Clin Soc Work J
DOI 10.1007/s10615-011-0348-z

ORIGINAL PAPER

Ethical Standards for Transnational Mental Health and Psychosocial Support (MHPSS): Do No Harm, Preventing Cross-Cultural Errors and Inviting Pushback

Siddharth Ashvin Shah

Abstract Important components of bioethics are routinely underappreciated in cross-cultural and transnational mental health and psychosocial support (MHPSS) efforts. This article provides case examples of cultural errors and/or harm by outsiders delivering MHPSS on different continents. The errors illustrate violations of informed consent (principle of autonomy) and avoiding harm (nonmaleficence). Ethical cultural adaptation standards are presented in order to avert such errors. Given the real risk of outsiders applying culturally erroneous and/or harmful practices in the process of delivering aid, the ability to discern pushback (resistance and redirection by intended beneficiaries) can yield ethically significant data. Actively inviting pushback is proposed as an additional methodology for ethical cultural adaptation with the purpose of at least gaining informed consent and, at best, shaping the most beneficent MHPSS.

Keywords Global health · Complex emergencies · Disaster mental health · Cultural competence · Cross-cultural trauma · Cultural adaptation · Bioethics · Medical errors · International social work · Transcultural psychology · Humanitarian aid · First responders

Background

In 2007, the Interagency Standing Committee released a landmark document to set guidelines for Mental Health and Psychosocial Support (MHPSS) in complex emergencies and mass disasters. Their working definition of MHPSS is "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC 2007; p. 1). MHPSS is routinely applied in humanitarian aid, development work and post-conflict programming. Previous social work literature has described ways in which outside support can reproduce inequitable North/South power relations or adversely affect local practices (Kleinman 1995; Puig and Glynn 2004; Wehbi 2009; Xu 2006). Other literature has begun to address the thinness, invalidity or absence of informed consent procedures in MHPSS for non-Western populations (Summerfield 2008). In response, this article seeks to provide ethical standards to promote best practices for MHPSS that is offered by cultural outsiders and transnational organizations.

Disasters today draw thousands of well-intentioned workers and volunteers from outside the affected community. Therefore, in addition to social service agencies providing shelter, security, water and sanitation, mass disasters are a key site for MHPSS delivery by cultural outsiders. Usually after a few weeks, despite good intentions, stories accumulate regarding "do-gooders" and how they are causing problems. This pejorative term, do-gooders, implies individuals who are perceived to have "no business being there" or those who make culturally significant errors. These can be individuals with little to no experience in transnational disaster work or those who may be affiliated with a legitimate aid organization.

In *Crazy Like Us: The Globalization of the American Psyche* (2010), author Ethan Watters chronicles do-gooders and legitimate workers employing culturally erroneous attempts at MHPSS. In the chapter covering the 2004 tsunami response, Watters documents several problematic and/or harmful MHPSS attempts by transnational outsiders: psychological trauma checklists, drive-by research,

S. A. Shah (✉)
Greenleaf Integrative Strategies, LLC,
http://www.greenleaf-is.com
e-mail: drshah@greenleaf-is.com

play therapy without translators, and single sessions of grief counselling. Those of us who have what we consider good educations, certifications and licenses might take comfort that these critiques are directed at unsophisticated, unprofessional people. Closer examination, however, shows that academic professionals and career relief workers are also prone to make these cultural errors (Shah 2006; Watters 2010). Similar to an adverse drug reaction in medical care, a cultural error can have serious consequences; therefore, it is our duty to do whatever we can to prevent, mitigate, report and correct such errors. This article recommends a fundamental, ethical re-evaluation of MHPSS, both in its disaster and non-disaster applications.

Ethical Considerations: Informed Consent and Avoiding Harm

In a 2009 article "Do No Harm: Toward contextually appropriate psychosocial support in international emergencies," Michael Wessells identifies and critiques violations of the Do No Harm imperative in MHPSS. He recommends "the provision of greater specificity in ethical guidance" (Wessells 2009; p. 851). However, multiple literature searches have demonstrated no well-articulated, internationally accepted standards for MHPSS that are grounded in bioethical foundations. Instead, previous arguments for cultural adaptation in MHPSS have appealed to two reasons: (a) properly adapted MHPSS is more clinically effective, and (b) it is wrong or harmful to encroach upon the culture of others with maladapted/erroneous MHPSS (Baron et al. 2003; Betancourt 2005; Bolton and Tang 2004; de Jong 2007; de Jong and van Ommeren 2002). While reason "b" has an intuitive ethics that is usually grounded in principles of self-determination or human rights, a bioethical justification for cultural adaptation is not strongly represented in the literature. This article addresses this lacuna by arguing for the standard of *Ethical Cultural Adaptation* (ECA).

In the Western literature, the ethicality of health care choices has long been evaluated by two foundational principles: autonomy and beneficence. *Autonomy* (self-rule) is the freedom from the control of others; or freedom from constraints that prevent meaningful choice. *Beneficence* (doing to others their good) is acting in the best interests of the intended beneficiary. We can now employ these bioethics principles to characterize the ECA by which Westerners do MHPSS.

A cornerstone method for promoting autonomy is informed consent (American Psychological Association 2002; Beauchamp and Childress 2001; Engelhardt 1986; Fallon 2006). Informed consent consists of providing to intended beneficiaries a meaningful understanding of the potential benefits, risk and methods that will be employed in the intervention. The intended beneficiary then has the right to freely choose the intervention or the right to be left alone. This right (even to refuse lifesaving treatment) has been upheld in Anglo-American courts through cases such as *Schloendorff v. Society of NY Hospital* (1914) and *Natanson v. Kline* (1960).

Granted, utilizing United States federal cases as a basis for rights elsewhere begs the question of whether rights-based societal norms should be applied to societies that actively challenge rights-based norms on the basis that it assumes Anglo-American individualism. This deserves a larger discussion. One reasonable view to hold for the time being is that outsiders should at least maintain their *own* society's minimum ethical standards when dealing with new cultures unless these ethical standards are shown to cause unintended harm. However, probably more compelling is Amartya Sen's case for universalizing basic freedoms—in contrast to "rights." Here we might appreciate that the idea of "freedoms" has a clearer bloodline to autonomy than does the idea of rights, which are derivative of Franco-Anglo notions of the nation-state. Put plainly, freedom is more fundamental than rights. Sen (1999) argues that basic freedoms are valuable to secure for three reasons: intrinsic importance, consequential roles and constructive roles. And he goes further to write, "The case [for basic freedoms] is no different in Asia than it is anywhere else, and the dismissal of this claim on the ground of the special nature of Asian values does not survive critical scrutiny." (Sen 1999; p. 246)

Beneficence is an imperative to do others their good. The "good" can be a slippery concept subject to abuse; hence the following bracketing from Engelhardt (1986) *The Foundations of Bioethics:*

> Because of the divergent understandings of what should count as actually doing the good, one *cannot understand the principle of beneficence as the Golden Rule.* If one does unto others as one would have them do unto oneself, one may in fact be imposing on others against their will a particular view of the good life. …To avoid such tyranny, one will need to phrase the principle of beneficence in this positive form: Do to others *their* good. (Emphasis mine, p. 75–76)

In Anglo-American jurisprudence and bioethics, the principle of beneficence is frequently found to be in tension with the principle of autonomy. For example, a health professional could be convinced that a specific intervention is the right one (qualifying as *beneficence* by the Golden Rule or by a "reasonable person standard"), but a patient does not see it the same way and wishes not to have the intervention (*autonomy*). Another challenging tension is between beneficence and *nonmaleficence* (do no harm). An absolute adherence to nonmaleficence is rarely possible in modern health care, especially when it comes to using

technology and medications. A life-saving surgery violates the principle of nonmaleficence by making an incision (harm); but since the surgery's benefits can outweigh the harms, it is considered beneficent. In order to navigate which harms are acceptable, the highest standard remains informed consent—the intended beneficiary has the ultimate right to deliberate the risks and benefits of a treatment, and it is with his/her authority that a health professional is justified to act.

Accordingly, Ethical Cultural Adaptation for MHPSS can flow from bioethical foundations in the following ways:

- The discussion of informed consent is easiest in the case of individuals who can decide competently and are free of control. Consultants who are poised to provide MHPSS to entire communities will have to gauge the consent of the collective in some way that is meaningful and permissive. Individuals in the community should be convinced that they can opt out.
- "First, Do No Harm" (Latin: *primum non nocere*) in bioethics is a principle reminding us to consider the harm of any intervention. It suggests that sometimes it is better to do nothing if the intervention may do more harm than good. Primum non nocere should not be taken to mean strict nonmaleficence, that is, *never do any harm for any reason.* (Beauchamp and Childress 2001; Engelhardt 1986). Indeed, surgery would never be permissible under this condition because an incision is by definition harmful.
- With informed consent, communities and individuals can take on intervention risks in the hopes of appreciable benefit. They can thus trump strict nonmaleficence (no harm whatsoever) in favor of beneficence (desired benefit) under the condition of informed consent.
- Do No Harm would be a paralyzing standard in many MHPSS situations because inadvertent harms do occur (e.g. loss of traditional culture in which *someone* stands to lose). However, Do No Harm (strict nonmaleficence) is the best principle in the absence of an informed consent process.

Cultural Adaptation

Culture, defined operationally by Marsella et al. (2008), is made up of "the shared behaviors and meanings that are socially transferred in various life-activity settings for purposes of individual and collective adjustment and adaptation" (p. 5). Cross-cultural challenges are manifold. Psychological disorders, psychosocial constructs and help-seeking behavior may vary wildly across cultures—without an ability to work with such variations, the validity of measurement can be compromised and local signs of distress can be missed. Now that a definition of culture is in place, it is worthwhile to expand on what is meant by cultural competency and cultural adaptation as they relate to MHPSS.

Cultural competency is described in the literature in two essential modes: (1) the ability to function effectively by applying a knowledge of cultural differences and attitudes (Marsella et al. 2008); and (2) an attitude of learning in which it is recognized that competency is a process of cultural adaptation with no established endpoint (Norris and Alegría 2006). Both descriptions are reasonable and have their proponents. The former description can be problematic if taken to mean: "Once you have the keys to people's hearts, they will accept whatever therapies you have to give." The latter description can be problematic if taken to mean: "Just stay curious and the context will tell you what needs to be done." Whichever approach is taken, accommodation of the following parameters, while not exhaustive, will assist in the initial shaping of MHPSS: language, rituals, family structure, gender, hierarchies and community structure, prejudice and bigotry, organized religions, degrees of modernization, history with disasters and armed conflict, history with the government, history with outsiders, trust in medical science and physicians, mourning practices, beliefs about death and dying, spiritual and mythological beliefs around disasters, help-seeking behavior, culturally-bound syndromes, traditional therapies, recovery and miracles, attitudes towards mental distress, mental illness and stigma.

By engaging informed consent and maintaining nonmaleficence, ECA is integral to transnational MHPSS best practices; it optimizes program design and protects communities. Culturally optimized MHPSS amplifies opportunities to work with diverse communities in positive and synergistic ways. ECA goes beyond cultural competence usage #1 (above) in that not only are consultants asked to know enough about a different cultural context to provide standard (Western) therapies, but that they are also expected to have an openness to work with non-standard therapies. Cultural competency usage #2 is operationalized in ECA through what has been called *ethnomedical competence* (Shah 2007) and *interculturalisation of services* (J. T. V. M. de Jong, personal communication, June 5, 2008). The success of ECA relates directly to an intervention's effectiveness, which is measured by (1) the degree of local acceptance and (2) relief from psychosocial problems.

It is now widely accepted that different cultural groups warrant context-specific, culturally adapted treatment for disaster (Baron et al. 2003; Bolton and Tang 2004; de Jong and van Ommeren 2002; Eisenman et al. 2006; IASC 2007; Shah 2007, 2009a, b, 2010; Wilson 2008). It should be acknowledged that there is a tension in what constitutes appropriate MHPSS for any one culture. On the one hand, it has been argued that preserving pre-existing [local] coping mechanisms and leaving a small cultural footprint is crucial

for successful MHPSS (Pedersen et al. 2008). And on the other hand, outsiders/consultants [terms which will be used interchangeably here] are institutionally configured by a worldview that propounds Western evidence-informed methods as desirable.

Suffice it to say that there is no virtue in, or evidence for, applying the extreme of either pole (e.g. purely local or purely outsider). Intervention design should not begin and end purely in the mind of the consultant—stakeholders and key informants should be engaged as early as possible to provide guidance on how to shape the interventions and make choices about content/process. Indeed, experience shows that without the input of the affected community, MHPSS can be rendered effete or harmful (Brenner 2009; Shah 2007, 2009a, b; Watters 2010; Wilson 2008).

Best Practices for Cultural Adaptation

A well-developed ECA protocol mitigates the chances that MHPSS suffers from under-adaptation, unilateral decisions, confusion, arbitrariness and having to "re-invent the wheel" with each project. The most fundamental goals of ECA are to enable consultants to (1) optimize interactions, avoid intrusions, and guard against giving offense; and (2) optimize the sustainability of benefits. In order to meet these goals in the design, implementation, monitoring and evaluation phases, it important to keep in mind at least four parties: intended beneficiaries, stakeholders, key informants and outside consultants.

Stakeholders are selected from among the intended beneficiaries and other persons who will be affected within the community (including leaders/elders, parents, representatives of vulnerable groups, and representatives of median/majority group). Stakeholders represent the views of those who directly stand to gain or lose by the MHPSS; therefore, they are central to the informed consent process.

Key Informants are knowledgeable persons or "cultural brokers" (who may or may not be intended beneficiaries) who are able to provide feedback on local norms and how MHPSS might be received. Key informants might be counselors, anthropologists or physicians who have had some exposure to the outsider's culture and can act as a bridge; or they may be people with special understanding or "gatekeeping" status such as traditional healers. Caution should be observed in that a key informant might be from a privileged part of the society and thus not representative of the needs of the most vulnerable (Brenner 2009; Wessells 2009).

Table 1 below represents a compilation of ECA practices derived from methodologies with credible theoretical and empirical bases (Betancourt 2005; Bolton and Tang

Table 1 Ethical Cultural Adaptation (Goals and Best Practices)

Goals	Best practices supporting goal
Regard community as valuable partners	Establish relationships on the basis of trust to work in unfamiliar contexts. Counteract power/knowledge asymmetries so that the ideas of outsiders are not uncritically assumed to be better or desirable.
	Engage Stakeholders *and* Key Informants to design the MHPSS. Find ways to re-tool a traditional approach, or integrate modern and traditional approaches.
	Implement and monitor MHPSS in consultation with Stakeholders *and* Key Informants so that adaptation can be ongoing process. Choose local staff based on those who will inspire trust in the community.
	Work to reduce power differential among members of the coordination group (expatriate vs. local staff). Facilitate the participation of under-represented, less vocal or less powerful groups.
Avoid Harm	Avoid work that would diminish local strengths/resources.
	Facilitate the cessation of harmful local practices in ways that are face-saving and that maintain important relationships.
	Be aware of and mitigate potential negative impacts of the work. Communicate expected tensions or unknown outcomes so that they are fully understood by stakeholders.
	Protect communities from work that has a lopsided benefit to outsiders (e.g. "drive-by research").
Alleviate suffering and facilitate fruitful change	Implement and evaluate work according to the parameters of validity, safety and efficiency.
	Work to alleviate symptoms of distress as identified by Stakeholders *and* Key Informants (local concerns) in addition to commonly accepted conditions.
	Facilitate community learning that supports positive change and fruitful reflection.
Sustainability	Cultivate relationships and practices that can benefit stakeholders long after discrete projects are completed.
	Share the exit strategy upfront.
	Build projects that interface with existing community institutions, non-governmental organizations, or government programs with similar missions/goals.
	Formulate "lessons learned" from discrete projects in such a way as to contribute to larger policy developments.

2004; de Jong 2007; Hinton 2006; IASC 2007; Pedersen et al. 2008; Shah 2009a, b; Shah et al. 2009; van Ommeren and Wessells 2007).

Cases of Cultural Errors

Outsiders typically arrive with MHPSS that is either "off the shelf" (i.e. interventions developed for one population and thought to be applicable to a differing context) or MHPSS that is translated into what is perceived to be the local context. This section presents four possible outcomes when erroneous MHPSS is implemented in communities: (A) a suboptimal result in which the opportunity to adapt optimally is missed; (B) harm and resultant loss of trust in the community for MHPSS; (C) an ineffective intervention that wastes resources/time (i.e. harm by opportunity cost); or (D) consultants take the error seriously, take the opportunity to do ECA, add to their knowledge and design an optimal intervention. These outcomes are represented in Fig. 1.

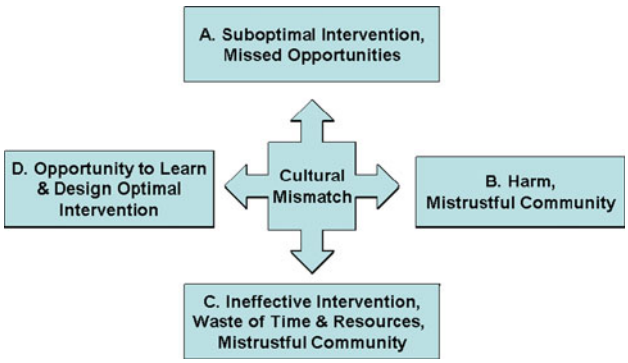

Fig. 1 Outcomes of cultural error

Each of the four outcomes is now illustrated by a fieldwork case:

Case I: India (outcome A—Missed Opportunity)

In tsunami affected South Asia, this author provided MHPSS consultation to humanitarian aid workers in India and Sri Lanka. He was invited by two local non-governmental organizations (NGOs) in the Nagapattinam District, the hardest hit part of India, to come train their managers who were overseeing the handling of human remains. They confirmed that their staff and volunteers were feeling vicariously traumatized. This author proceeded to teach skills which blended Western grounding techniques, Indian calming techniques (yoga and breathing) and organizational strategies. While yoga, a locally-known technique, was utilized, no consultation was made to shore up local resources for resilience or healing. The NGOs expressed gratitude and proceeded to implement their programs without any further feedback. The author later realized that he had not optimized the MHPSS for the context. Traditional healers were in good supply locally, and they communicated to the author that they felt underutilized. The author observed in one case that a credible healer was connected with an NGO, and the demand for his work was powerful—maybe stronger than the demand for the consultation that the author had provided.

Discussion This case represents a very common story. Local people are trusting and open to an outsider who gets the chance to do MHPSS. However, it represents missed opportunities and an intervention that did not inspire excitement or sustainability in the intended beneficiaries. More ECA might have yielded a better matched MHPSS.

Case II: Sub-Saharan Africa (outcome B—Harm & Mistrust)

Combatants who killed believe that they are haunted by the spirits of the people they had killed and that to rid themselves of spiritual pollution (haunting) they need to undergo a cleansing ritual performed by a traditional healer. This spiritual affliction is terrifying and the angry spirit can attack and harm one's family and community. Counseling an individual is not viewed as addressing the spirit or protecting the community. People thus polluted generally seek a traditional cleansing ritual, and they are told not to look back, which in the local idiom means 'don't talk of this or else the angry spirit will return.' Well intentioned counselors who sought to enable a person to 'open up' could cause a lot of harm because the person reacts as if the angry spirit will return. (Honwana 1997; Wessells and Monteiro 2004; M. Wessells, personal communication, September 9, 2009)

Discussion This case represents a counterproductive MHPSS element (talk therapy) that would cause distress in intended beneficiaries. These counselors may have had an intuitive approach: "I will use supportive, not expressive, methods of therapy. I will be as empathic and open-minded as possible when I hear someone's story. How could a supportive approach fail to address these combatants' shame and residual terror?" All the while, the very process of asking people to talk about their feelings could be experienced as perilous (invitations for angry spirits to return).

Case III: Sri Lanka (outcome C—Waste & Mistrust)

Anecdote (J. Jayawickrama, personal communication, September 9, 2009) related to this author: A fisherman from tsunami affected Eastern Sri Lanka in October 2005 describes an outsider doing interventions—"He came in to our village after the tsunami with an assistant. We were told [by the local NGO] that he is a mental health expert from the UK. They said that they are going to treat us with our mental health problems. Then this man sat down in front of my wife and started pointing a finger at her eyes. Yes, we are sad and upset about all what happen. I thought that they are going to help us to re-build our lives, but I got really mad when I saw this strange man pointing a finger at my wife. When I questioned this in an angry tone, the translator said that my anger is the mental health problem and I need special support. What nonsense? I asked them to leave my place immediately."

Case III: Sri Lanka (outcome C—Waste & Mistrust)

Discussion This MHPSS ended up wasting resources, time, and more certainly eroded the community's trust in MHPSS conducted by outsiders. Some harm (outcome B) may have also occurred if the wife was distressed or offended by the finger pointing or the husband experienced more than a temporary dysregulation of affect.

Case IV: Angola (outcome D—Pushback & Optimization)

Consultants wanted to work with behavioural and mood problems. Key informants insisted that a proposed intervention would not work because it addressed the victim instead of the agent of witchcraft believed to have caused the problem (Bolton and Tang 2004). Conversations with key informants and stakeholders gave rise to a new intervention, a ritual allowing the victim to confront the agent of witchcraft.

Discussion A proposed MHPSS caused key informants to push back. The outsiders learned from this and collaborated on an optimal MHPSS.

Power Asymmetries

Within the interdisciplinary field of global health, research of MHPSS is in its infancy. The current paucity of research lends to an "anything goes" atmosphere (Wessells 2009). Outsiders are willing to lend help on the basis of evidence that is either institutional or anecdotal. For example, a consultant who had been active in the 9/11 response said to this author that his educational technique for children would be effective in South Asia for tsunami-affected children. When asked why he thought a technique developed in New York City could work in South Asia, he replied, "Our treatment style has no cultural component." Given the uncontrolled state of the MHPSS field, especially in humanitarian emergencies, there is nothing stopping this consultant from going and providing his MHPSS. As an US consultant who could have financed his own project, he might have been welcomed, have used his technique, and have come home with stories of the many children he successfully treated.

Outsider-Local Asymmetry

Perceptions and the power that flows from perceptions both deserve to be handled ethically. Consultants that have the means to reach the Global South and/or disaster-affected communities are likely to be perceived as successful and knowledgeable experts. Some communities will be impressed by and deferential to the ideas of such a consultant, possibly more so if the consultant is a white male. Academics and health professionals in the Global South might similarly be impressed by and deferent to the ideas of this consultant since he/she will be a representative of the West, embodying the highest standards of education, training and ethics (Shah 2007).

Furthermore, if MHPSS is part of an international NGO's (humanitarian aid) efforts, then outsiders might be viewed as gateways to funding, jobs and other material resources (Wessells and Monteiro 2004). This is not an imagined gateway; if communities are deemed good partners by international NGOs or donor agencies, they might enjoy material benefits. Impoverished communities are vulnerable to the promise of resources that outstrip anything they have ever seen.

This article by no means prescribes that we adopt a cynical defense towards development sector gamesmanship. Indeed, most of these dynamics are more complicated, unconscious and culturally-coded than the formula of "poor community plays the game in order to profit." In fact, consultants themselves may profit from these dynamics because it is convenient to be accepted by stakeholders. Customs may dictate that outsiders are not to be questioned; in India, many hold the value that "A guest is a representative of the divine," and this would discourage people from pushing back against outsiders. In the matter of MHPSS, the local etiquette that one must never say 'No' can have problematic consequences.

Local-Local Asymmetry

Another power asymmetry that must be handled ethically is that of local power balances. Individuals in the community that affiliate with outsiders might gain informal power or prestige. The use of local cultural resources may privilege some local groups over others. Consultants must be especially mindful when subtle or gross competition exists for attention and partnership—a subgroup's interests may be at stake.

Outsider-Local Practitioner Asymmetry

There is often competition between Westernized health professionals and traditional healers. As mentioned above as a component of ECA, a consultant should be open to re-tooling a traditional approach or integrating Western and traditional approaches. This notion may be met by Westernized health professionals with scepticism. These professionals may be more in favour of implementing protocols and medications that are tried and tested in the West. Even if strongly favored by stakeholders, re-tooling a traditional approach or integrating Western and traditional approaches must be chosen responsibly—that is, because their expected positive outcomes outweigh the possible harms. The role of the consultant may very well be one of diplomat to multiple parties. Ultimately, the merits

of all competing interests must be balanced with as many practices of ECA as possible, including parameters of validity, safety and efficiency.

Avoiding Harm

In addition to asymmetry considerations, due to uncertainties, complexities and loosened oversight during emergencies, there exists a real risk of outsiders, even seasoned practitioners, doing harm by utilizing MHPSS that is culturally erroneous (Shah 2010). Factors that increase the chance of harm include inadequate training for workers that "parachute" in during disasters motivated by the feeling "I just had to come and help." The urgency of an emergency situation may be stated as a reason not to spend time on ECA, which becomes dismissed as a waste of time or luxury. Such dismissal fails to recognize that ethicality is routinely employed (and not considered a luxury) in Western nations during emergency measures. Ethical considerations employed in the most mundane acts (providing blankets, hydration, sanitation) are capable of providing enhanced psychosocial benefits. In the absence of ECA, best practices are not operationalized and MHPSS suffers. The astute provider of MHPSS will be alert to incremental opportunities for ethicality, resulting in avoiding harm.

In fact, there are sources of harm to which communities are exposed particularly in emergency situations. In the absence of tight Institutional Review Board oversight, research teams may collect data (from human subjects) that do not contribute to a provision or improvement of services for the affected community. The human subjects may be under the impression that they are going to benefit from the contact with the outsiders. In a related matter, simply interviewing survivors of trauma has potential to cause harm by re-traumatization or creating transitory hope/attachment (again, subjects having the perception that the interviewer will help).

The trust and enrollment ("buy-in") of communities and partners is also at risk without ECA. Community members might be offended by well-intentioned outsiders who do not understand local norms and priorities. Erroneous MHPSS may alienate a community so that people are lost to follow-up or may discourage future help-seeking behavior. Consultants who have influence can put large programs into motion, perhaps with the cooperation of some local institutions—even the government. Thus, a lack of due diligence or misunderstanding of ground-level realities could easily lead to poor public policy institutionalizing violations of autonomy and failing to meet parameters of validity, safety and efficiency.

Off the shelf interventions are convenient and/or advantageous for outside consultants to offer. The idea of an already tested intervention being applicable somewhere else can be seductive. Self-interest may play a role in selecting off the shelf—any success in utilizing a protocol-driven MHPSS may contribute to the reputation of that consultant or add to the evidence for a branded protocol. Medications are particularly problematic in MHPSS if they are off the shelf of a well-resourced outside institution. An impoverished community may not be able to acquire those specific medications once relief operations and the MHPSS project have ended. Such a cultural error constitutes missed opportunities (outcome A) and waste/mistrust (outcome C). Ethically, the principle of beneficence is violated. Off the shelf MHPSS may be quick, provider-convenient or inexpensive; however, any off the shelf intervention warrants ECA because otherwise the intervention could have significantly reduced effectiveness in an untested context and thereby supplant more effective intervention that *could* have been offered.

Inviting Pushback

In this paper, the term pushback describes the modes (active or passive, noticeable or covert) by which a group expresses its resistance and/or provides redirection to any intervention. Pushback is a given, whether outsiders perceive it or not. *Inviting pushback is a specific methodology for ECA with the purpose of at least gaining informed consent and, at best, shaping the most beneficent MHPSS.* This article regards inviting pushback as a methodology, and not a best practice, because it is not in wide usage with empirical backing as of yet. This methodology is proposed to be especially relevant in the Global South where Institutional Review Boards or governments do not have clout to protect persons from suboptimal or harmful interventions. Perhaps other methodologies will be proposed by other Global South practitioners for gaining informed consent and a best practice can evolve. This article proposes that given the power asymmetries discussed earlier, it is not adequate to simply *be open* to pushback from Stakeholders *and* Key Informants (S/KI). Indeed, to rigorously seek ECA, we must actively *invite* pushback. Another way of saying this is that we must actively dismantle barriers to pushback because, in the absence of our active efforts, existing power asymmetries and outsider self-confidence may snuff out resistance or redirection from S/KI.

Ethically, inviting *pushback* is simultaneously a defense of autonomy (freedom from control or constraints) and a defense of beneficence (the discernment of *their* good). More specifically, S/KI are invited to pushback if anyone detects problems of relevance, quality or potential harm. When pushback comes, it always has a complaint *process*

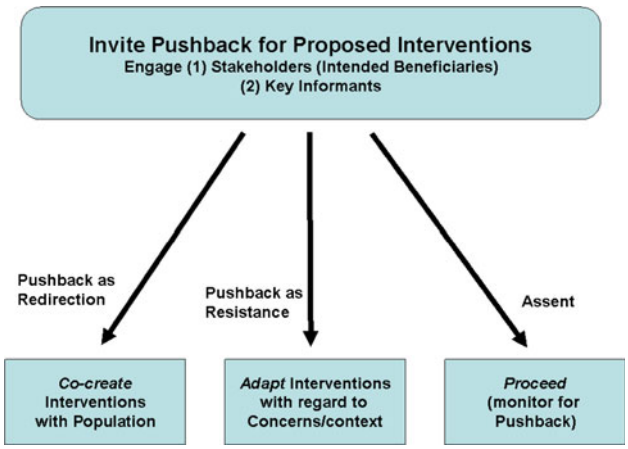

Fig. 2 Inviting pushback and the resulting routes of work

(the way problems are conveyed), and it may or may not have distinct complaint *content* ("this specifically is the problem"). Actually noticing that pushback is occurring can be demanding for outsiders because—without a shared cultural lens by which to apprehend the complaint process—pushback can go unnoticed ("under the radar"). Methods to mitigate this challenge will be discussed in the next section.

The content, or communication, underlying pushback can vary between resistance and redirection. *Resistance* is the expression of dissent or dissatisfaction without a distinct counter-proposal. *Redirection* has specific content regarding ideas to optimize the MHPSS (improve relevance, improve quality or reduce potential harm). If there is a greater degree of resistance, then it is the responsibility of the consultant to utilize ECA and adapt the MHPSS with respect to concerns and context according to S/KI. If there is a greater degree of redirection, then there is an opportunity for the consultant to co-create MHPSS that satisfies all the concerned parties. Finally, maybe after inviting pushback, there is none detectable. In case of no detectable pushback, consultants should implement the MHPSS in dialogue with S/KI who monitor progress and express pushback if something new comes into view. Figure 2 depicts these different routes.

Methods to Actively Invite Pushback

Inviting pushback can be thought of as eagerly asking for feedback or criticism. In many cross-cultural settings, S/KI will not feel safe to provide feedback of any kind, let alone criticism, until they perceive that the consultant can handle the assertive force of resistance or the correcting nature of redirection. Therefore, one condition for a free flow of pushback is a consultant who conveys to S/KI that feedback or criticism towards the MHPSS design can be handled without retaliation (e.g. consultant abandons the community, and the community is denied a MHPSS or other desired resources).

Being "corrected," as happens when redirection is being provided, has the capacity to stimulate shame in the corrected party. A consultant's self-importance will determine how much shame can be tolerated. If a consultant cannot handle the shame associated with the circumstance, he/she will place further barriers to incoming pushback. Protecting oneself from that shame will take precedence over a group's needs. It might be comforting to know that given the complexity and unpredictability of MHPSS, it is virtually impossible to do this work without making mistakes. We should become accustomed to receiving feedback.

Admitting mistakes—or being confronted for mistakes we make—is always a challenging life activity, and yet resilience is imperative for MHPSS consultants who want to do ethical work. Therefore, along with needing to handle assertive force and manage shame, a consultant must have a stomach for the work. The methodology is, in summation, a highly participatory, elicitive pedagogy that invites honest and active participation and asks that no one hold back (Wessells and Monteiro 2004). There will be difficult moments when a consultant is put to the test, and a good consultant will maintain engagement with S/KI rather than being defensive or hiding behind the role of "subject matter expert."

Group Dynamics of Inviting Pushback

In the field of mental health and psychosocial interventions, group dynamics theory normalizes assertive force and works with such pushback energy as a source of creativity (Gans 1989; Shapiro and Gans 2008). Group theory pays attention to the "conduct of the leader," and admitting one's faults, blind-spots or mistakes can be quite consistent with good leadership (Weber and Gans 2003). An ability to be plain about one's fallibility can contribute to the kind of atmosphere that invites pushback. It is thus useful to send the message "There won't be anything unusual about my getting pushback, and I can handle it." When a group realizes that the leader is OK with pushback, and that they will not be harmed, it amounts to a believable invitation to push back (Ormont 1994; Billow 2010).

Even if an outsider demonstrates a readiness to work with assertive force and manage shame, asking for pushback directly may not meet with success. Many communities discourage such direct communication, especially when the communication involves negative feedback. One's social location—gender, ethnicity, position in hierarchy, religious orientation, social class, and national origin—can impact the pushback. Actively examining social

location occurs in a co-created "matrix," which Green and Stiers (2002) describe in the following:

> Based on each group member's relative perceptions of power, privilege and capacity for personal agency, as well as the mutual projections that come to exist as members interact, an intersubjective matrix is created and sustained. (p. 237)

While power asymmetries are unavoidable, social location can be negotiated through elicitive methods by which local people feel they have a voice. Proactively mentioning social location and legacies of colonialism, class, sexism, homophobia, poverty, racism and discrimination can open the door to thinking about how to dismantle damaging asymmetries. Wessells (1999) suggests that we ask on a continuing basis 'who benefits' and 'who's excluded' in the MHPSS. As mentioned above in describing ECA, it is important to work effectively with different sub-groups, building bridges between constituencies whenever possible (Debiak 2007).

There are strategies for working within complicated social matrices. For instance, an experienced humanitarian worker, Michael O'Neill, related this method: (1) Ask people to imagine a situation in which they are worried that an individual, let's call him "Loko," is about to do something that may have negative consequences. (2) Ask "If you wanted to communicate this concern to Loko or an intermediary who could stop Loko, how would you do it appropriately in this community?" (3) Listen for methodologies that emerge from the group and adapt those into a pushback methodology for yourself (M. O'Neill, personal communication, October 21, 2009). By occupying the role of a "Loko" needing to be informed of erroneous MHPSS, the consultant can then support culturally-consistent methods by which the community will share concerns. This method can be useful when indirect styles of communication are valued, and the use of hypotheticals (or intermediaries to speak on behalf of the consultant) can promote comfort or save face. Also, this method is simply more elicitive (and thus culturally adapted) compared to unilaterally prescribing one's own methodology for gaining pushback.

Questions to Guide Ethical Cultural Adaptation

Given the complexities typical of disaster, outsiders should be prepared to implement ECA, and address any attendant ethical dilemmas, in a timely fashion. In addition to the collated best practices and pushback methodology described above, there is a growing literature on what constitutes and does not constitute cultural adaptation in the field (Shah 2007, 2009a, b; Shah et al. 2009; Wessells 1999, 2009). Here it may be helpful to list some questions by which a MHPSS program designer can consider what time/resources can be devoted to ECA:

- Given an unfolding crisis and the exigencies of timely implementation, how much ECA is possible? Would ECA be viewed by the community as "wasting time?"
- Given a project's finite resources, which components of ECA will most benefit the community?
- What will it cost to research/create/adapt new modalities (constructs, instruments, interventions)? What reduction in benefit will result if those new modalities are not incorporated?
- What ECA will get the job done sufficiently? What constitutes "sufficiently?"
- How do we bring about benefits that are lasting and sustainable? What constitutes "sustainable?"
- If there is a tension between autonomy and beneficence in MHPSS development, who resolves the tension and by what methodology?

Recommendations for Further Research

Although much has been written in the past two decades about cultural adaptation for MHPSS, significant gaps in knowledge remain (Shah et al. 2009). Given the unpredictable and urgent nature of disaster response, it is difficult to conduct evidence-based research and comparison studies to evaluate MHPSS variations. For this reason, cultural studies, ethnography, discourse analysis and social anthropology offer particularly helpful and complementary methodologies to interpolate and extrapolate MHPSS that is ethically sound and culturally matched (Patterson 2009). What follows is a non-exhaustive list of studies that would help catalogue best practices:

1. Of all the peoples who are vulnerable to disaster, only a small fraction of the cultural groups in the world have been studied with regard to trauma. Studies are needed to further map culturally-specific factors (including strengths, vulnerabilities, culturally-bound syndromes) for traumatic stress reactions.
2. Methodologies for cultural adaptation tend to lack empirical evidence. Adaptation methodologies should be scaled and measured for relative successes/gaps.
3. Discern which components of adaptation are essential and which are optional.
4. Delineate novel community participatory methods to do ECA.
5. Compare outcomes for local, culturally embedded therapies with outcomes for evidence-based Western interventions. Map the cross-cultural outcomes for both validated and unvalidated Western therapies.

Comparative studies would begin to build a case for selecting specific interventions over less effective ones. Finally, binary distinction of local versus Western is only one of many notable distinctions. Other binaries relevant for mapping are North-South, dominant-marginal and mainstream-alternative.

Critical Discussion

Before concluding, some critical qualifications are in order. This article is not making an argument for the irreducible supremacy of local customs, traditions and preferences. There are indeed local norms or ethnocultural practices that are harmful or counterproductive (Baron et al. 2003; Shah 2009a, b; van Ommeren and Wessells 2007). The Inter-Agency Standing Committee, established by the United Nations General Assembly, in its Guidelines on Mental Health and Psychosocial Support in Emergency Settings, urges action against harmful norms even while urging practitioners to use local norms whenever a benefit may be possible (IASC 2007). Ideally, we should act against harmful norms in a way that maintains relationships in the best possible way and might lead to positive policies that discourage such practices.

There is a risk of over-exceptionalizing cultures that are different from our own. It is unrealistic to strive for cultures remaining maximally distinct or in a pristine, undisturbed state. Regarding cross-cultural work in the Muslim world, analyst Manal Omar (2009) comments that "over-exceptionalization or strong judgmental attitudes has hindered projects in these contexts." ECA does not stipulate that MHPSS should champion only traditional notions. Cultures are continually in flux, and with proper social dialogue and auto-reflective critique, MHPSS can be a source of desirable cultural change.

In a 1989 essay "Who Claims Alterity?" Gayatri Chakravorty Spivak critiques how cultural specificity and difference are packaged for transnational consumption. Such a discourse [including this article] is class-specific and may over-strive to reject a monolithic 'other' in order to promote a postmodern thesis. Spivak suggests that numerous dilemmas—intellectual and practical—exist in this field and that a transnational consultant is continually vulnerable to oversimplifying, over-generalizing, over-exceptionalizing, and just plain getting it wrong.

This author is not immune to the critiques herein and has written about his own failures to observe best practices (Shah 2007). As argued by Wessells (2009), it is part of "Do No Harm" to publish our failures, negative studies and unintended negative consequences without regard to the concerns over image loss, reputational damage, and possible loss of funding. Wessells goes on to say: "In my experience, humanitarian workers can be convinced to keep records of incidents of unintended harm if the documentation is done in a spirit of mutual learning and identifies ways of improving psychosocial practices without pointing fingers and naming and shaming particular agencies or people." (p. 851)

This article is not suggesting that Western interventions are inferior or undesirable. It does, however, caution against off the shelf interventions that are applied for strictly intuitive ("it *should* work") reasons and against the blind use of Western methods. Western interventions that are adapted or validated through a process of engagement with the affected population have been shown to be effective (Hinton et al. 2005). Even so, an astute consultant will monitor whether the use of adapted Western interventions has a negative impact on the utilization of local healing practices.

Conclusion

MHPSS best practices are ones that are firmly grounded in the principles of autonomy and beneficence. Strict non-maleficence (Do No Harm) is argued to be appropriate in the absence of informed consent; and this principle is moderated to one of *Avoiding Harm* once there is informed consent. Different instantiations of culturally erroneous MHPSS were described, and ECA is promoted as a way to mitigate error. As an additional methodology of ECA, inviting pushback is proposed as a simultaneous application of autonomy and beneficence. Inviting pushback is intended to be a bulwark against the real risk of outsiders applying culturally erroneous and/or harmful practices in the process of delivering MHPSS and/or social services.

Globalization and transnationality are causing paradigmatic changes in the practice of social work and mental health (Kayser et al. 2008; Midgley 1990). While disaster relief may be the most dramatic site of MHPSS by cultural outsiders, social service agencies in the West are also sites where diverse populations—refugees, marginalized communities—receive MHPSS (Xu 2006). There is a risk for transnational and cross-cultural work to be viewed as exotic or good learning experiences; therefore, ethical standards are necessary to protect vulnerable populations and promote the most effective MHPSS practices (Puig and Glynn 2004). The lack of cultural competence (i.e. incompetence) exposes vulnerable populations to errors in MHPSS. These errors are under-reported, partly because we have had no standard by which to judge the appropriate level of cultural competence, partly because we have few comparison studies on MHPSS programs with varying cultural adaptations to see which yield good outcome and which yield harm, and partly because disciplines

under-report negative outcomes. Social work as a discipline has an ethos of protecting the vulnerable, prioritizing clients' agency, promoting positive adaptation and engaging in symmetrical collaborations. ECA is a set of practices that strive to augment and codify this ethos for transnational MHPSS.

Acknowledgments The best practices of cultural adaptation and recommendations for further research in this paper are predicated on work done by the author while commissioned by Psychology Beyond Borders to establish organizational guidelines for cultural adaptation.

References

American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060–1073. Also available from http://www.apa.org/ethics/code2002.html.

Baron, N., Jensen, S. B., & de Jong, J. T. V. M. (2003). Refugees and internally displaced people. In B. Green, M. Friedman, J. de Jong, S. Solomon, T. Keane, J. Fairbank, et al. (Eds.), *Trauma interventions in war and peace: Prevention, practice, and policy* (pp. 243–270). New York: Kluwer Academic/Plenum.

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press.

Betancourt, T. (2005). Stressors, supports and the social ecology of displacement: Psychosocial dimensions of an emergency education program for Chechen adolescents displaced in Ingushetia, Russia. *Culture, Medicine and Psychiatry, 29*(3), 309–340.

Billow, R. M. (2010). Modes of therapeutic engagement part I: diplomacy and integrity. *International Journal of Group Psychotherapy, 60*(1), 1–28.

Bolton, P., & Tang, A. M. (2004). Using ethnographic methods in the selection of post-disaster mental health interventions. *Prehospital and Disaster Medicine, 19*, 97–101.

Brenner, G. H. (2009). Fundamentals of collaboration. In G. H. Brenner, D. H. Bush, & J. Moses (Eds.), *Creating spiritual and psychological resilience: Integrating care in disaster relief work* (pp. 3–18). New York: Routledge.

de Jong, J. T. V. M. (2007). Nongovernmental organizations and the role of the mental health professional. In R. J. Ursano, C. S. Fullerton, L. Weisaeth, & B. Raphael (Eds.), *Textbook of disaster psychiatry* (pp. 206–224). Cambridge, UK: Cambridge University Press.

de Jong, J. T. V. M., & van Ommeren, M. (2002). Toward a culture-informed epidemiology: Combining qualitative and quantitative research in transcultural contexts. *Transcultural Psychiatry, 39*, 422–433.

Debiak, D. (2007). Attending to diversity in group psychotherapy: An ethical imperative. *International Journal of Group Psychotherapy, 57*(1), 1–12.

Eisenman, D., Weine, S., Green, B., de Jong, J., Rayburn, N., Ventevogel, P., et al. (2006). The ISTSS/rand guidelines on mental health training of primary healthcare providers for trauma-exposed populations in conflict-affected countries. *Journal of Traumatic Stress, 19*, 5–17.

Engelhardt, H. T., Jr. (1986). *The foundations of bioethics*. New York: Oxford University Press.

Fallon, A. (2006). Informed consent in the practice of group psychotherapy. *International Journal of Group Psychotherapy, 56*, 431–454.

Gans, J. S. (1989). Hostility in group psychotherapy. *International Journal of Group Psychotherapy, 39*, 499–516.

Green, Z., & Stiers, M. J. (2002). Multiculturalism and group therapy in the United States: A social constructionist perspective. *Group, 26*(3), 233–246.

Hinton, D. E. (2006). Special Issue culturally sensitive CBT: Introduction. *Cognitive and Behavioral Practice, 13*, 246–248.

Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of CBT for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress, 18*, 617–629.

Honwana, A. M. (1997). Healing for peace: Traditional healers and post-war reconstruction in Southern Mozambique. *Peace and Conflict: Journal of Peace Psychology, 3*, 293–306.

Inter-Agency Standing Committee (IASC) (2007). *IASC guidelines on mental health and psychosocial support in emergency settings.* Geneva: IASC. Also available from http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

Kayser, K., Wind, L., & Shankar, R. A. (2008). Disaster relief with in a collectivistic context. *Journal of Social Service Research, 34*, 87–98.

Kleinman, A. (1995). *Writing at the margin: Discourse between anthropology and medicine*. Berkeley, CA: University of California.

Marsella, A. J., Johnson, J. L., Watson, P., & Gryczynski, J. (2008). Essential concepts and foundations. In A. J. Marsella, J. L. Johnson, P. Watson, & J. Gryczynski (Eds.), *Ethnocultural perspectives on disaster and trauma* (pp. 3–13). New York, NY: Springer Science.

Midgley, J. (1990). International social work: Learning from the third world. *Social Work, 35*, 295–301.

Norris, F. H., & Alegría, M. (2006). Promoting disaster recovery in ethnic-minority individuals and communities. In E. C. Richie, P. J. Watson, & M. J. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (pp. 319–342). New York: Guilford Press.

Omar, M. (2009, July). *Diversity in the Muslim world—How NGOs can work more effectively with communities.* Paper presented at the Interaction Forum 2009. Washington, DC.

Ormont, L. R. (1994). Developing emotional insulation. *International Journal of Group Psychotherapy, 44*(3), 361–375.

Patterson, G. T. (2009). An Examination of evidenced-based practice interventions for public emergencies. *Journal of Evidence-Based Social Work, 6*, 274–287.

Pedersen, D., Tremblay, J., Errazuriz, C., & Gamarra, J. (2008). The sequelae of political violence: Assessing trauma, suffering and dislocation in the Peruvian highlands. *Social Science and Medicine, 67*, 205–217.

Puig, M. E., & Glynn, J. B. (2004). Disaster responders: A cross-cultural approach to recovery and relief work. *Journal of Social Service Research, 30*, 55–66.

Sen, A. (1999). *Development as freedom*. New York: Knopf.

Shah, S.A. (2006). Resistance to cross-cultural psychosocial efforts in disaster and trauma: Recommendations for ethnomedical competence. *The Australasian Journal of Disaster and Trauma Studies*. Retrieved June 30, 2010, from http://www.massey.ac.nz/~trauma/issues/2006-2/shah.htm.

Shah, S. A. (2007). Ethnomedical best practices for international psychosocial efforts in disaster and trauma. In C. S. Tang & J. P. Wilson (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (pp. 51–64). New York: Springer Verlag.

Shah, S. A. (2009a). "To do no harm", spiritual care and ethnomedical competence: Four cases of psychosocial trauma recovery for the 2004 tsunami and 2005 earthquake in South Asia. In G. H. Brenner, D. H. Bush, & J. Moses (Eds.), *Creating spiritual*

and psychological resilience: Integrating care in disaster relief work (pp. 157–178). New York: Routledge.

Shah, S.A. (2009, July). *Diversity in the Muslim world—How NGOs can work more effectively with communities.* Paper presented at the Interaction Forum 2009. Washington, DC.

Shah, S. A. (2010). Mental health emergencies and post-traumatic stress disorder. In G. B. Kapur & J. P. Smith (Eds.), *Emergency public health: Preparedness and response* (pp. 493–516). Boston: Jones and Bartlett Publishers.

Shah, S.A., Seyle, C., Skiadas, T., & Naturale, A. (2009, September). *Do no further harm: Guidelines for psychosocial work across cultures* (Psychology Beyond Borders Working Paper). Available upon request from http://psychologybeyondborders.org.

Shapiro, E. L., & Gans, J. S. (2008). The courage of the group therapist. *International Journal of Group Psychotherapy, 58*(3), 345–361.

Spivak, G. C. (1989). Who Claims Alterity? In B. Kruger & P. Mariani (Eds.), *Remaking history: DIA Art foundation discussions in contemporary culture no. 4* (pp. 269–292). Seattle: Bay Press.

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal, 336*, 992–994.

van Ommeren, M., & Wessells, M. (2007). Inter-agency agreement on mental health and psychosocial support in emergency settings. *Bulletin of the World Health Organization, 85*(11), 822–823.

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. New York: Free Press.

Weber, R. L., & Gans, J. S. (2003). The group therapist's shame: A much undiscussed topic. *International Journal of Group Psychotherapy, 53*(4), 395–416.

Wehbi, S. (2009). Deconstructing motivations: Challenging international social work placements. *International Social Work, 52*, 48–59.

Wessells, M. G. (1999). Culture, power, and community: Intercultural approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow, & B. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss* (pp. 267–282). New York: Taylor & Francis.

Wessells, M. (2009). Do No Harm: Toward contextually appropriate psychosocial support in international emergencies. *American Psychologist, 64*(8), 842–854.

Wessells, M. G., & Monteiro, C. (2004). Healing the wounds following protracted conflict in Angola: A community-based approach to assisting war-affected children. In U. P. Gielen, J. Fish, & J. G. Draguns (Eds.), *Handbook of culture, therapy, and healing* (pp. 321–341). Mahwah, NJ: Erlbaum.

Wilson, J. P. (2008). Culture, trauma, and the treatment of post-traumatic syndromes: A global perspective. In A. J. Marsella, J. L. Johnson, P. Watson, & J. Gryczynski (Eds.), *Ethnocultural perspectives on disaster and trauma* (pp. 351–375). New York, NY: Springer Science.

Xu, Q. (2006). Defining international social work: A social service agency perspective. *International Social Work, 49*, 679–692.

Author Biography

Siddharth Ashvin Shah, M.D., M.P.H. is Medical Director of Greenleaf Integrative Strategies in the Washington, D.C. metro area. Dr. Shah is board certified in Preventive Medicine sub-specializing in Behavioral Medicine. He leads teams providing expertise on psychosocial trauma mitigation, mind-body therapies, trans-cultural adaptation, vicarious traumatization, staff care and stress control.