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The first decade of *Intervention*: facts, figures & trends

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This paper aims to explore trends in developments in content and authors' locations and perspectives in 'Intervention, the International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict', from 2003 to 2012. Over this 10 year period, Intervention has published 139 peer reviewed articles, 73 field reports, 36 book reviews and 33 debate papers. The articles cover academic expertise, practical experience and debates on mental health and psychosocial interventions in the aftermath of both natural, and manmade, disasters. The authors of most papers (61%) originated from developed countries, versus 28% from low and middle income countries. Thematic analysis of the content of peer reviewed articles reveals shifting consensus and emerging new debates on mental health and psychosocial interventions. In the first years of Intervention, individual therapeutic approaches were more prominent than in later years, which saw more attention given to community based approaches. Another emerging theme is the trend to involve 'beneficiaries' in planning and evaluation of programmes, through participatory approaches. A significant number of peer reviewed papers (28%) describe policy development issues, such as guidelines (IASC) and processes of integration of mental health into general health care systems in post conflict settings. Recommendations are that the editorial priorities for the next years should continue strategies for increasing submissions from authors originating from areas affected by conflict, and increasing inclusion of perspectives of those who have experienced extreme events.

Keywords: disaster settings, post conflict, practice, psychosocial intervention, systematic review, theory

Introduction

In 2013, *Intervention, the International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*' (hereafter: '*Intervention*') celebrates its 10th anniversary. The journal was an initiative of Dutch and Sri Lankan mental health and psychosocial professionals from the local nongovernmental organisation (NGO) 'Shanthiham' in Jaffna, Sri Lanka.[1] Until 2006, it was published by the Intervention Foundation, under auspices of the NGO War Trauma Foundation, in the Netherlands. As of 2006, a professional academic publisher, Lippincott Williams & Wilkins, publishes the journal on behalf of the War Trauma Foundation.

The journal aims to be a platform for those involved in the provision of mental health and psychosocial support in (post) conflict settings, to exchange experiences, and to learn from each other, at all levels. *Intervention* was conceived to serve as a working link between practitioners in the field, policy makers and academics, and has been at the centre of the emerging, multidisciplinary field of mental health and psychosocial support in (post) conflict areas (Ventevogel, 2012).

The editorial board of the journal invited the authors, three professionals in mental health

and psychosocial support (MHPSS) from the Netherlands, Uganda and India, to conduct an independent, external review of the journal's contents and provide recommendations for future editorial policies.

Specifically, the authors were requested to look at the representation of journal article authors from low and middle income countries (LMICs). Most major peer reviewed journals still publish very few research papers on MHPSS issues in low and middle income countries (Tol et al., 2011). Although the situation does seem to be improving slowly, the representation of LMIC authors remains low (Saxena et al., 2006; Razzouk et al., 2010); in six leading psychiatric journals, the percentage of authors from low income countries increased from 3.2% in the period 1996–1998 to 3.7% in the period 2002–2004, while LMIC countries account for 80% of the global population (Patel and Kim, 2007).

The authors were also requested to explore patterns and trends in the content of the published manuscripts. The emerging field of MHPSS has been characterised by fierce paradigmatic debates about what constitutes *'good'* MHPSS interventions in post conflict settings (Galappatti, 2003), and is marked by a considerable fragmentation of approaches (Tol et al., 2011b). There are, however, signs of an emerging consensus (Van Ommeren, Saxena & Saraceno, 2005; Wessells and van Ommeren, 2008).

This review, therefore, explores the following questions:

- What types of manuscripts were published in the journal (i.e. how many peer reviewed articles, field reports, book reviews, and other types of articles)?
- Which geographical regions did the authors of *Intervention* articles come from?
- What is the specific contribution of article authors from LMICs?
- Which countries do the reviewed articles (explicitly) refer to?
- What are the main themes in the (peer reviewed) articles, and what trends can be observed?

Procedures

Quantitative data

The following data was collected for each article published in *Intervention*:

1) Geographical background of authors: for each (co) author of a manuscript, the country of residence at the time the manuscript was submitted was documented.[2] The resulting calculated percentages of authors from LMICs were based on World Bank classifications (World Bank, 2012).
2) Geographic classification of the paper: the summaries of all papers and the listed country reference were analysed. If the paper did not describe a specific country, it was assigned a *'generic'* coding.
3) Characterisation of the main topic of the paper: for all peer reviewed articles, the main thematic topic or theme was recorded by assigning a keyword, characterising the main content represented. For this content rating two subcategories from the list of keywords in *Intervention's* electronic submission system (Editorial Manager: EM) were used[3]: 1) *Activities/ intervention types* (34 keywords), and 2) *Research types* (12 keywords). Each of the three authors of this paper assigned key words separately and independently. In cases of diverging choices, the first author consulted the other authors to reach mutual consensus. In order to observe emerging or changing trends over the

10 years, a separate analysis was conducted for three periods of 10 issues.

Qualitative data

The three authors read all abstracts, browsed through 30 issues of the journal and noted observations and impressions with the aim of identifying trends and emerging themes. These three viewpoints were merged and adapted until a consensus was reached between the three authors.

Results

Types of papers

Over the span of a decade, *Intervention* published 30 issues, containing 281 manuscripts, with a total number of 2526 pages.[4] Of these manuscripts, 139 were peer reviewed. The other papers were reviewed by the *Editorial Board*: 73 field reports, 36 book reviews, and 33 papers that can be described as *'debate contributions'*: letters to the editor, invited comments, feedback and reactions from fieldworkers, and *'personal reflections'*.[5] The distribution of these four types of papers is shown in Fig. 1.

Six of the issues published were thematic issues. Two of these were policy oriented, including a double issue on the *IASC Guidelines for MHPSS in Emergency Settings* (2008) and another on the integration of mental health into existing health care systems, during and post humanitarian emergencies (2011). Two special issues were more research oriented, on the evaluation of community based psychosocial programmes (2008), and on mixed method evaluation research (2009). The other two special issues had a mixed content: on *'reconciliation in practice'* (2005) and on *'disarmament, demobilisation and reintegration of child soldiers'* (2006). Some of these thematic issues sparked debates that continued in subsequent issues.

Geographical origin of authors

Geographical origin was analysed separately for *'first authors'* and *'all authors'* of each published paper (Fig. 2 and Table 1). Most authors (64%) resided in high income

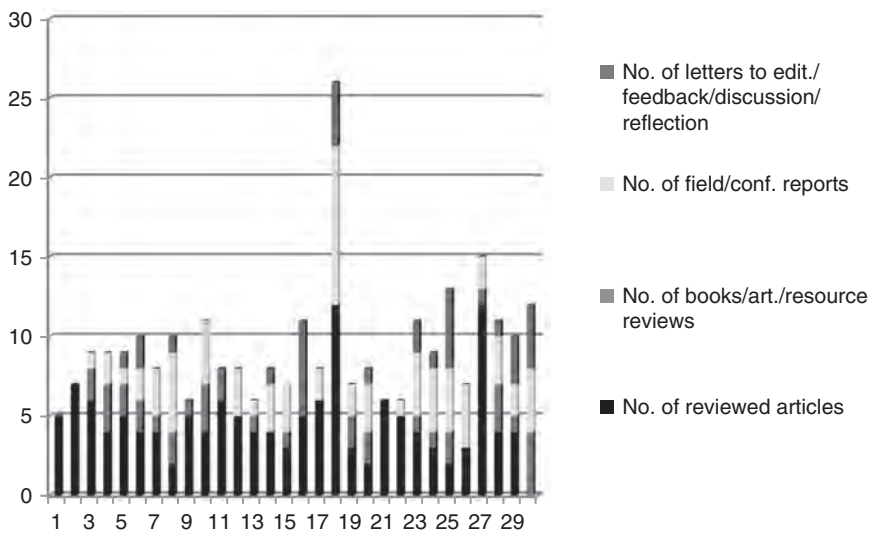

Figure 1: Intervention (volumes published 2003 – 2012): relative distribution of types of papers.

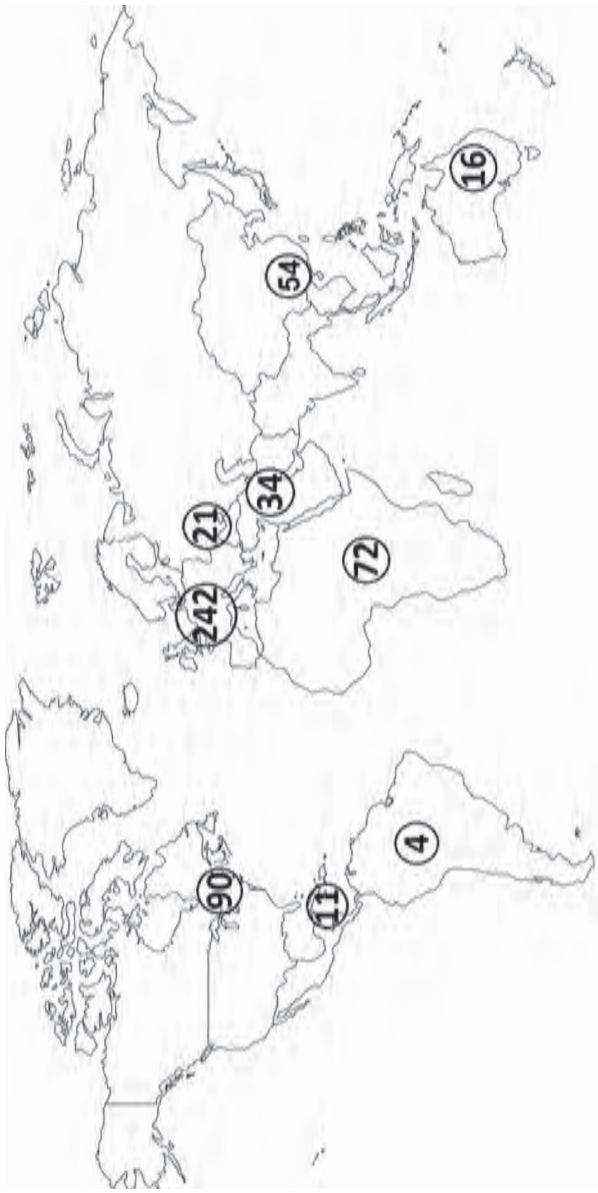

Figure 2: Geographical origins of all Intervention authors (n = 544), including all articles, reviews, reports and debates.

Table 1. Geographic origin of authors (n = 544) of 280 manuscripts: peer reviewed articles, book reviews, field reports and debates)

NORTH AMERICA	90	WESTERN EUROPE	242	MIDDLE EAST	34	AFRICA	72
USA	81	Netherlands	117	Occupied Palestinian territory	14	Uganda	23
Canada	9	UK	32	Jordan	7	South Africa	9
		Spain	24	Israel	3	Mali	8
LATIN AMERICA	11	Switzerland	21	Iraq	3	Egypt	5
Haiti	8	Germany	19	Syria	3	Burundi	4
Puerto Rico	2	Denmark	10	Lebanon	2	S Sudan	4
Guatemala	1	France	8	Qatar	2	Kenya	3
		Belgium	4			Eq. Guinea	2
SOUTH AMERICA	4	Eire	2	ASIA	54	Libya	2
Peru	2	Italy	2	Sri Lanka	18	Somalia	3
Uruguay	1	Norway	2	Nepal	15	Tanzania	2
Colombia	1	Sweden	1	India	6	Benin	1
				Afghanistan	5	Congo	1
		EASTERN EUROPE	21	Indonesia	2	Ethiopia	1
		Slovenia	6	Pakistan	2	Mozambique	1
		Bosnia-Herzeg.	5	Thailand	2	Nigeria	1
		Croatia	4	Bangladesh	1	Rwanda	1
		Kosovo	2	Cambodia	1	Sierra Leone	1
		Russia	2	China	1	Liberia	1
		Georgia	2	Philippines	1		
		Serbia	1			AUSTRALIA	16
						Australia	16

countries (HICs), mainly Western Europe (44.5%) and North America (16.5%). This rate includes highly prolific authors, often working in groups, and often credited for several papers. Also, this rate conceals residence origin of authors who originated from a LMIC, but were residing in Western Europe, North America or Australia for reasons of education or employment at the time of publication, and were therefore classified as HIC. Rates for LMIC included: 16.3% of authors were from Asia (6.3% from Western Asia, or the Middle East[6], and 10.0% from other parts of Asia). African authors represented 13.2% of all authors. For all authors from Eastern Europe (including the Balkans), and Latin America, the rates were 3.9% and 2.0%, respectively.

When examining separate countries, a relatively large representation of authors from (recent) conflict areas, such as: Uganda (23), Sri Lanka (18), former Yugoslavia (17), Nepal (15) and Palestine (14) was noted. Additionally, reports from natural disasters in fragile contexts leading to complex humanitarian emergencies, such as post earthquake Haiti (8), and Sri Lanka (after the 2004 tsunami), were also noted. Authors from some war/armed conflict affected areas, such as Afghanistan, Iraq, Somalia, Sierra Leone and Liberia were infrequently represented. The same is true for some low income countries that faced major natural disasters, such as Indonesia and India after the tsunami.

When the analysis is limited to peer reviewed articles, the cornerstone of a scientific journal, a similar pattern appears for '*first authors*' and '*all authors*', respectively (See Table 2).

The geographical distribution of authors of peer reviewed articles was also compared with those of non peer reviewed papers, such as field reports, personal reflections, invited comments (Fig. 3). In the non peer reviewed section, there are a higher percentage of authors from LMIC, particularly from Africa.

The relative contribution of authors from LMICs per (annual) volume was also calculated (Fig. 4). In the first year, more than 50% of the authors were from LMICs, declining sharply in 2004, and then increasing once more from 2008 onwards, ending with a decline of first authors in 2012. On average, 27.5% of both first and co-authors originate from LMICs.

Country references

As expected, most articles are about countries in LMIC, for the simple reason that most armed conflicts and complex humanitarian emergencies occurred in these countries, and resulting humanitarian programmes were launched there. A high percentage of papers referenced Africa, followed by papers on Asia, Western Asia (Middle East) and Eastern Europe, respectively (Fig. 5).

African countries, represented frequently were: Uganda (17), Burundi (5), Rwanda (5), Sierra Leone (5), South Africa (5), Somalia (4), Congo (3), Kenya (3), and Liberia (3). On the Asian continent, many papers were focused on Sri Lanka (19), followed by Nepal (7), India (6) and Afghanistan (6). In Western Asia (Middle-East), most attention went to the occupied Palestinian territory (6), Iraq (6), Jordan (3), while the papers based in Europe focused on the Balkans, Bosnia-Herzegovina (4) and Kosovo (4).

Trends in content

Of the 139 peer reviewed articles, 92 (66%) were classified as descriptive papers, primarily documenting and discussing interventions or policies, and 47 (34%) were

Table 2. Geographical origin of first vs. co- authors of peer reviewed articles (n = 139 vs. n = 318)

NORTH AMERICA	30 (59)	WESTERN EUROPE	61 (150)	MIDDLE EAST	5 (13)	AFRICA	15 (30)
USA	28 (54)	Netherlands	28 (57)	Occupied Palestinian territory	– (6)	Uganda	4 (10)
Canada	2 (5)	Spain	7 (23)	Lebanon	1 (2)	South Africa	5 (7)
		UK	11 (20)	Qatar	1 (2)	Burundi	(2)
LATIN AMERICA	1 (2)	Germany	5 (18)	Iraq	1 (1)	Eq. Guinea	(2)
Haiti	1 (2)	Switzerland	4 (11)	Israel	1 (1)	Kenya	2 (2)
		France	2 (8)	Syria	1 (1)	Benin	1 (1)
SOUTH AMERICA	1 (4)	Denmark	1 (5)			Egypt	1 (1)
Peru	– (2)	Belgium	– (2)	ASIA	15 (36)	Mozambique	– (1)
Uruguay	1 (1)	Italy	1 (2)	Nepal	4 (14)	Nigeria	1 (1)
Colombia	– (1)	Norway	2 (2)	Sri Lanka	5 (9)	Rwanda	– (1)
		Eire	– (1)	India	4 (4)	Sierra Leone	– (1)
		Sweden	– (1)	Afghanistan	1 (4)	Tanzania	1 (1)
				Thailand	– (2)		
		EASTERN EUROPE	5 (12)	Cambodia	1 (1)	AUSTRALIA	6 (12)
		Croatia	3 (4)	China	– (1)	Australia	6 (12)
		Slovenia	1 (4)	Pakistan	– (1)		
		Bosnia-Herzeg.	– (3)				
		Serbia	1 (1)				

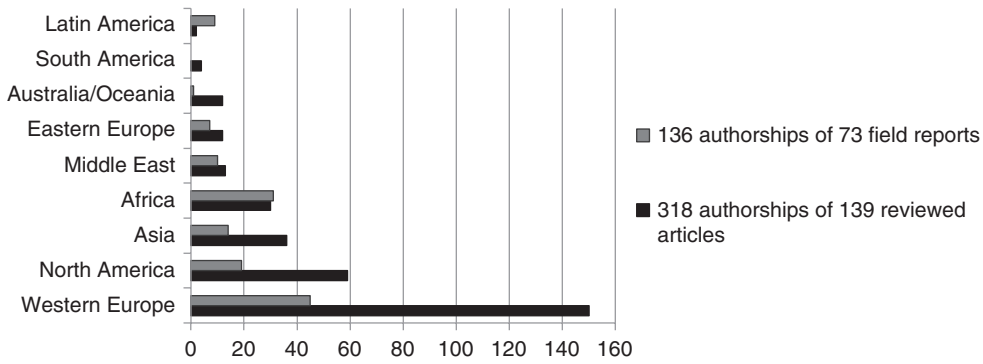

Figure 3: Continental distribution of all authors of field reports compared with peer reviewed articles.

classified as research articles, primarily reporting findings from original research (Table 3). The latter group of papers routinely included methodology sections, with a description of data collection, results and findings, followed by a discussion or conclusion of the findings. Research papers in *Intervention* often reported on ethnographic, or other qualitative research, for example: *'action research'.*

Over the first three years, some types of interventions, most notably individual approaches in psychotherapy (including counselling), as well as group psychotherapy and family support interventions, were well represented. Thereafter, papers on these topics were largely absent, in favour of group based, and community based approaches. Topics such as policy development and/or guideline development tended to appear more frequently over the last five years.[7]

A qualitative review of content

Each of the three authors independently reviewed the content of ten volumes of *Intervention,* and shared the findings with the other authors. The observations described below are based on a consensus between

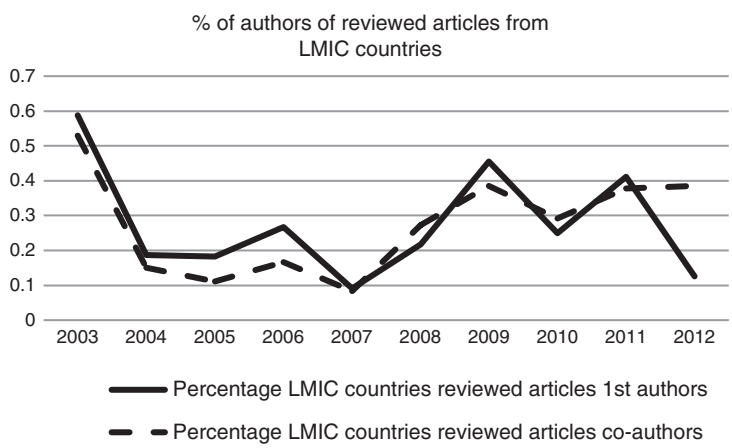

Figure 4: Percentages of peer reviewed articles' authors from low and middle income countries (LMIC) per volume.

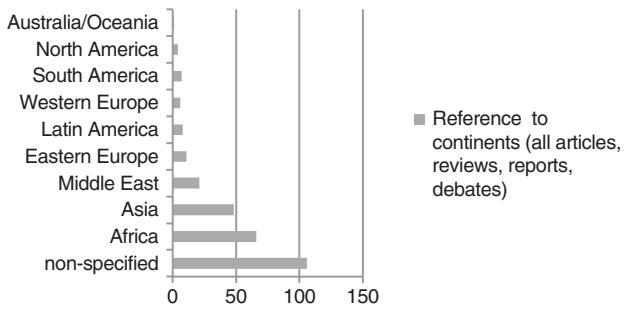

Figure 5: Global reference to continental regions: all articles, book reviews, field reports, and debates (n = 278).

the three authors. Considering the elements in the title of the journal (*'mental health', 'psychosocial work', 'counselling', 'areas of armed conflict')* a wide range of multilevel thematic content could potentially be expected, covered scientifically by diverging academic disciplines, including: sociology, anthropology, clinical psychology and psychiatry. The journal explicitly courts multidisciplinary cooperation and close interaction between field practice, and theoretical or research issues.

The content included in 10 years of *Intervention* reflects the state of the art in the field, as well as the dilemmas that created debate among academics and policy makers. From its earliest issues, the journal described a wide diversity of interventions in the field. Unlike many other psychiatric of psychological journals, the articles in *Intervention* frequently describe creative methodologies using art, music, dance, theatre, photography, ritual and storytelling.[8] Their use exemplifies the challenges of working in this field, and innovative strategies to deal with such challenges; overcoming language and cultural barriers (Holmgren, Sondergaard & Elklit, 2003), accessing experience not easily rendered through verbal means, and engaging community participation and mobilisation (Boniface et al., 2009).

Papers reporting on field-based experience have initiated important discussions and analyses of a variety of content themes, such as spirituality (Schafer, 2010) or the value of psychodynamic counselling in chronic emergencies (Gaboulaud et al., 2010). Analysing the content of 10 years *Intervention*, eight debates have been identified that have played a role in bridging gaps and reaching consensus in the field.

1. Theoretical models/principles

Discussions on what constitutes a *'psychosocial intervention'* were present from the very first volume (Galappatti, 2003; Strang and Ager, 2003). This debate continued later, for example in a critical paper by Williamson and Robinson (2006), who proposed to replace the term *'psychosocial intervention'* by the more holistic *'integrated programming for wellbeing'*. This paper was followed by responses to the debate (Van Ommeren, Morris & Saxena, 2006; Ager, Strang & Wessells, 2006), and in review papers for specific groups (such as psychosocial interventions for war-affected children, Kalksma-van Lith, 2007), and in articles on psychosocial appraisal and evaluation (Lekskes, Van Hooren & De Beus, 2007), and in comparing a variety of approaches to psychosocial work (Paratharayil, 2010).

Table 3. Thematic topic distribution of peer reviewed articles: totals and in three equal periods (2003–1 to 2006–1; 2006–2 to 2009–2; 2009–3 to 2012–3)

		3 equal periods (10 issues)		
Thematic topic keywords: interventions, activities + research	All	2003–1 to 2006–1	2006–2 to 2009–2	2009–3 to 2012–3
Interventions, activities				
Policy (including advocacy, influencing, development, guidelines)	26	5	17	4
Health care: integration of mental health in general health care	12	–	1	11
Demobilisation, disarmament and reintegration (DDR) programme	11	–	9	2
Mediation	7	6	–	1
Art, music, theatre and dance as therapeutic means	5	5	4	–
Community based psychosocial support	5	1	2	2
Counselling	5	4	1	–
Training	5	3	–	2
Psychotherapy: individual approaches	2	2	–	–
Psychotherapy: trauma focused approaches	2	2	–	–
Staff support/care for caregivers	2	1	–	1
Supervision and 'on the job mentoring'	2	1	1	–
Traditional and complementary healing (including: local healing practices)	2	–	1	1
Training of trainers	2	–	2	–
Family support interventions	1	1	–	–
Psycho-education	1	1	–	–
Psychotherapy: group approaches	1	1	–	–
Sport and recreational activities	1	–	–	1
Research				
Ethnographic studies and other qualitative studies	13	5	3	5
Monitoring and evaluation	8	2	5	1
Action research/participatory research approaches	7	–	4	3
Screening	6	3	–	3
Needs assessment	4	1	1	2
Policy analysis	2	–	–	2
Survey	2	–	1	1
Generic	2	2	–	–
Case study	1	–	–	1
Randomised controlled trial	1	1	–	–
Systematic review	1	–	1	–

However, some areas of psychosocial work are not as well represented in the journal. For example, the political violence occurring in several countries in Latin America has spawned community oriented, participatory psychosocial work that is grounded in a social justice and human rights framework. Yet, few papers focus on this Latin American tradition (Berliner et al., 2006; Garcia-del Soto, 2008; Martínez & Eiroá-Orosa, 2010).

2. Cultural relevance of interventions

The editor, on the first page of the first issue, drawing from his own extensive field experience, posed the question: to what extent a '*Western model*' of mental health intervention is consistent with the needs of beneficiaries (Van der Veer, 2003a). He highlighted the fact that MHPSS interventions may appear alien within local meaning and value systems, and could sideline, or even devalue local ways of coping and healing. On the other hand, MHPSS may fail to take into account the impact of processes, such as globalisation and urbanisation, which may already be changing local beliefs, practices and aspirations. As a result, well intended interventions may be quite problematic in non Western, socio-cultural settings (Scholte, Van de Put and De Jong, 2004; Van der Put and Van der Veer, 2005). For example, this is described in an article on the establishment of post tsunami mental health care in the Indonesian region of Aceh. De Gryse (2007) documented objections reported by tsunami affected populations about interventions initiated by both local and international teams, which were partly unsolicited and often not particularly culturally relevant, or conflict sensitive. These latter two points (making psychosocial interventions culturally relevant and context sensitive) are quite significant in the journal, and can be seen reflected, for example, in articles on training local people to assist war-affected populations (Omidian, 2012).

3. Capacity building

Local capacity building and training in psychosocial interventions has a consistent presence in the journal, as can be seen in articles on: developing relevant knowledge and practical skills training for MHPSS work (Van der Veer, 2003b; Jordans et al., 2003); mental health modules for general health care workers (Ventevogel and Kortman, 2004; Byaruhanga et al., 2008; Budosan and Aziz, 2009; Budosan, 2011); culturally sensitive clinical supervision (Van der Veer, de Jong & Lansen, 2004; Haans, 2008), training of trainers (Baron, 2006); and training lay counsellors (Salem-Pickartz, 2007; James, 2012), A special issue in 2011, on '*Integrating mental health care into existing systems of health care: during and after complex humanitarian emergencies*', collected 11 case studies on mental health, capacity building in fragile contexts.[9] Never far away from articles on '*capacity building*', however, is the thorny issue of '*insider vs. outsider*' tensions (can be caused by conflicting perspectives and interests between local stakeholders and external '*experts*'), as well as power asymmetries between local and expatriate staff (Abramowitz and Kleinman, 2008; Gilbert, 2009).

4. 'Individual' or 'trauma' approaches versus approaches focusing on strengthening of community support and wider socio-economic context

Many articles have reflected the debates on individual versus community based interventions, and between trauma-focused approaches and those targeting a wider range of psychosocial issues. Additionally, clearly represented in the content of the

journal is recognition of the trend towards projects that are primarily geared towards the material reality of people's lives, such as those that are concerned with poverty alleviation and livelihoods development, or the practicalities of resettling refugees. Over the years, the goals of psychosocial interventions have gone increasingly beyond a narrow concept of mental health (as the *'absence of mental disorder'*), in favour of interventions that promote a more holistic version of psychosocial wellbeing. For example, articles published on theatre action group methodology (Sithamparanathan, 2003), followed later with various related approaches, like community healing (Fries, 2003), community based *'narrative theatre'* and folk theatre methodology (Sliep and Meyer-Weitz, 2003; Souza and Sloot, 2003; Sliep, 2004; Meyer-Weitz and Sliep, 2005), community based socio-therapy (Richters, Dekker & Scholte, 2008), community systems strengthening, focussing on the Afghan women's agency (van Mierlo, 2012), and on promoting inter-group contact within segregated Bosnian communities (Freeman, 2012). Within the first five years of the journal, there was a lot of debate on the relevance and importance of using a trauma focused model. While some authors seemed to suggest that people exposed to extreme events inevitably need help, and that trauma focused project interventions were best suited to provide this help (Amone-P'Olak, 2005; Joosse, 2007; Kamau et al., 2004; Olij, 2005; Onyut et al., 2004; Schauer et al., 2004; Silove et al., 2005), others expressed major concerns around such a narrow focus of psychological trauma and posttraumatic stress disorder (PTSD) (e.g. Somasundaram, 2003; Tankink, 2004; Vazquez and Perez-Sales, 2007; Miller, Fernando & Berger, 2009; Schafer et al., 2010), or promoted a focus on resilience (Westerveld-Sassen, 2005; Ward and Eyber, 2009), posttraumatic growth (Kryger and Lindgren, 2011), or mainstreaming psychosocial support into poverty reduction programmes (Salih and Galappatti, 2006). Ager (2008b) documented attempts by UNICEF to clearly define what constitutes psychosocial intervention, suggesting a focus on three important components: skills and knowledge, emotional wellbeing and social wellbeing. However, the author's impression is that this model is not yet widely used.

5. Finding out what works: how do we monitor and evaluate?

Starting with the sixth volume (Van der Veer, 2008), there were increasing calls for establishing an evidence base for MHPSS, a field that has often been critiqued for their lack of rigorous evaluation of effectiveness (Cardozo, 2008). *Intervention* has published several papers on how to develop culturally relevant indicators to measure the effect of MHPSS interventions, integrating perspectives of local stakeholders (see Bragin, 2005 and Salem-Pickartz, 2009). Such tools often use participatory methods to identify appropriate approaches in psychosocial intervention, within a wide range of populations, such as war affected children in Sri Lanka (Hart et al., 2007), former child soldiers in Sierra Leone (Stark et al., 2009) and Nepal (Karki et al., 2009), war affected mothers in Liberia, Sierra Leone and Uganda (McKay et al., 2011), and children in Uganda (Claessens et al., 2012). In 2009, a special issue was published on combining qualitative and quantitative research in planning, monitoring and evaluating psychosocial interventions (Bolton, Tol & Bass, 2009), which included examples of how ethnographic methods and questionnaire based research can strengthen each other (Miller, Fernando & Berger, 2009;

Jayawickreme et al., 2009; Horn, 2009; Kohrt, 2009). Another recent development, to attempt to bring some sense of order within an increasingly complex humanitarian response and the growing place of MHPSS in that spectrum, is to use systematic tools to map which MHPSS actors are doing what, where and when, within a specific emergency setting (O'Connell et al., 2012; Baca et al., 2012; Fitzgerald, Elkaied & Weissbecker, 2012).

On the other hand, the potentially negative impact of too rigorous and bureaucratic evaluation is also expressed by a seasoned MHPSS worker (Mikuš Kos, 2008), which gave rise to a lively debate (Tol and Jordans, 2008; de Graaff, Janveld & de Jager, 2008; Poudyal et al., 2008; Onyango Mangen, 2008; Kortmann, 2008).

6. Need for guidelines

The proliferation of diverse organisations and approaches with the well intended objective to ensure mental wellbeing, and offering psychosocial work within complex emergencies, has led to chaotic and ineffective humanitarian responses, that in some cases could be deemed to be harmful (Van Der Veen and Somasundaram, 2006; Wickramage, 2006; Ganesan, 2012). In 2007, the Inter-Agency Standing Committee published their *Guidelines for Mental Health & Psychosocial Support in Emergency Settings* (IASC, 2007). This document reflected a growing consensus among UN agencies, NGOs, academics and funding agencies on the need to develop a common framework to improve coordinated and joint action. The very fact that dozens of different organisations were able to actually reach a consensus was, in itself, a remarkable fact (Ager, 2008a). In the year after the launch of the *IASC Guidelines, Intervention* published a voluminous special issue discussing the pros and cons of these guidelines. In general, the reception was positive, and they were thought to be useful within a wide range of settings. However, some voiced concerns that the guidelines were not fully *'evidence based'* (Yule, 2008; Cardoso, 2008), or would be too embedded within the (strict) UN structures (De Jong, Mills & Mackintosh, 2008). Of particular note, in terms of this special issue, is the wide variety of stakeholders involved: academics, policy makers, donors, NGO workers and governmental staff.[10] Early experiences with the actual implementation of the guidelines were modestly positive (Melville and Rakotomalala, 2008; Horn & Strang, 2008 a & b). Other papers reported on the implementation of guidelines (Jordans et al., 2010) or critically discussed underlying concepts (Aggarwal, 2011).

7. Mental health in relation to peace building and reconciliation approaches

There seems to be an uneasy position in relation to peace building, reconciliation and the host of interventions customarily linked to transitional justice processes. Although an entire issue of the journal was devoted to reconciliation in practice[11], there are few other papers in its 10 years that deal with peace building initiatives. Indeed, how psychosocial intervention relates to development on one hand, and to peace building on the other, within contexts of political violence, is a matter of current concern. This may stem from ambivalence around defining the field, and delineating its scope and boundaries.

8. Donor requirements versus beneficiaries' priorities

Needs based, psychosocial interventions basically follow the priorities of the emergency affected population. These self

defined needs may differ from what outsiders, such as funding agencies, see as the most urgent. Donors for psychosocial projects still tend to prioritise trauma focused interventions. However, people in emergency settings may, for example, prioritise material needs. This was the case among internally displaced persons in a camp in Northern Uganda who were mainly concerned with the structural, social and economic difficulties that affected them, and far less with '*psychological needs*' (Horn, 2009). Weyermann (2007) developed a tool to facilitate a more integrated psychosocial approach that links '*emotional needs*' to economic and social needs. Taking the needs of marginalised groups seriously may have unexpected outcomes, and lead to innovative projects: in India *low caste* participants in a psychosocial programme after the tsunami saw the lack of educational opportunities as a root cause of problems, and as a result, the psychosocial intervention developed into a project on education and empowerment (Bragin, Prabhu & Czarnocha, 2007).

Beneficiaries

In terms of the potential beneficiaries represented, the articles in *Intervention* present a somewhat skewed pattern of population sectors known to be particularly '*vulnerable*'. While children, women, the elderly, the displaced and those with disability are thought to be at increased risk, there seems to be and over representation of displaced persons and ex-combatants, including child soldiers. There are four papers on ex-combatants (Belo, 2004; Odenwald, Hinkel & Schauer, 2007; Anaya, 2007, Bandeira, 2009) and 18 papers on former child soldiers[12]. On the other hand, there are few papers on survivors of sexual violence (Amone-P'Olak, 2005; Yohani and Hagen, 2010; Van Mierlo, 2012), and very little attention to gender as an analytical category. Discussions on issues of masculinity are completely absent in the papers.

Another point in terms of beneficiaries of interventions is age. While the journal has published several papers on children and adolescents in each volume, no single paper is devoted to the elderly, nor to infants and toddlers. A new group of potential beneficiaries are the MHPSS workers themselves. Over the past few years some papers on '*staff support*' have been published (Curling and Simmons, 2010; Anonymous, 2010; Gray, 2010).

Another emerging psychosocial issue arising in beneficiaries is alcohol use. Papers dealing specifically with this topic also date from the past few years (Streel and Schilperoord, 2010, Ezard, Debakre & Catillon, 2010), although one paper discussed drug abuse in Somali combatants (Odenwald, Hinkel & Schauer, 2007).

Coming of age: perspectives for the next decade of the journal

Intervention has aimed to bridge the gap between theory and practice within the complex area of mental health and psychosocial support in disaster settings by publishing viewpoints from a variety of stakeholders, including academics, psychosocial workers and in the recent past, beneficiaries. In examining this information, and making psychosocial work and debates available to the public, *Intervention* influences the prevailing discourse on the way that projects can be best implemented. Readers do not only acquire information on existing interventions, but are also encouraged to reflect on the dynamics within approaches of assisting people in coping with adversity in low income settings.

MHPSS interventions can be improved by listening carefully to all stakeholders' experiences, including those of academics, psychosocial workers and the persons directly affected by disasters. Key stakeholders often have divergent views, and the journal publishes all of these perspectives.

However, the authors would like to see more attention given to gender, particularly masculinity issues, and ask the question if the journal been neglecting these issues unintentionally, or were contrasting voices or feasible papers simply not submitted?

Other topics that deserve more attention include alcohol and substance use. Alcohol and substance use has always been a critical issue among distressed populations, but may have been neglected in the field of MHPSS, due to the bias towards the '*trauma*' effects of war.

The tendency of the journal to listen to muted voices, and empower them to participate in decision making processes, will help to make interventions more widely known.

Ultimately, there is a consensus that people in disaster settings need material, medical/biological and psychosocial interventions. The '*psychosocial*' adjective is widely used, but often without being defined. The IASC definition, underscores the need for diverse, complementary approaches in providing appropriate supports.[13] A holistic, multilevel approach in interventions, which integrates biological, social, psychological and spiritual elements of wellbeing, is often regarded as most promising and fruitful.

A question that *Intervention* might need to address is how to prioritise psychosocial, psychological and materials needs in complex emergencies. The power to set the research agenda is usually in the hands of researchers from outside the area of humanitarian aid settings, which may tend to marginalise local practitioners and researchers. The vagaries of funding also play their part in determining which sectors and issues receive attention, and this also might be reflected in the papers submitted. Therefore, the three party stakeholders model of academics, psychosocial workers and beneficiaries, needs to be supplemented with donors. The paradigm could be strengthened by looking at the kinds of debates associated with each stakeholder's position. Beneficiaries and field workers form the grass-roots. From their close interaction basic, multilayered needs can be articulated and assessed. Psychosocial workers may have to deal with the insider-outsider, expatriate-national staff tensions (e.g. psychosocial programmes might be '*captured*' by local elites). Relationships between mental health professionals and community psychosocial workers require continuous attention, for the simple reason that academics may not be adequately familiar with these complexities of field contexts, and their cultural specificity. Although this concern is sometimes addressed in the growth of participatory methodologies and action research, this does not answer how, for instance, academic research on clinical trauma may be integrated with field practice. So, in the future, academics might be encouraged to include in prevailing, research based, intervention models what donor organisations are trying to accomplish, thereby also potentially involving target groups. Other issues that need to be addressed are: funding priorities not fitting the needs of a community, or donors unconcerned by seeing through an endeavour until it sustains itself, or becomes redundant. Finally, it also raises the issue of donor organisations imposing standards and procedures of monitoring and evaluation that may be burdensome, offensive or beside the point.

A related question that was not addressed, is which organisations have funded the programmes described in the journal's papers, and to what degree these donors might have influenced the actual content of the papers.

The apparent shift away from a trauma model to an emphasis on psychosocial well-being and community mobilisation in the journal also raises the question as to whether this a case of the pendulum swinging to the other extreme, ultimately neglecting the needs of people who are indeed clinically traumatised and require specialised support?

Finally, the previously described uneven distribution of peer reviewed papers from low income areas might obviously be associated with the humanitarian (West European) origin and residence of the journal. It also might be an unintended consequence of the Western academic publishing culture. Apart from this, the recent history of Europe, with two world wars, systematic genocide and post war threat between international political systems, undoubtedly triggered interest and research into post conflict mental health consequences. The authors believe efforts are needed to further position *Intervention* as an internationally interactive forum, for both field reports, as well as peer reviewed research articles. In the same vein, it must be asked if an increase of the research based character of peer reviewed articles, exploring interventions and activities, not be a next goal? *Intervention*'s growth is reflected in its expansion to publish not only from contexts of armed conflict and post conflict, but also from complex emergencies following natural disasters. Perhaps it is time to change the journal's name slightly, omitting '*Counselling*' and substituting '*Armed Conflict*', so it becomes: '*Intervention – International Journal of Mental Health and Psychosocial Work in Post-conflict and Disaster Settings*'.

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[1] The first issue had as its title 'The International Journal for Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict'. From the second issue the word 'Intervention' was added, and became the leading title.

[2] A maximum of eight (co)authors per manuscript were included. In cases of more than eight authors, the first seven and the last author were used.

[3] http://www.editorialmanager.com/int/default.asp.

[4] This excluded: tables of content, translated abstracts in Arabic, French, Sinhala, Spanish Pashto, Russian and Tamil, and advertisements or announcements.

[5] 'Personal reflections' are short contributions, in which the author, a MHPSS professional, reflects on the interplay between involvement in MHPSS work and personal life stories. Examples are: Samadi (2009), Lekaj (2011), Ganesan (2011), Jones (2011), Yohannes (2012), Jaafar (2012) and Penge (2012).

[6] Middle East is a historical term that positions a region in relation to Western Europe rather than its location within Asia. Due to this perceived Eurocentrism, international organisations such as the United Nations prefer the term 'Western Asia'.

[7] A number of other interventions/activities keywords from the editorial system did not receive ratings. Keywords that did not receive ratings as a 'main topic' were: activism and social action; advocacy; child friendly spaces; community mobilisation and self-help (including social mobilisation); education; health care; general health interventions; specialised psychiatric services (including psychiatric hospitals); immediate emergency responses (including psychological first aid and debriefing); medication and drug treatment; organisational capacity building; public awareness raising; relaxation, meditation and mindfulness techniques; school based interventions; stress management; training: vocational training. This does not mean that these subjects were not discussed in Intervention, but that they were not rated, by the authors, as a central topic.

[8] For example: dance (Harris, 2007), sport & play (Ley & Rato Barrio, 2010), theatre (Souza & Sloot 2003; Sithamparanathan, 2003; Sliep, 2004), story telling (Veerman, 2004), drawing (Rabaia, Nguyen-Gillham. & Giacaman, 2011) and photography (Denov, Doucet & Kamara, 2012).

[9] For an overview of this special issue, see the introduction (Ventevogel et al., 2011) and the conclusions (Perez-Sales et al., 2011). The issue also

contains descriptions from Burundi (Ventevogel, Ndayisaba & Van de Put, 2011), Equatorial Guinea (Morón-Nozaleda et al., 2011), Haiti (Budosan & Bruno, 2011; Rose et al., 2011), Iraq (Sharma & Piachaud, 2011), Lebanon (Hijazi, Weissbecker & Chammay, 2011), Peru (Kohan et al., 2011), the occupied Palestinian territory (de Val' d'Espaux et al. 2011), Syria (Quosh, 2011) and Uganda (Baingana & Onyango Mangen, 2011).

[10] The issue has 26 papers with more than 50 authors. See the introduction of the special issue for a quick overview of the content (Ventevogel, 2008).

[11] Some examples: Becker (2005), LeTouze, Silove & Zwi (2005), Richters, Dekker & de Jonge (2005) and Galtung (2005).

[12] Mogapi (2004), Williamson (2006), Akello, Richters & Reis (2006), Stark (2006), Boothby (2006) Furnari (2006), Specht & Attree (2006), Ager, Boothby & Wessells (2007), Moor (2007), Harris (2007), Sonpar (2008), Stark et al. (2009), Karki, Kohrt & Jordans (2009), Ruiz Serna & Marchand (2011), Kryger & Lindgren (2011), Krishnan (2011), Awodola (2012), Denov, Doucet & Kamara (2012).

[13] The Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) use the composite term 'mental health and psychosocial support': to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms mental health and psychosocial support are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Aid agencies outside the health sector tend to speak of supporting psychosocial well-being. Health sector agencies tend to speak of mental health, yet historically have also used the terms psychosocial rehabilitation and psychosocial treatment to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries.

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