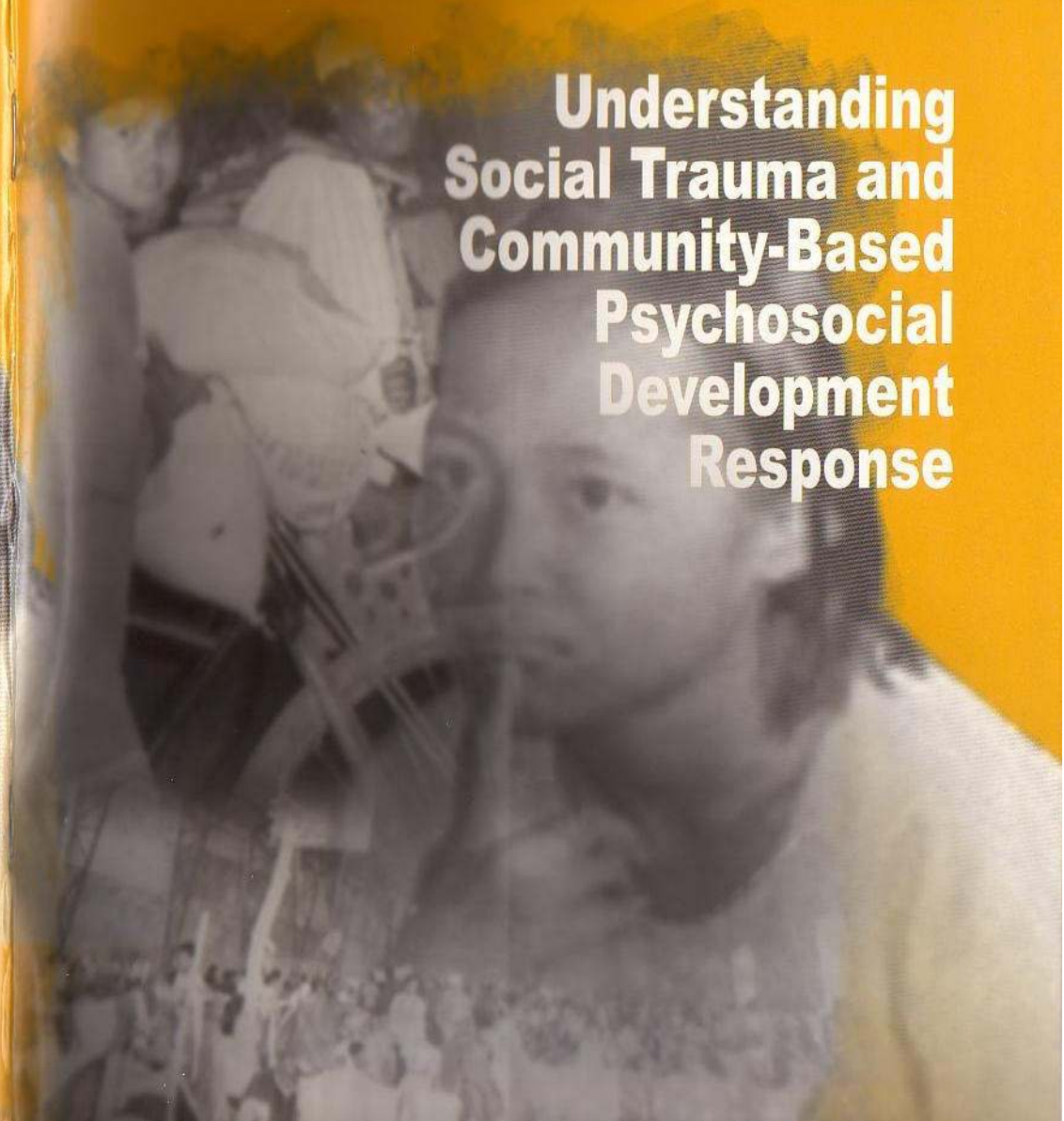

Understanding Social Trauma and Community-Based Psychosocial Development Response

DIALOGOS

Dialogos is an occassional publication of Balay Rehabilitation Center. It seeks to encourage the generation and dissemination of different perspectives in the field of psychsosocial praxis and to contribute to the discourse in human rights and peace-building.

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Review of Related Literature

Understanding Social Trauma and Community-Based Psychosocial Development Response

This review provides a background for understanding the interrelated concepts of trauma and well-being in armed conflict and post-armed conflict settings.

It begins with the various definitions of the said concepts and proceeds with exploratory discussions and various views on subjects such as Post Traumatic Stress Disorder (PSTD), resilience and healing. The concepts are presented both in the western and non-western perspectives, and as much as possible, in the Philippine context. The same are also presented and examined in the light of either their individual or collective nature or both.

The second part explains the dynamics of trauma and well-being in armed conflict situations, using the trauma and the well-being paradigms respectively. The significant issues are discussed in both the first and second parts.

The last chapter tackles the current imperatives for research on social trauma. The said chapter presents as well the tasks for the intervention programs of rehabilitation insti-

tutions that work in places where armed hostilities pose a threat among the affected population. It raises the challenge of filling the gap in related literature in the Philippines towards increased awareness and strengthening psychosocial resources of civilians in conflict-affected communities.

NOTIONS ON TRAUMA

Trauma is commonly understood as a bodily or mental injury on a person which is usually caused by an external agent or environment. The term was first used to refer to physical injury due to psychogenic ailments in the 19th century (Pedersen, 2002). This definition is linked to what is known today as physical trauma or psychological trauma.

The concept of trauma was originally used in relation to the psychological symptoms of victims coming from global catastrophes, but the term is now also used in relatively minor occurrences (Newman and Fellow, 2004).

This extensive and modern use of the term can be traced from a breaking down syndrome observed in men after World War I, which resembled a condition called hysteria in women, and was called by psychologists as traumatic war neurosis (Pagaduan-Lopez, 1994; Pedersen, 2002). The same was observed among US troops sent to combat in World War II (Pedersen, 2002). The term was also used in the 1970's to describe the psychological effects of rape, a condition labeled as rape trauma syndrome (Pagaduan-Lopez, 1994).

This paper is produced by Mr. Raymond Cagampan under the auspices of the BALAY Research and Development Program. He holds a degree in Psychology. This is a part of an evolving study on the concepts of trauma, psychosocial well-being and rehabilitation of the people affected by armed conflict and organized violence.

Another concept that incorporated the term trauma was introduced in 1980 in the Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. (DSM-III) in the US. The concept was the famous Post Traumatic Stress Disorder (PTSD) which was then used to describe traumatic experiences observed in Vietnam War veterans, a major symptom of which was the repeated occurrence of unpleasant, usually violent memories, in the patients' minds (The National Academy of Sciences [NAS], 2003).

With the prevalence of this clinical term during that time, studies on war-affected areas focused on PTSD and not on trauma. The PTSD symptoms included reliving of memories of traumatic experiences, avoidance of reminders of trauma, and a pattern of increased arousal. These symptoms, and PTSD itself were classified as equal to trauma (Pedersen, 2002), making trauma just one of the many health problems in war-afflicted areas (Eyber, ND).

This new pathological term came to a wide use among clinical psychologists, even outside the range of war. Later on, as a diagnostic criterion, PTSD no longer fitted the survivors of most extreme situations (Pagaduan-Lopez, 1994). It is known that there have been some problems with PTSD as a definition of trauma which include the following:

> ***Trauma*** is commonly understood as a bodily or mental injury on a person which is usually caused by an external agent or environment... This definition is linked to what is known today as physical trauma or psychological trauma.

1) Individual Focus. PTSD focuses on individual intra-psychic and individual therapy, though trauma often arises and is resolved in a social context.

2) Past Trauma. PTSD pre-supposes that trauma is completed and receding in the past, but in real life, traumatization is continuous (Summerfield, 1991).

3) Low Correlation/Causation. Traumatic events have no direct causal relationship to PTSD. Furthermore, collective trauma is not correlated with individual PTSD of people in the community (Pedersen, 2002).

Peltzer (1996) delineates three differences that separate traumatic experience from PTSD. In contrast to PTSD, traumatic experience is characterized by prolonged repeated trauma, acute episodes, sociopolitical and multigenerational in nature, and collective nature.

To make the distinction clear, it is said that PTSD is just an effect of trauma. Defining trauma in a wider range, Kirmayer (1996, in Pedersen, 2002) describes trauma as a socio-political event, psycho-physiological process, and physical-emotional experience.

Other Concepts of Trauma

Trauma was originally a pathology-related concept. In other cultures, an equivalent single concept for trauma hardly exists. In Kosovo, for instance, Kosovar Albanian students participating in an international training course on trauma pointed out that the word "trauma" was rarely used by Kosovars prior to the arrival of international trauma experts. Instead, they used terms such as pain, despair, suffering, and a deep spiritual disorder (International Organisation for Migration [IOM], 2000, in Agger 2004).

In Chichewa, Malawi, the most which the refugees could do was to provide metaphors for PTSD criterion B (describe the experience of trauma). One such metaphor is "Ndimasowa mtendere mumtima wanga." (I lack peace in my heart.) (Peltzer, 1996).

On the other hand, Bosnian refugees use a single concept: they talk of "nerves" rather than trauma. In their context, nerves is a widespread/well-documented phenomenon resembling the kinds of embodied distress (Eastmond, 2000). Bosnian refugees never used "trauma" because they think this would undermine the state of their well-being. They used nerves instead because, to them this condition is curable.

On the contrary, the widening range of conditions linked to trauma as mentioned by Newman and Fellow (2004) comes with increasing attempts to define trauma in non-western cultures. In the Philippines, for instance, Carandang defines psychological trauma as an affliction of the powerless. She went on to say that trauma destroys many aspects in an affected persons including their fundamental assumption about the safety of the world, positive value of the self, belief in the meaningful order of creation, and sense of security especially when the effects of trauma violates the person's right to security.

This description of trauma is further enlarged in Carandang's definition of another type of trauma which she called vicarious traumatization (VT). This further concept defines the contagious nature of trauma—people dealing with or even just witnessing a traumatic event are traumatized themselves.

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Social Trauma

Thus far, the available literatures on the effects of war from both western and non-western cultures contain only a small and almost negligible percent providing direct definitions of a collective trauma of a community although terms like massive social trauma (Twemlow, 2004/2005), community healing (Fries, 2003) and social healing (Boyden, UNP) are widely used to address issues that involve the psychosocial impacts of catastrophes in a community.

According to De Young (1998), social trauma is the unexpected ruptures in social life. He said that: "*The experience of trauma, at its worst, can mean not only a loss of confidence in the self but a loss of confidence in the scaffolding of family and community, in the structures of human government, in the larger logics by which humankind lives, and in the ways of nature itself.*" [p. 242].

This view resonates with the ideas offerred by Kirmayer (1996, in Pedersen, 2002) who described trauma as a sociopolitical event; and Peltzer (1996) who differentiated social trauma from PTSD as sociopolitical, multigenerational and collective in nature. Audergon (2004) also pointed out explicitly that trauma is a "collective dynamic" wherein "whole communities are traumatized".

According to a Salvadoran psychologist and Jesuit Priest Ignacio Martin-Baro (1996), war-related post-traumatic reactions cannot be understood solely at the individual level, because they are imbedded in a historical, social context. Rather than applying the medical model of PTSD in order to understand the traumas of war, Martin-Baro argued that recognition must be given to trauma in terms of a pervasive and collective experience rooted in the distortion of social relations and the disruption of community life. To bolster this view, there are three essential aspects of psychosocial trauma that must be emphasized:

1. That trauma has a dialectic character, which means that trauma is produced in actual social relationships of which the individual is just one part;
2. That since psychosocial trauma is socially produced, intervention aiming at alleviating the suffering should be addressing the social fabric of the community; and
3. That social relationship may multiply and sustain the traumatic stress on the community level, leading to individual experience of suffering for traumatic stress, which then becomes a normal reaction to an abnormal situation.

In fact, there are profound psychosocial effects of torture and organized violence that are seen at the community level (Martin-Baro, 1996; Pedersen, 2002) where communities may have been destroyed by a climate of mistrust and fear. In the many cases of 'low-intensity warfare', deliberate and systematic violence deployed to terrorize whole populations have seriously affected whole populations psychosocially, as whole communities have experienced assaults.

There are profound psychosocial effects of torture and organized violence that are seen at the community level where communities may have been destroyed by a climate of mistrust and fear... Deliberate and systematic violence deployed to terrorize whole populations have seriously affected whole populations psychosocially, as whole communities have experienced assaults.

Similarly, in many developing countries, structural conditions like unfair distribution of land and income, poverty, impunity, and discrimination against people of indigenous origins still exist several years after the violent conflict has officially ended, showing the long-term consequences of collective trauma. In order for societies subjected to a climate of terror,

systemic violence and structural inequality to engage in processes of reconciliation and national healing, the social reparation needs to go through the sequential steps of truth, compensation, justice and pardon (Comas-Diaz and Padilla, 1987; Becker, 1990; Bronkhorst, 1995).

On the other hand, De Young said that the alleviation of collective trauma is generated from and fulfilled by a collective process of the community through its culture. If culture, along with its customary beliefs, social forms and material traits functions well, it saves people from collective trauma. For instance, cultural stories passed on by word of mouth containing themes about how the ancestors of the community were able to handle traumatic conflicts, strengthen the community members and enable them to deal with present similar events.

De Young pointed out further that collective trauma happens when a disaster succeeds in destroying the normal functioning of a culture, thereby bringing severe psychological stress to individuals. Along this line, collective trauma is explained as one form of response of a social, racial or religious group to aggression or violence that could initiate the disruption of a people's culture. Within the breadth of the same assumption, it can be said that collective trauma brings about individual trauma, and not the other way around.

Issues on the Concepts and Study of Trauma

Thus far, no literature directly defining social trauma in absolute terms is existent in the Philippines, in the same way that there is no known such unqualified definition of social trauma in other societies affected by armed conflict. There are several issues and dilemmas surrounding the study of trauma particularly those dealing with non-medical perspective in areas of armed hostilities such as:

1. **Labeling** – There are two sides on the issue of labeling a condition such as trauma. On one hand, labeling the suffering of refugees as PTSD and using trauma scales emphasize the weakness of the war-affected population, not their resilience. Too much emphasis on resilience, on the other hand, may neglect the fact that the victims do suffer (NAS, 2003).

2. **Issue on the universality of trauma** – The characteristics of refugees and internally-displaced population vary cross-culturally. Thus, it is difficult to treat trauma or address the problem of displaced population in different cultures by using a common assumption on their cases (Rack, 1981, in NAS, 2003). Such common assumptions often use western theories. The western models are, however, inadequate to study the majority of the world's population in distress. In view of this, it is suggested that research on anthropology and cultural psychology be paid more attention (NAS, 2003). Before trauma discourse can be applied to non-western cultures, three types of realities should be considered: 1) political, 2) cultural reality, and 3) social reality (Bracken and Petty, 1998). It must be noted that these realities are overlapping.

3. **Looking at trauma in different contexts: rival approaches to trauma** – Trauma is studied in different contexts, which include the clinical/biomedical, social welfare and human rights perspective. From these contexts, several divergent approaches have emerged. These include the discourse between the Trauma Approach and the Human Rights Approach. The Trauma Approach has been described as suffering-based. It regards refugees as needy of psychosocial help. Yet the concept of trauma here is occasionally misused especially in cases where obtaining help and intervention becomes the more dominant concern both on the part

of the service providers and the recipients. For instance, war victims in Kosovo deliberately label themselves as "traumatized" in order to win the competition for attention and help from international intervention organizations (Agger, 2004).

The practical problems encountered with the Trauma Approach have led to the formulation of the Rights Approach, which thereby shifted emphasis to the human rights of war victims. This is exemplified by the Testimony Method, which is a documented story-telling of war experiences. But this approach has not been fully embraced by mental health professionals who try to avoid the political implications that go together with such an approach, such as the possibility of the facts being exploited, the diminished objectivity in the interpretation of such facts by the various stakeholders to the possible cases of human rights violations, and the danger of provoking biased political leanings or the or the tendency to take sides among the parties involved (Agger, 2004).

Aside from the view that trauma has to be cured, the state of people's health also needs tackling when psychosocial issues are concerned. This is to give a complete picture of the effects of trauma on health and well-being.

Another dichotomy is the "Refugee Approach" vs. "Anthropological Approach." The Refugee Approach assumes that trauma is overwhelming, while the Anthropological Approach assumes that trauma is normally experienced by all people. Both approaches are extremes and limited; both neglect other factors that influence trauma and being traumatized (Pedersen, 2002).

4. **The refugee-IDP debate: an issue arises on the comparison and the differentiation of the categories of war evacuees** – IDPs (internally displaced peoples) refer to evacuees who move within national territory to escape persecution or harm. The other category, the refugees, refers to those who cross an international border to seek safety in another state (Balay, 2002). One side of the debate argues that refugees are more traumatized than IDPs, and therefore in need of greater help than IDPs. The other side sees no difference between the two categories.

5. **Trauma and disease** – Aside from the view that trauma has to be cured, the state of people's health in general is also an issue that needs tackling when psychosocial issues are concerned. This is to give a complete picture of the effects of trauma on health and well-being (Eastmond, 2000). Kleinman, Das and Lock (1997, in Pedersen, 2002) define "social suffering" as a result of what political, economic and institutional power does to people. In this literature, they have included not just trauma but also issues on general health conditions.

PSYCHOSOCIAL WELL-BEING

Equally important with knowing the meaning of well-being is grasping what the term "psychosocial" denotes. Understanding these terms would lead towards a fuller understanding and contextualization of well-being in a community. To begin with, the word psychosocial is widely used in humanitarian work programs that have been in force in many parts of the world. The concept gives emphasis on the

influence of social factors on human thoughts and behavior, and the influence of thoughts and behavior on people's social world (NAS, 2003).

Well-being has been understood as the state of being or doing well in life (*e.g.* happy, healthy, prosperous); it refers to achieving a certain standard or quality of life (Protacio-De Castro, 2004), which is positive and acceptable to the human possessor.

Ahearn (2002, in Protacio-De Castro, 2004) looked at well-being not only as a state of possessing or experiencing a good quality of life but also as "consisting of the ability, independence and freedom to act, and the possession of the requisite goods and services to be psychologically content." Ahearn's definition opens up a new angle in the understanding of well-being by suggesting that social and political health (aside from physical health) are also central to well-being. This definition argues in favor of the belief that the environment affects the well-being of a person even when s/he is well nourished or free from sickness. A healthy person can exhaust, compromise, or lose altogether her/his well-being (physical, emotional and mental health) when political and social factors in the environment such as conflicts and pressures are intense and prolonged enough to strain and weaken the capacity to cope.

The Domains of Psychosocial Well-Being

The Oxford-based Psychosocial Working (PWG) identified the factors influencing the psychosocial well-being of a community in their paper entitled "Conceptual Framework for Psychosocial Intervention in Complex Emergencies." They referred to these factors as Community Resources (Strang and Ager, 2001) which they categorized under the following domains:

1. Human Capacity—includes health, mental well-being, physical well-being, skills and knowledge, and household livelihood.
2. Social Ecology—includes social relationship with the family, peer groups, religious institutions, and links with civic and political authorities.
3. Culture and Values—includes cultural values, beliefs and practices.

These domains are interdependently disrupted in the occurrence of catastrophic events and respectively referred to as "human capital", "social capital", and "cultural capital" of the community (Colleta and Cullen, 2000, in Strang and Ager, 2001).

The PWG model indicates a way to evaluate trauma; it can be assessed in terms of the depletion of resource domains (Strang and Ager, 2001). Trauma in this sense can be defined as a disruption of the well-being.

In a parallel fashion, community psychologists describe three types of wellness: personal, relational ad collective wellness. But they pay more attention to personal and relational wellness than to collective wellness. This creates an imbalance since values are needed to be promoted in these three domains at the same time. (Prilleltensky, 2001).

The Filipino Concept of Well-being

The Filipino term for well-being seemed initially to be a problem of translation because definitions of well-being may vary considerably between cultures, community, and people in varied habitat and life context (Protacio-De Castro, 2004).

Well-being or *kaginhawaan* is described as the ease or feeling of lightness one experiences when everything aspired

for is in order or easily attainable. Another term is *kasaganaan* or prosperity. Both are related to the notion of good life and a prosperous community. However, in the end, the term *magandang buhay* or simply "a good life" was adopted for the study because it encompassed the material and non-material components that defined well-being in life (Protacio-De Castro, 2004).

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In a study conducted in the Philippines by Sycip, Asis, and Luna in 2000, they concluded that the core of the Filipino concept of well-being is non-material, and includes:

1) Spirituality

2) Social relationships, and

3) Doing good to others

These three aspects of well-being are given more priority by all Filipinos over the material sub-domains of the quality of life.

The closest single-word Filipino translation for the non-material aspect of well-being is the term *ginhawa*. It usually means *aliw* (comfort, consolation, joy) or *mabuting pakiramdam* (good feeling). For many religious believers, true *kaginhawahan* (*ginhawa*) is in the after life; it is believed that in this present world, the hardships predominate. In Filipino psychology, *ginhawa* means *pahinga* (to take a rest) or *"hinga"* (breath). Other meanings of *ginhawa* include:

1) *Gaan sa buhay* (ease in life)

2) *Aliw sa buhay* (life's joy/comfort)

3) *Paggaling sa sakit* (recovery from sickness)

4) *Kaibsan sa hirap* (ease from poverty)

5) *Mabuting pamumuhay* (good life) (Pe-Pua, 1982).

The absence of a single Filipino term equivalent to trauma has led to a search on Filipino terms referring to the "disruption of psychosocial well-being." But the indigenous Philippine terms in the available literatures were at best only loosely related.

For instance, "memory" is a necessary aspect in trauma. Traumatization or disruption of psychosocial well-being occurs when a catastrophic event is embedded in the memory of an individual. As for collective trauma, though it is not directly related to the catastrophic event (Trapman, 1997), the origins of trauma may be traced through "constructed memory", "symbolical memory", "false memory" and "collective memory" (Trapman, 1997).

Alaala is an improvised Filipino equivalent to the term "memory" but it has a deeper emotional connotation, as in the phrase *buhay na alaala* (living memory) (Pe-Pua, 1982). By submitting to this emotional aspect, the traumatization and disruption of psychosocial well-being among Filipinos is better contextualized in the alaala rather than just in the memory.

The disruption or traumatization may also attack one's *damdamin* or *pakiramdam*. Author Pe-Pua (1982) has differentiated these Filipino terms by explaining that *damdamin* is a native word describing one's inward nature, thoughts or feelings; it refers to the internal (mental or emotional) state of a person. On the other hand, *pakiramdam* pertains to the capacity for sensing outside or external things and occurrences, although the basis of this perception is in understanding one's own inward condition (*damdamin*).

The richness of this term is further indicated in its alternative definition *pakiramdam* which involves not only feel-

ings but the use of other spontaneous and instinctive perceptions and other similar capacities. In the Philippine context, this includes sensitivity to supernatural phenomena and focuses on the psychic/intuitive power of the mind. Whether the persons concerned are evacuees or traumatized, *pakiramdam* as a rich term becomes a new category for further research (OP-OPAPP, 2003), probably since traumatic or catastrophic events occur "outside" while traumatization or disruption happens in the individual's "inside" – both sides being considered as equally significant in the term *pakiramdam*.

In the political context, the condition called individual trauma is a crime against the *"identidad"* of a person. *"Identidad"* or identity is the knowledge of oneself (Pe-Pua, 1982).

Collective trauma, on the other hand disrupts the "national character" of a nation. Although a borrowed term, "national character" has been used in indigenous Filipino literature as an assimilated term: it involves the special and dominant characteristics of a nation (Pe-Pua, 1982). *"Identidad"* is a part of the political aspect of psychosocial well-being, while "national character" is a part of the political aspect of collective well-being.

RESILIENCE AND HEALING

Though the term resilience has been used in mamy literature on the psychosocial impacts of war, a number of definitions have been offered by different authors. However, individual articles written on the subject do not contradict each other. This implies that the scientific community has already assumed an implicit understanding among themselves on the meaning of resilience. In general terms, they correlate the idea of resilience to one's ability to cope with difficult circumstances. Yet, this definition is limited to the concept of "individual resilience".

In light of the term resilience and its meanings, it has also become necessary to look deeper into human capacities and potentials and thus to regard people in armed conflict situations not as weak, passive victims but rather as active survivors (NAS, 2003; and Newman and Fellow, 2004), directly focusing on their capacity for resilience.

The importance of focusing on the resilience of the survivors is in line with one existing direct definition of resilience: Resilience is the universal capacity allowing a person, group or community to prevent, minimize or overcome the damaging effects of adversity. It is based on a realistic hope and focuses on strength rather than limitations (OP-OPAPP, 2003). This implies that a person, community, or group possesses strength factors from which the power of resilience will emerge to boost the capacity of people in the midst of a distressing situation.

Such definition points out further that contrary to the earlier definition, resilience is not restricted to individuals, but can also be a characteristic of a community.

Factors to Resilience

Factors to resilience fall into one of the three categories cited in the study of Garmezy and Masten in 1990 (in NAS, 2003). These are personality, family and immediate social ecology, community and society.

It must be noted that among all the factors to resilience, age (or the developmental stage), which is under the personality category is singled out as the most critical indicator of children's resilience (Newman and Fellow, 2004), since children are thought of as generally more vulnerable than adults (NAS, 2003).

Yet, age does not function by itself as a reliable factor to resilience. For instance, the age category of youth and adolescents is not defined biologically but rather socially, culturally, economically and politically in many cultures (Newman and Fellow, 2004).

Even genetic personal psychological factors to resilience in children like temperament and cognitive capacity are influenced by the environment. The environment and social factors strengthen/intensify the genes to generate resiliency (Boydem, ND).

This dependence of the personality factors, such as age and genetic abilities, upon social factors shows a clear interaction of the self and society, and implies the psychosocial nature of resilience. As Fonagy *et al.* (1994, in NAS, 2003) have put in, resilience is not made up only of traits or attributes but of psychosocial processes as well. This means that the inherent complex of mental and ethical qualities marking a human person are either honed and strengthened or neglected and weakened over time depending on the involvement and inputs of sociological units, structures and dynamics on the development of the person's psychosocial make-up towards the formation of traits and attributes such as resilience.

But for resilience to be a complete psychosocial process, a two-way process should be involved (NAS, 2003):

1. The society should affect the individual and produce individual resilience, and
2. The individual should affect the society and produce collective resilience.

The first process has already been studied as shown in both the western and non-western definition of resilience and with the manner by which the factors affect individual resilience. Yet the second process is only partly explored—collective resilience is merely defined and not yet significantly examined and discussed in the western texts.

Since the second process whereby individuals are able to influence the community and bring about collective resilience is desirable because it is empowering, sources of this kind of experience must be found and tapped for research. Current studies should focus on the non-western definitions of collective resilience and its dynamics.

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Filipino Concept of Healing

Terms like community healing (Fries, 2003) and social healing (Boyden, unpublished) are widely used to address issues involving psychosocial impacts of catastrophes in a community.

According to Pe-Pua (1982), there is no single term equivalent for the word healing in the Filipino indigenous literature. Only certain aspects of healing have the corresponding ter-

minologies; healing per se hauls in a wide range of indigenous ideas. One of the aspects brings in the idea of "who heals": the *albularyo* is the one who heals the sick by using medicines concocted from herbs and other indigenous methods.

Filipinos also have terms for "what is healed": *ginhawa* (comfort) has been defined earlier as the non-material ease in life. Another concept that is healed is the *kaluluwa* (soul). Among Christians, *kaluluwa* is the animating spirit of the human person while in the world, that is bound for either heaven or hell, depending on whether it has attained "full wellness" before the expiry of the corporeal vessel (body). The soul is separated from the body at the time of physical death to obtain *ginhawa* and *kaluwalhatian* (glory). For the Filipino ancestors, the goal of life is for the soul to remain in good health and stay inside the body to provide it with *ginhawa* and life. In Filipino psychology, *kaluluwa* means *hininga* (breath) and *init sa buhay* (warmth in life). Presently, *kaluluwa* pertains to the whole personality, personhood, or *pagkatao*. The richness of the meaning of *kaluluwa* in the Philippine culture reflects the inseparability of spirituality and well-being.

Lastly, Filipinos have specific terms for a number of notions associated with self-healing. *Tiis* (to bear) is for the soul (to put up with hardships and torture), while *sikmura* (stomach) is for the body (to endure all types of physical and non-physical assaults). *Timpi/Pigil* (control/restraint) pertains to one's ability to hold back and keep in check one's negative feelings and thoughts so as to prevent harmful consequences such as aggression and/or breakdown. *Timpi* or *pigil* directly means to control feelings. By restricting Filipino self-healing terminologies to descriptions that signify repressed behaviors/responses, some practitioners inadvertently highlight the natural repressive coping responses of victimized Filipinos. As this is unconstructive, more harm than help could be done to persons when weaknesses in term usage are left unaddressed by intervention organizations.

PARADIGMS IN TRAUMA AND ARMED CONFLICT

This paper employs two paradigms namely, Trauma Paradigm and Well-Being Paradigm, in order to see the dynamics of the foregoing concepts in an armed conflict or post-armed conflict setting. The significant issues underlying these concepts are also discussed on this topic.

The Trauma Paradigm views trauma and traumatization as the primary phenomena underlying the problems in war-afflicted communities.

The Well-Being Paradigm views all the aspects of well-being vis-avis trauma in analyzing the problems of war-afflicted communities. Separate but parallel discussions will be done using the two paradigms. Later on, the implications of the two paradigms will be compared and contrasted.

Psychological trauma is considered as one of the main concerns in armed conflict situations. A survey undertaken in war-besieged Marag Valley and in Misamis Oriental in the late 1980s shows that 46% of the children were psychologically traumatized as a result of exposure to the armed violence (Citizens' Disaster Response Center, Inc. [CDRC], 1993).

Existing literature has identified five conditions in armed conflict situations that lead to trauma. The highlighted letters in brackets indicate the domains well-being or community resource (*i.e.*, human capacity, social ecology and culture and values), which is correspondingly depleted when a particular problem (*i.e.*, violence, separation from or death of parents, sexual violence, torture, vicarious traumatization, political repression, pressure to care for others extensively) occurs (Strang and Agger, 2001). Thus, H stands for "Human Capacity," S for "Social Ecology," and C for "Culture and Values."

1. **Violence [H]**

The constant exposure to violent death and destruction causes persons to break down in shocking numbers (Pagaduan-Lopez, 1994).

2. **Separation from or death of parents [S]**

Due to primary relocation or evacuation of children in conflict areas, the experience of sudden separation from parents may be traumatic to these children (Children's Rehabilitation Center [CRC], 1992, and Amore-P'Olak, 2005). It is difficult to explain to a child the death or disappearance of his or her parents (CRC, 1992), thus making inexperienced caretakers helpless about dealing constructively with the child's emotional responses.

Torture methods are the same all over the world, because the aim of torture is the same: to breakdown the victim's identity so that he or she would collaborate with the perpetuator

3. **Sexual Violence [H, C]**

Sexual violence in a war situation is a deliberate military policy of the perpetrators to demoralize individuals and the collective psyche of the community (Newman and Fellow, 2004). This issue has been raised in studies conducted since the 1970s, calling attention to the fact that rape and other domestic violence bring trauma to women (Pagaduan-Lopez, 1994).

4. **Torture [H]**

Torture methods are the same all over the world, because the aim of torture is the same: to breakdown the victim's identity so that he or she would collaborate with the perpetuator (Genefke, 1997; Agger and Jensen, 1996). The difficulty with torture is that the victim is left with two false choices: to betray comrades and one's own stand/principles or to be injured in all aspects imaginable (psychologically, physically, sexually, politically and socially) (Agger and Jensen, 1996).

5. **Vicarious Traumatization [S]**

Lansen (1997) concluded that Vicarious Traumatization (VT) also exists between patient and therapist. Therapists, who treat patients severely affected by violence, terror, persecution, torture and incest, develop classical symptoms of PTSD themselves. The symptoms may also manifest from one therapist to group of therapists. If there is a lot of stress among group therapy members, the quality of group therapy is being influenced negatively.

6. **Political repression [H, S, C]**

Political repression is a general term for a phenomenon that causes the disappearance, murder and torture of family and community members. The aim of the perpetrators is intentional secondary traumatization and collective fear and traumatization (Agger and Jensen, 1996).

7. **Pressure to care for others extensively [H, S]**

The less severely affected victims of armed conflict are usually compelled to take care of the more severely affected ones, especially when the shortage or absence of social workers is a problem. Most of the time, women from internally displaced populations provide care for their families, leaving their own mental health needs unattended (Arnado and Arnado, 2004).

The abovementioned problems developing in war-stricken communities do not exist independently. As what would be expected from catastrophes, a problem often leads to another. For instance, the death or disappearance of a child's parents leaves another mother (not the child's mother) the pressure to care for this child (Arnado and Arnado, 2004). Likewise, the death or disappearance of a parent brings impoverishment to the abandoned family members, which in turn leads the eldest siblings to take on economic roles unfit for their age.

The "problem-leading-to-another-problem" cycle is just one of the damaging sequence of events victims have gone through in armed conflict situations.

All problems in war that contribute to trauma can be exhaustively classified as a depletion of one or more of the resource domains. And since these resource domains are regarded as the core of well-being, the categorizations strengthen the point made earlier [see section on Domains of Well-Being] that trauma is a "disruption of the well-being".

Manifestation of Trauma

Much work has been done on the manifestations of trauma on people. Most of the works tried to categorize these manifestations.

In his comprehensive, pioneering work, "Trauma and Recovery", Herman (1992, in Carandang UNP), cited three categories of what a traumatized person goes through:

1) Hyperarousal—system on "red alert";
2) Intrusion—flashbacks, images nightmares, disorganized, fragmented; and
3) Constriction—numb, fearful, passive, child cannot play, adult limits life.

Another categorization is implied in the work of Carandang (UNP), in her description of the nature of trauma. This involves intense fear, helplessness, loss of control, and threat of annihilation.

Another criterion for the categorization of trauma is the categorization of victims as children, adolescents or adults. Much of the literature categorized under this criterion focused on the first group, the children. Generally, the traumatized child becomes afraid of armed men or anything associated with the event; cries and does not talk (CRC, 1992). An observation of the short-term symptoms found in children liberated from concentration camps highlights their:

1) Destructive behavior marked by aggression, and
2) Their being suspicious of adults (Garmezy and Masten, 1990, in NAS, 2003). Bad dreams and nightmares are also thought of as produced from the anxiety due to a frightening or traumatic experience (CRC, 1992)

Adult trauma symptoms are further dichotomized as either symptoms on men or symptoms on women. Hysteria for instance, which is the archetypal disorder of women was diagnosed exclusively for this gender. Later on, symptoms of hysteria were also observed in men, dubbing the condition as "shell shock," "combat neurosis" and "traumatic war neurosis" (Pagaduan–Lopez, 1994).

More recently, three basic spheres of the symptoms of traumatized persons have been identified. These are the emotional sphere, sphere of risk behavior and the physical sphere (Tata Arcel, 1999)

Another exhaustive set of categories are provided in a study by Carandang (1992, UNP):

1. Paranoid/Fear—suspicious of adults, fear of armed men or anything associated with war, threat of annihilation.
2. Disturbing visions—flashbacks, images, nightmares.
3. Excessive emotion/action—hysteria, crying, hyperarousal, loss of control.
4. Self becomes limited—not talking, helplessness, constriction, numb, passive, child cannot play, adult limits life, fragmented, disorganized.

The above-presented scheme seems exhaustive, but a closer look at the last two categories leads to questions as to whether these actions are genuine uncontrollable symptoms, or voluntary responses of those who suffer. This reopens the debate whether the traumatized victim deserves care or not (Pagaduan–Lopez, 1994).

Manifestation of Social Trauma

Thus far, literatures on the manifestations of trauma largely focus on children, consistent with the overall assumption that children were thought to be more vulnerable than adults to the vicissitudes of life (Turkel and Eth, 1990, in NAS, 2003).

Any single perspective regarding trauma like focus on children has specific limitations...it naturally veers away from and curbs information on the adult constituents of a community...and tends to shed more light on the children population and downplays the other parts. It poses the danger of inadvertently obstructing the view for a clearer picture of the collective trauma of a community.

Just as any single perspective regarding trauma has its own specific limitations, this focus on children is also at risk of certain restraints. For one, it naturally veers away from and curbs information on the adult constituents of a community who are afflicted with trauma. Thus, it tends also to shed more light on the children population and downplays the other parts. This focus or point of view in itself is by all means legitimate. But while a very rigid focus on the children population poses the danger of inadvertently obstructing the view for a clearer picture of the collective trauma of a community, increased vigilance on the part of the researching party has to be practiced. Parallel researches on trauma which look at the entire community and examine equally the manifestations on all the actors must be undertaken as well.

One such symptom of collective trauma is the deliberate and motive-influenced revision of community history. The oppressor group will not include the traumatic story of the oppressed minority group to escape accountability (Audergon, 2004). Such findings have only been discussed lately and in need of further research. Nonetheless, major progresses in civilization has made possible that oppressive episodes in history be scrutinized, made amends for, and the truthful narratives of the people be part of as many studies as needed and disseminated and promoted where they could be significant and of help to the people.

Responses to Trauma

There have been observations that a general response to trauma may depart from the reaction pattern of children to the trauma they experience due to the death or disappearance of parents. This pattern is summarized in a paper by the CRC (1992) as follows:

Phase 1. Shock and denial (can't sleep, hyperactive, fear that others, including self will die too)

Phase 2. Intensive longing and searching (characterized by regression)

Phase 3. Intensive sorrow, anger or guilt (negative feelings)

Phase 4. Loss of Organization (loss of normal functioning)

Phase 5. Hopelessness (to stop physically)

Phase 6. Integration (healing process)

Although the CRC outline of trauma responses and behaviors was initially formulated from the observation of children (not of the entire community) and was limited to a specific traumatic event (loss of a parent), general responses to trauma including those of the adults fit into the pattern.

The general periodic reaction of young and old people to the death or disappearance of a parent described by CRC (1992) is consistent with further information as follows:

After the preparatory phase of the desire to know the consequences, a traumatized person goes through a period of mourning (consistent with phase 3: negative feelings), and then a period of healing (consistent with phase 6: integration).

Responses of severely traumatized women may also fall within the six-phase pattern. As in three cases of mental distress patients involving ethnic minority women in Mindanao which resulted in their killing their own children, suicide, and sudden death (Arnado and Arnado, 2004), extreme traumatic reactions are consistent with Phase 4 – loss of normal functioning.

With respect to children under a different traumatic situation, a short-term observation of children liberated from concentration camps shows that they sought to avoid discussing the trauma they have experienced (Garmezy and Masten, 1990, in NAS, 2003). Silence, depending on the individual reasons may be categorized under Phase 1: shock and denial or Phase 5: hopelessness. Silence being categorized in Phase 1 is consistent with Carandang's (UNP) finding, that secrecy and silence is the first line of defense of a traumatized person.

Reducing general responses to trauma into a child reaction pattern may be an oversimplification, but this scheme is supported by the finding that regression is one of the primary responses to trauma.

Adapting to this pattern the current and future efforts to study the traumatic responses of people in Mindanao has a good amount of cultural validity since such pattern was observed from Filipino children and is free from the cultural limitations of western studies.

Responses to Trauma by the Community

Nevertheless, a link is needed to consistently adapt this pattern to the collective responses of a traumatized community as a whole. Yet, individual responses were more prevalent than collective responses since communities are broken in response to political repression (Perez-Sales, Duran-Perez, and Bacic-Herzfeld, 1998).

Still, it can be considered that "being broken" is the characteristic response of a community to collective trauma. An empirical manifestation of "being broken" is keeping silent, which is considered by the people who have had war experiences in Mbrara District in Southwest Uganda, as the best thing to do in order to continue life (Tankink, 2004). Thus far, no harmful implications are proven to arise from collective silence.

Resilience and Trauma

Factors to resilience specifically in the face of trauma are characterized by a stronger reliance on social and community factors than on personal resilience factors. Children can cope with death or disappearance of parents with the support of other living relatives (CRC 1992). Figley and Mc Cubbin (1983 in Escalante, 2002) singled out the family as the most important resource in emotional recovery from tragedies.

In a focus group study among internally displaced women in Mindanao, participants exhibited social support with one another—helping themselves cope constructively with war trauma (Arnado and Arnado, 2004). Finally, the study and therefore treatment of psychosocial trauma has been depen-

dent on the support of advocacy and service-providing organizations within the political movement (Pagaduan-Lopez, 1994).

Media, though not an inherent part of traumatized communities, also emphasizes the importance of social factors in resilience, but it gives greater emphasis on the interaction of the personal with the social factors. Media may either facilitate a person's healing or further traumatize the individual depending on the nature of the action of the media and individual resilience and personality of the victim (Carandang, UNP).

Thus far, the Trauma Paradigm has been employed to describe the war-affected individuals and communities. A contextualization of the situation using the Well-Being Paradigm follows next.

WELL-BEING AND ARMED CONFLICT

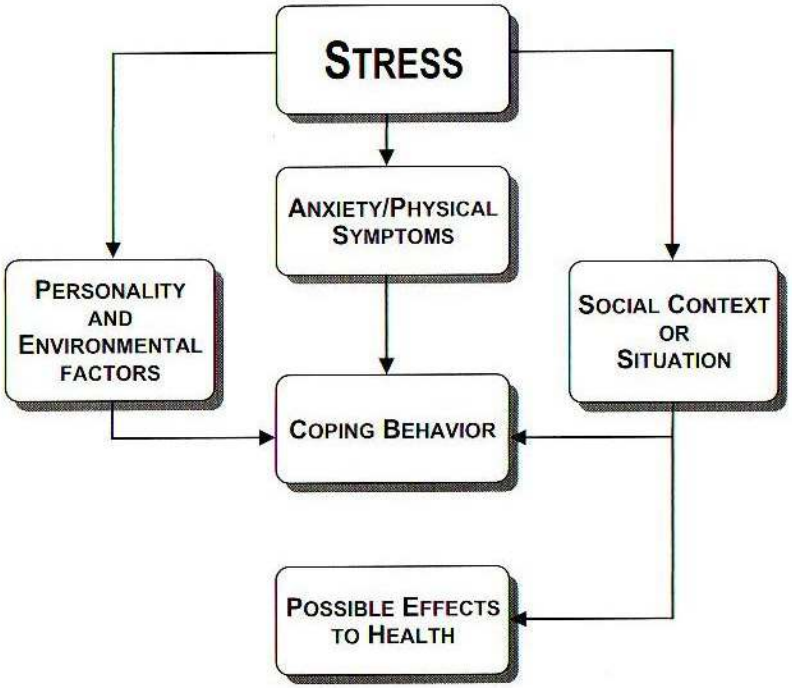
A study on refugee children focused on the aspects of well-being, coping and resilience (NAS 2003). Discussion on the interaction between these three is parallel to the flow of the Stress and Coping Framework (Protacio-de Castro, Camacho, Balamon, Yacat, Galang, and Ong, 2004), which in turn will facilitate the discussion on the psychosocial problems, manifestations and responses that involve well-being in the context of armed conflict.

The Stress and Coping Framework

The Stress and Coping Framework describes the processes a person goes through due to stress. The pattern goes from stress (problem), to symptoms (manifestation), to information-seeking, to coping behavior (response), and then to effects.

But the flow does not assure a perfect cause-effect relationship since two other elements, the personality and environmental factors and the social context, mediates both the nature and the level of stress and the type of coping behavior. (Protacio-de Castro, Camacho, Balamon, Yacat, Galang, and Ong, 2004).

Fig. 1 **The Stress and Coping Framework**



Protacio-de Castro, Camacho, Balanon, Yacat, Galang, and Ong, 2004)

The following points have to be made about the parts of the framework:

1. **Stress vs. Traumatic Stress.** Traumatic Stress is a person's strong reaction to a critical event. This is caused by either personal loss (injury to self and/or survival when others have been killed), or a traumatic exposure characterized by a horrific experience; witnessing violence, death or suffering; caring for distraught survivors; and physically dangerous/psychologically hazardous conditions.

   Stress, on the other hand is a highly individualized mental pressure by a positive or negative stimulation. Traumatic stress is differentiated from stress in three ways:

   * Traumatic stress is sudden while stress gradually accumulates.
   * Traumatic stress may have long-term effects while stress is short-term.
   * Traumatic stress frightens almost everyone while people are affected differently by stress (OP-OPAPP, 2003).

   Though stress is different from traumatic stress, the dynamics of both can be discussed using the same framework (Protacio-de Castro, Camacho, Balanon, Yacat, Galang, and Ong, 2004). But studying trauma focuses only on traumatic stress (OP-OPAPP, 2003). To be able to learn the detailed dynamics of both traumatic stress and stress in general, researchers have to deviate from the trauma paradigm and be guided by a broader-ranged paradigm. Further on in this paper, the question as to whether the well-being paradigm can serve the purpose mentioned will be answered.

   In this paper's discussion so far and in the rest of the review, stress (or traumatic stress) in an armed conflict setting was studied by examining the stressors, towards automatically incorporating the "social context or situation," which is on the right side of the stress and coping framework (see Fig. 1). The stressors are referred to as Problems.

2. **Anxiety/Physical Symptoms.** When a child or a person is exposed to stress, there are physical symptoms and anxiety reactions (feelings of unease and nervousness). Physical symptoms include inability to sleep or eat, skin disease, acidity or stomach ulcers (Protacio-de Castro, Camacho, Balanon, Yacat, Galang, and Ong, 2004). Anxiety and physical symptoms are referred to as Manifestations.

3. **Information Seeking and Coping Behavior.** As a reaction to their uneasiness and to understand what is happening to them, individuals and children seek information. While adults often think that children do not understand what is happening around them, young children actually can perceive the situation at hand. Older children can, meanwhile, deduce and analyze situations based from the information they have gathered through observation, inquiry, and listening. One's ability to cope rests on the kind and degree of available information (Protacio-de Castro, Camacho, Balanon, Yacat, Galang, and Ong, 2004). Information seeking and coping behavior are referred to as Response.

4. **Personality and Environmental Factors.** Located at the left side of the framework, personality and environmental factors influence the type of coping behavior (Protacio-de Castro, Camacho, Balanon, Yacat, Galang, and Ong, 2004). Coping behavior is referred to as Resilience.

   By focusing on the central vertical flow of the stress and coping framework and altering the terms used (based on the recommendations of Dr. De Castro), a rough framework for the discussion of the review has been designed, and dubbed as the Problem-Manifestation-Response framework (Fig.2).

Fig. 2 **The Problem-Manifestation-Response Framework.**

This framework was originally designed to discuss well-being in an armed conflict situation. This part of the review, however, shows how this same framework was used to support a prior discussion (found in a preceding section) on trauma and armed conflict. It must be noted that the "problem-leading-to-another-problem" cycle (Fig. 3) revolves around the PMR, and that the said cycle is actually a variant of such framework.

Fig. 3 **The Problem-Leading-To-Another-Problem Cycle (PP-Cycle)**

At this point, the Problem-Manifestation-Response framework is employed for the discussion of well-being in war situations.

Problems: Disruption of the Well-Being

Since traumatization disrupts the "wellness of health" aspect of psychosocial well-being (Ahearn, 2002, in Protacio-de Castro, 2005 draft), and since the point that "trauma is a disruption of the well-being" has been strengthened, it is now assumed that the problems leading to trauma would also affect the psychosocial well-being of the individual. At this point, the problems discussed earlier may be set aside (and revisited later on), and a list of other problem categories that disrupt psychosocial well-being be devised.

The highlighted letters in brackets indicate the category of well-being resource domain, which are depleted in each particular problem as put in by Strang and Agger (2001): H for "Human Capacity," S for "Social Ecology," and C for "Culture and Values."

1. **Evacuation and adjustment to new things [H]**

   Displacement or evacuation refers to the voluntary or involuntary relocation or transfer of persons, families or communities from their permanent areas of residence to another area because of militarization (Espiritu-Acuna, 1989). The effects of evacuation on the mental health of children are worse than if they have stayed and witnessed the bombing of their original environments (Langmeier and Matejcek, 1975, in NAS, 2003).

2. **Military engagement and other forms of exploitative behavior [H]**

   In armed conflict situations, young people are forced into the military and are assigned to dangerous tasks (Newman and Fellow, 2004). Related to this, there had been accusations against non-state military organizations in the Philippines regarding the recruitment of children. The situation for children grows more alarming when a party, or parties to the conflict, willfully enlist children in combat or in war-related activities.

3. **Family activities are disrupted [S]**

   Displaced and dispossessed families are forced to engage in very hard work in order to survive after the

war. In many families, women take men's work since the traditional breadwinners are rendered powerless. The eldest of the siblings learn to work at a young age (Balay, 2002).

4. **Dangerous coping of others in the community [S]**

The greatest threat to the young people's well-being often come from within the community itself—from relatives, neighbors, friends, and immediate family. For instance, the parents of a threatened family may sacrifice the eldest sibling and send him to forced soldiering in order to remove the threat to the younger sibling (Newman and Fellow, 2004).

As in the last example, the "problem-leading-to another-problem" cycle likewise operates in these additional problem categories.

But given the implications of these additional categories, earlier observations that studies on problems surrounding well-being are biased for the child population build up. This heightens the critique against such studies as neglecting to consider the problem of the community in its entirety. On the other hand, another view tends to reconsider this issue. This other view believes that the perspective for the children population is not at all bad and that while there are indeed boundaries as to the scope of information and insight, this could inspire other researchers and students of trauma as a psychosocial reality to conduct equivalent and more inclusive researches.

Another view believes that the perspective for the children population is not at all bad and that while there are indeed boundaries as to the scope of information and insight, this could inspire other researchers and students of trauma as a psychosocial reality to conduct equivalent and more generalized researches.

Manifestation of the Problems

Manifestation of a disrupted well-being in refugees such as being wary of strangers, having private sorrows, fluctuation of mood, feeling helpless/dehumanized/incompetent, and bereaved or mourning (Rack, 1981, in NAS, 2003), are similar to those symptoms found on traumatized refugees (or those who are labeled as such). But these manifestations are generally milder versions compared to those in trauma victims.

In addition, trauma sufferers or those who have experienced problems which destroy their well-being also experience other struggles as refugees (such as need for food, shelter, etc.), and are physically and emotionally exhausted (Rack, 1981, in NAS, 2003).

Since a wider range of psychosocial symptoms to problems are observed by looking at psychosocial well-being than when looking exclusively at psychosocial trauma, a study of the conditions of people in an armed conflict setting is more comprehensive using a well-being paradigm rather than the trauma paradigm.

Yet, this statement is not as conclusive as hoped for, since it is derived only from the study of problems and its manifestations. The study of stress (problems) and the conclusion that stem from such studies are deemed as limited because: 1) different stress models are not mutually exclusive (making it difficult to choose the right stress model to predict the effect of stress on an individual); 2) stress has different definitions; and 3) the categories of stressors are not exhaustive (NAS, 2003). In view of this, the need to focus current and future research on coping and protective mechanism comes to the fore. Whether the foregoing conclusion on the superiority of the well-being paradigm is true will depend on the supportive findings which this group of literature can come up with.

Response, Coping Styles and Well-Being

Coping is defined as a response to stress to reduce the stress condition. In a crisis condition, a person goes through a series of responses to regain imbalance. Failure results to anxiety and frustration (Domingo, 1992).

Though coping is voluntary, stress also triggers involuntary defense behaviors such as fight (attack), flight (regression) and freeze (helplessness) [Domingo,1992].

Gerhardt (in Domingo, 1992), however identified three types of voluntary coping, namely:

1) Psycho-physiological,

2) Psychological (meaning construction), and

3) Social (collective endeavor to change environment).

Most recently, a coping model has identified four exhaustive coping styles, arranged in increasing order of the resilience of the individual. These were observed among the refugees in Netherland asylum centers (Kramer and Bala, 2004):

1) Drifter – hopelessly goes with the flow, accepts defeat (helpless)

2) Hybernator – sticks to comfort zones (not helpless, but avoids problems)

3) Fighter – controls changes in the environment, but limited to the present, immediate environment (finds solution to present problems only)

4) Explorer – open to new options, flexible, sees the good in things (thinks about an attainable brighter future)

Specific coping responses involve military enlistment and forced sexual services. These two examples create yet another problem, which may be dubbed as "response-leading-to-another-problem cycle." Military enlistment is a form of coping because it may be the best option for survival and a way to achieve social power (Newman and Fellow, 2004). Girls are forced to offer sexual services in exchange for money (Newman and Fellow, 2004). Sex and sexual relationships become a coping mechanism as it brings solace in the face of crisis and instability (Newman and Fellow, 2004).

Fig. 4 **The Response-Leading-To-Another-Problem Cycle [RP-Cycle] Effects, Consequences and Implications The RP Cycle in Trauma and Well-Being**

The effects of the "response-leading-to-another problem cycle" (RP cycle) can be illustrated in the context of sexual violence in armed conflict. Voluntary victims of sexual abuse in armed conflict are often neglected by their soldier-perpetrators (when pregnant) and by the community. This heightens their shame, alienation and suicide tendencies (Newman and Fellow, 2004). Also, the youth and adolescent victims of sexual violence are more likely to have STDs (Newman and Fellow, 2004).

This observation of the RP cycle came up through the Well-Being Paradigm, and without giving priority to trauma.

But digging deeper into the literature of coping styles among traumatized refugees, it was observed that specific coping responses to trauma could also create problems. The coping styles of Vietnam veterans suffering from chronic combat-related PTSD led to disordered personality functioning, reinforcing and maintaining the trauma-induced personality

characteristics and symptoms associated with chronic PTSD. For example, confrontational and escape avoidance coping led to passive-aggressive personality style; and escape avoidance coping style alone leads to avoidant personality style (Hyer, McCranie, Boudewyns, and Sperr, 1996).

Thus, the RP cycle is not limited to well-being studies, but may also be observed using the Trauma Paradigm. How then can the RP cycle be used to differentiate the Trauma Paradigm and the Well-Being Paradigm?

Individual and Collective RP Cycles

At this point, more examples of the RP cycle using the well-being paradigm are given. The eldest siblings taking on adult jobs as a response creates the problem of disruption of family activities (Balay, 2002).

Some community members may collaborate with the armed men as their response in order to gain personal protection. This is a type of dangerous coping, since armed men in power usually collaborate with community individuals to compel children to perform activities related to armed struggle such as by becoming child soldiers or couriers and spies.

From such examples, we may arrive at this conclusion: although individual RP cycles can be observed using both the Trauma and Well-Being Paradigms, a collective RP cycle, one that affects the entire family or community can only be observed using the Well-Being Paradigm.

The "response-leading-to-another problem cycle" (RP cycle) has far more danger than the "problem-leading-to-another problem cycle" (PP cycle). The results of the PP cycle can be expected, as an average individual would expect problems to arise from previous problems. But not all individuals expect a problem to arise from a response to solve a problem, as what happens in the RP cycle. The imbalance that comes with surprise in not expecting a problem to arise from an act/measure meant to address a problem, creates stress. Catastrophic events are distressing because they happen with very little or no warning to anyone (Escalante, 2002). Therefore, prevention of the RP cycle should be prioritized over the PP cycle.

Furthermore, a collective RP cycle should be prioritized over individual RP cycles since the complete picture of the effects of catastrophe in human life is better manifested at the social and community level than the individual level.

Finally, since the collective RP cycle arises from the study of well-being (in contrast to the PP cycle and individual RP cycle which came from studies of trauma), the well-being paradigm should be prioritized in studying the psychosocial impact of war in communities.

Bridging the Gaps in Studies on Social Trauma and Psychosocial Response

The phenomenon of social trauma is now a life-size concern for social investigation in the Philippines. Especially in the last two decades when continuing military confrontations have rocked the country's southern and other rural regions, the problems and effects concomitant to social trauma were markedly felt. These have been as real in the Philippines as they are in various parts of the world where sociological, political, not to mention, natural and environmental factors, strain the security and well-being of peoples in the exposed and vulnerable communities.

In Mindanao where armed conflicts and the associated problems have caused displacements, along with the short-term and permanent effects on the community residents, a condition that can be interpreted as social trauma has been observed and documented. The physical, psychological and behavioral responses manifested by the sufferers in the community are comparable to and not unlike the symptoms shown by populations in other conflict-impacted societies across the globe especially those in the developing and underdeveloped countries.

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While a level of informed knowledge on the problem of social trauma is emerging and organized responses have so far begun so that various programs for intervention are breaking ground in affected environments in the country, preparedness remains minimal and the risk and vulnerability of the civilian populations with regard to trauma will not likely be contained over the years. On the contrary, the susceptibility of people especially those in the poorest and marginalized regions, is expected to increase. The rising trend and predictability of incidences are premised on the known and direct relationships between poverty, want and aggression. Within the said dynamics, increasing disputes over resources vis-a-vis dwindling reserves create social and political tensions that lead by and large to conflict situations and eventually to repression and violence. The continuing political debacle, widespread corruption in government and mounting crises in fuel and food supply are likely to further erode the capacity of the government to rule effectively. The depressed current economic status of the country and the poor prospects for economic relief are expected to further provoke and foment an atmosphere of aggression. The outcomes may put in peril human security and well-being thereby producing a phenomenon such as social trauma among the unprotected populations.

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But in the meantime, natural sociological processes continue to work by opening up opportunities for solutions. In the last several years, the conditions for the rise of social trauma in the country have triggered synergies of resources and paved avenues for optimistic and pro-active responses toward psychosocial remedies specifically among the groups within the organized sectors and advocacy communities. Non-government organizations and other agencies of support are now building and strengthening their conceptual understanding and developing their technical skills and capacities in order to respond to the causes and impacts of social trauma particularly through programs of interventions based on psychosocial frameworks and paradigms, approaches, strategies, and methods. Current efforts to learn about social trauma and create forms and techniques of community-based psychosocial development responses especially through specialized literatures and research studies are actively being undertaken by organizations in the country which have the philosophy, vision, mandate, resources and specialization to do so. But although research work has taken off the ground to provide functional help to the sufferers of social trauma, it still has not come a long way so that more work is definitely needed to increase resources and capacities and prime the area of research in the local field of advocacy for healing social trauma through community-based psychosocial development response.

In the said context, the foregoing review of literatures is being presented and shared to the public especially the trainers and practitioners engaged in psychosocial rehabilitation programs for traumatized people in communities caught in, or have experienced and survived armed aggressions. The review, however, forms only a small part of BALAY's continuing attempts to promote, bolster and accelerate research work as a strategy for understanding the interrelated phenomena of armed conflicts and social trauma, towards further institutional capacity-building for appropriate programs of interventions that will help heal and strengthen at-risk, affected, and

recovering populations in the country. While related literature and studies are collected and used to serve as the theoretical bedrock of any methodological research undertaking, this review of documented and consolidated information on social trauma and community-based psychosocial development response represents a most significant output in terms of the institution's research agenda for program development.

Still, it must be said too that even as the current review is being presented, an earlier effort by BALAY to gather and consolidate locally available literature on social trauma and healing has pushed to the fore realizations that are now at the same time disturbing and instructive. The observations raised from a review of literature on social trauma conducted in 2005 indicated a relatively low volume of relevant and locally-framed literature on the topic domestically available. The research team noted the deficiency of comprehensive and unbiased information that has been written to date about the subject. The available printed materials are offered predominantly in the western perspective and the authors' treatment of the phenomenon of social trauma in conflict-besieged communities was explained largely from a clinical and medical standpoint and thus far removed from the framework of social and cultural contexts where the phenomenon happen.

These materials are rare, unpopular and poorly disseminated. There are also a few literatures containing home-grown views and interpretations on social psychology, but these are not widely circulated and are thus hardly accessible. While the scarcity of existing research on social trauma could somehow serve as a spur to create impetus for new and further research efforts, the contrary effect is also possible. The implication of a confined and west-influenced body of knowledge that is at hand to serve as baseline information for further inquiries is restrictive and thus invites intellectual inertia and may not be an encouraging starting point for BALAY's research ventures.

But the external environment, as mentioned in the above, for research endeavors on social trauma and the appropriate community interventions is only part of the current chal-

lenge. More importantly, institutional research work itself has yet to fully mature and be strengthened. It may be worth pointing out that attempts at producing studies on rehabilitation, especially among survivors of torture and organized violence have been initiated by BALAY in its early years as an organization. The outputs involved were, however, only the ground breakers towards structured and more methodologically thorough research projects. In 1995-1999, no proprietary, full-scale and conclusive research was yet done except discrete, tentative and unrepeated initiatives to consolidate some baseline information such as community profiles and preliminary research designs which did not see finalization, validation and/or implementation. Efforts at producing studies and articles on psychosocial trauma and rehabilitation have only made real headway in 2005, henceforth.

BALAY was able to make ample and significant documentation of its theoretical frameworks and field experiences towards 2005 and produced a sizeable compendium of resource materials and printed references to support the academic and conceptual background of future research and even non-research institutional projects.

Nonetheless, BALAY has been able to make ample and significant documentation of its theoretical frameworks and field experiences. It has been able to come up with a compendium of resource materials and printed references to support the academic and conceptual background of its future research and even non-research institutional projects. Along this line, a significant number of psychosocial studies, discussion papers, workshop outputs and proceedings, summing up accounts, assessment reports and other similar and related articles were already published as part of programmatic steps to build up the conceptual foundation not only for BALAY institutional research but for other psychosocial intervention thrusts as well. All of these have been providing the nuts and bolts for the desired infrastructure towards developing and sustaining the effective management of institutional knowledge.

At the same time, the program structures, systems, mechanisms and operations for instituting advocacy research have been set in motion and are being audited and upgraded vigilantly. At the regional office, the unit which provides easy environmental access to the field, and where the locus and scope of operations of research projects is geared at, the Community Action Research Team (CART) was formed in 2006. The CART, which is a product of the trial participatory research unit, was tasked to manage and conduct a research project on the establishment of peace zones covering some communities in North Cotabato.

Under the CART, the basic research functions such as framework and research design development, methodology training, research tool preparation, data analysis and interpretation, monitoring and evaluation, and consultative and training workshops for the research team were introduced. Although the CART was a temporary formation that provided manpower and technical support to a preliminary and exploratory study on building local peace areas as a community response to social trauma in Mindanao, its outcomes proved to be of long-term utility and are applicable to all future research efforts.

Basically, the CART has provided a venue for learning the rudiments of standard scientific research and the management of such projects. The strength of the CART experience is based on its participatory orientation and the direct involvement and supportive sharing of skills and inputs by the regional staff members as assistants, facilitators, trainers and learners as well. The opportunity opened by the CART processes for acquiring actual experience in research work and the management of study projects cannot be undermined. The experiences are now being summed up and consolidated; the insights and practices are being adopted and in-

corporated into all the pertinent program functions and operations for the current and forthcoming projects under the institution's research agenda for psychosocial interventions and responses.

A major task that has been accomplished in terms of research methodology and approach was the formulation and adoption of inquiry formats, framework models, and processes and procedures that were derived from best practices workshops at inter-NGO forums and other sources, and which were attuned and revised to make them more relevant and appropriate for local application.Earlier on, BALAY has already accepted and began the use of a research framework called Participatory Action Research (PAR) which has been acclaimed and highly endorsed within local academic circles as an effective technique for developmental social inquiries. Subsequently, the active use of the PAR has led the institution to devise and adopt its own brand of psychosocial research method called Participatory Psychosocial Inquiry (PPI). Within the institutionally-conformed outlines of the PPI, institutional research has come to recognize the community residents as the real generators of experience, insights, knowledge, concepts and wisdom. As such, when these inputs and interpretations are used in research work to find solutions to problems and effect constructive changes, the people who are the sources and generators must directly participate in the research processes and outcomes, and eventually benefit from the long-term impacts. The role of the organization in charge of the research project is only to provide technical and material support as enablers and facilitators.

The relevance and utility of the PPI in fostering an enabling environment for the institutional programs and in providing the momentum for authentic and quality research work is now only beginning to be tested. Initial and exploratory research undertakings toward full-scale studies are underway in Mindanao and in an urban poor focus community in Metro Manila, where the PPI methodology for gathering data and information will be applied. The outputs will be later organized and processed as data and information infrastructure

for further studies. Research collaborations and assurance of support from international and local partners and sponsors also continue to be worked out and have been boosting institutional prospects for the gearing up of research work on community-based interventions as well as on organizational program development.

The opportunity to augment, crystallize and fertilize the existing body of knowledge in the country, provide contextual parallels to the current literature and studies on social trauma, and generate appropriate community-rooted interventions among conflict-stricken populations, is now considerable and offers compelling invitation not only for BALAY but also for all researchers and stakeholders in psychosocial rehabilitation work.

With the "rediscovery" and increasing espousal of approaches and methods that return to people enablement and restore the qualities of community participation and change-centeredness as unique aspects of social investigations seeking the development of people's lives through positive and popular reforms, the vision and fulfillment of a vibrant and growing research environment on psychosocial development does not seem remote and difficult. But serious work has to be done.

With the "rediscovery" and increasing espousal of approaches and methods that return to people enablement and restore the qualities of community participation and change-centeredness as unique aspects of social investigations seeking the development of people's lives through positive and popular reforms, the vision and fulfillment of a vibrant and growing research environment on psychosocial development does not seem remote and difficult.

Towards realizing such vision, the urgency of increasing competence and strengthening capacities for research work is a priority area that has to be addressed and satisfied. Competence and capacity-building has to include not only the appropriate training for the conceptual and functional aspects of systematic social researches but also creating venues and opportunities to hone and develop the positive qualities – skills, knowledge, attitude and values of researchers especially on social trauma. Correspondingly, the task of generating, locating and tapping technical and material resources to sustain the research endeavors cannot be overlooked.

Finally, the value of acquiring relevant knowledge and continuous learning, and a firm organizational resolve to pursue this through immediate efforts as well as long-term investments in the field of knowledge generation, have to be developed and inculcated throughout all levels and spheres of institutional affairs and operations. This would require reviewing and relocating the rationale for research vis a vis the complementary units of the psychosocial programs. This will also entail putting in the correct perspective and effective use the institutional attention, energies, resources and willpower, by shoring up activity-focused services with exercises and practices that cultivate and utilize ground experiences and processes and the culling of knowledge, insights, expertise and remedies from them.

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- A Primer on Internal Displacement in the Philippines
- A Primer on the Optional Protocol to the Convention Against Torture
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