# Therapeutic Governance: the Politics of Psychosocial Intervention and Trauma Risk Management

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*This paper critically analyses the significance of psychosocial intervention as a new form of international therapeutic governance based on social risk management. Firstly the paper examines the international psychosocial model and its origins in an Anglo-American therapeutic ethos. Secondly the paper argues that psychosocial approaches jeopardise local coping strategies. Thirdly the paper highlights the potential political, social and psychological consequences of the pathologisation of war-affected societies. Finally the paper concludes that therapeutic governance represents the reduction of politics to administration.*

## Introduction

Trauma is displacing hunger in Western coverage of wars and disasters. The media invariably highlights the emotional scars of victims and how counsellors have been brought in to help the community come to terms with their grief. With this therapeutic understanding of experiences, the psychological state of war-affected populations has come to the fore of international humanitarian relief. Trauma counselling, or what is known as psychosocial intervention, has become an integral part of the humanitarian response in wars. Even animal charities refer to *war-traumatised* animals, symptomatic of the West's 'post-traumatic culture'. Development organisations too are involved in psychosocial interventions. Indeed current international development strategies are about psychosocial risk management. Hence aid officials who state they 'don't do psychosocial work', nevertheless, have adopted approaches informed by a therapeutic understanding of social problems.

Although psychosocial intervention has become a key component of international policy, there is much confusion over its meaning among aid agencies and the concept is under-theorised in academia. This paper critically analyses the significance of psychosocial intervention as a new form of international governance based on social risk management, or as I have termed it, 'therapeutic governance'.. Firstly the paper examines the international psychosocial model and its origins in an Anglo-American therapeutic ethos. Secondly the paper argues that psychosocial approaches jeopardise local coping strategies. Thirdly the paper highlights the potential political, social and psychological consequences of the pathologisation of war-affected societies. Finally paper concludes that therapeutic governance represents the reduction of politics to administration.

## The significance of psychosocial intervention

What is psychosocial intervention? Activities that come under a psychosocial heading in aid agency documents range from trauma counselling, peace education programmes, life skills, to self-esteem building initiatives. However, the impact of the

psychosocial model with its essentially psychological understanding of social problems is much more important than the sum of individual initiatives that specifically come under a psychosocial label. The psychosocial model embodies contemporary international policy as social risk management whose perspectives derive from social psychology. Social psychology developed rapidly in the 1930s from the disciplines of psychology and sociology, influenced by works on group psychology. In the context of fears about the masses and social instability, social psychology's interest in group behaviour, socialisation and violence meant that the subject was quickly embraced by policy-makers in the United States and Western Europe. For example, Quincey Wright in his seminal *Study of War* (1965) heralded social psychology as having 'perhaps contributed most of all the social disciplines to an understanding of the efficient causes of war, in a manner to suggest cures' (Wright, 1965, p. 714). Western officials intended social psychology to inform the work of international organisations set up after the Second War World. Its influence can be seen in UNESCO's constitution which states, 'Since wars begin in the minds of men, it is in the minds of men that the defences of peace must be constructed' (UNESCO, 1945). In particular, Western leaders were concerned with managing conflict and development in the newly independent developing countries. However, the model of a benign elite governing through a world community appealing to the non-rational envisaged by social psychologists was not politically acceptable (Durbin and Bowlby, 1938, pp. 48-49; Lasswell, 1935, p. 237; Wright, 1965, p. 1388). Social psychological approaches were sidelined in international policy during the Cold War. The Soviet bloc and the Non-Aligned Movement of states largely rejected Anglo-American social psychology's psychological functionalism. Firstly, treating war as psychological dysfunctionalism was viewed by the South as an attempt to delegitimise national liberation movements against colonial rule. Secondly, the South preferred to focus on North-South inequalities and structural approaches to tackle conflict and development.

The demise of the Soviet bloc and the Non-Aligned Movement has allowed Western conflict management approaches to dominate international policy. No longer challenged by these blocs, there has been an explosion of international initiatives based on Anglo-American psychosocial risk management strategies. Furthermore social psychology's perspectives have become central to Western domestic social policy, to how Western governments relate to their own citizens and also how individuals in the West understand themselves.[1]

**Therapeutic states**

Western therapeutic perspectives are not confined to the mental health sector but inform the whole spectrum of policy in the wake of disillusion with the post-war Keynsian welfare state model. The perception of a general moral, social and even emotional crisis (Goleman, 1996) has encouraged the adoption of a social risk management approach to social policy. In some respects there is nothing new about the preoccupations of social risk management and how to accommodation the de-stabilising impact of modernisation with order. As Mark Duffield discusses, the concept of development has been about 'a modernising reconciliation of order with progress' (Duffield, 2001). Yet contemporary risk management represents a retreat from a belief in social progress towards a defensive goal of managing social inequalities and conflict. While certain elements of the risk management model echo

the Victorian self-help ethos and entail individuals and families taking greater financial responsibility for their welfare, its understanding of the individual and the relation of individuals to their environment is distinct. The Victorians were believers in human ability and venture. 'We are capable of doing anything' exclaims Queen Victoria in her diary, exemplifying mid-nineteenth century confidence. As the historian James Morris writes:

> They believed in their providential destiny, in their servants of steam and steel, in themselves and their systems, and not least in their Empire [… ] in the triumphs of applied science […] they were called to be the great improvers […] (Morris, 1979, p. 318).

The nineteenth century's archetype of the robust risk-taking self-made man is the antithesis of the risk-averse twenty-first century's exemplar of the vulnerable victim whose actions and environment are to be governed by the precautionary principle. In Freudian terms, the higher self of the New Millennium is the id of the emotions, rather than the rationalist ego.

Conceiving the self as insecure, social policy as social risk management views the individual to be susceptible to psychological and social dysfunctionalism. The imperative to contain dysfunctionalism is leading to the expediential growth of counselling services to administer to individuals from cradle to grave. So although the social risk management model implies the privatisation of welfare provision, it also involves greater regulation of relations in the private sphere to ensure psychological and social functionalism.

The therapeutic paradigm has become integral to how state institutions relate to citizens: in public life with the new 'politics of feeling'; in education with self-esteem displacing intellectual understanding as the goal; in family policy with the expansion of relationship counselling and the professionalisation of parenting; in the economy with therapeutic support for the unemployed; in law with a shift from an adversarial system to a form of therapeutic intervention and mediation (Nolan, 1998). The therapeutic paradigm is redrawing the political relationship between citizen and state involving:

> the redefinition of political authority in therapeutic terms - and to the rise of a professional and managerial class that governs society […] by defining normal behavior and by involving allegedly non-punitive; psychiatric sanctions against deviance (Lasch, 1984, p. 49).

The consequence of this new 'therapeutic mode of social control' (ibid., p. 47) is that politics becomes both about appealing to the id and regulating the vulnerable id. Therapeutic governance, representing 'a direct pact between super-ego and id at the expense of the ego' (Zizek, 2000, p. 61), entails the erosion of the conceptualisation of the citizen as an autonomous rational subject, the premise of modern law and the prerequisite for democratic rights. The therapeutic's aim of securing emotional stability is resulting in rights being re-conceptualised in terms of psychological recognition and custodianship rather than freedoms, that is, as protection by official bodies, rather than protection from official bodies. It is striking how the contemporary subject of rights under human rights discourse takes the form of the vulnerable victim

who is to be enabled or protected by a third party as opposed to earlier civil rights movements where subjects empowered themselves.

Fostering psychological functionalism is considered crucial in the therapeutic conceptualisation of citizenship. The therapeutic understanding of citizenship regards self-esteem as a pre-requisite for being a good citizen. Although the idea that self-esteem is necessary for moral conduct is contested (Dawes, 1994), national emotional literacy programmes are being proposed to promote good citizens, on the grounds that:

> Individuals who have a good understanding of their own emotional makeup, and who are able to communicate effectively with others on a personal basis, are likely to be well prepared for the wider tasks and responsibilities of citizenship (Giddens, 1994, pp. 16 and 119).

Under psychological functionalism, an individual's emotional state is therefore no longer a personal matter, but becomes public property and related to 'the responsibilities of citizenship'. Re-socialisation and emotional stability is achieved through programmes sponsoring self-esteem and 'protective mimicry' (role-playing techniques) (Lasch, 1984, pp. 49-97). Any failure by public bodies to provide psychosocial programmes or any failure by individuals to take up the psychosocial support provided is thus viewed as socially irresponsible. Hence there is a coercive disciplining element to psychological functionalism. This element is not immediately apparent. As Duffield explores (2001), contemporary governance does not primarily utilise institution-based disciplinary technologies. Rather governance is conducted through developing regulatory technologies dispersed through supervising processes and networks appealing to self-realisation. Nevertheless, the coercive rehabilitative aspect is revealed in the rapid increase in mandatory psychosocial support: from parenting orders, to divorce mediation, therapeutic drug or non-drug programmes, compulsory citizenship classes in schools, and anger management courses.

Social risk management approaches underpin contemporary international policy from specific psychosocial programmes to IMF and World Bank development strategies to international documents such as the UN Convention on the Rights of the Child. The significance of social risk management for international politics should not be underestimated. Echoing the model of inter-war Anglo-American social psychologists, therapeutic governance implies a radical reshaping of domestic and international relations, although formally the international system of sovereign nation states remains. Taking the vulnerable victim as its subject, the concerns of social risk management fundamentally question the principle of non-interference in the internal affairs of states and the private lives of individual citizens. On the one hand, the social risk management model and its transformation into a human right challenges the authority of the (non-Western) state vis-a-vis the international community.[2] On the other hand, the enforcement of social risk management requires state and non-state actors to play a much more pro-active role in citizens' lives, eroding the distinction between the private and public spheres. Psychosocial intervention epitomises contemporary international social policy as social risk management, encapsulating the merger of development and security discourse, in which development and security policy are focused on securing the minds of people against violence (Duffield, 2001).

**Inventing PTSD**

Following Duffield (ibid.), metropolitan actuarial risk analysis informed by a risk-averse culture reads the borderlands as psychologically dysfunctional because of their distressful experiences. In essence the psychosocial model sees distressful experiences as triggering traumatic symptoms causing dysfunctionalism leading to abuse/violence, requiring intervention to rehabilitate victims and break cycles of trauma and violence. The mere description of a given community or population having experienced conflict is sufficient for international agencies to deem them to be suffering from post-traumatic stress disorder (PTSD) and in need of psychosocial assistance. The effect is to label whole populations as traumatised, rendering diagnosis irrelevant and psychosocial treatment universally required, albeit devised in a form considered appropriate to the local culture. It is this pathologisation of distress that distinguishes psychosocial intervention from a sympathetic word or kind gesture by individual aid workers.

Overlooked by the deterministic projections of international psychosocial model is the specificity of the concept of PTSD itself. The recognition of PTSD as a clinical disorder lies in the medical rationalisation of the US experience of defeat in the Vietnam War and resulted from extensive lobbying by the American Veterans Association and other veteran supporters (Lembcke, 1998; Scott, 1993; Young, 1995). Subsequent to its acceptance as a disorder, PTSD became the 'disorder *du jour*', its meaning stretched to encompass practically all the population (Dean, 1997). In effect, PTSD is not conceptualised as an abnormal pathological response arising in particular circumstances, but the pathological response is assumed to be the norm. As Wilbur Scott explains, 'With the PTSD diagnosis, psychiatrists now say that it is "normal" to be traumatised by the horrors of war' (Scott, 1990, p. 295). In this conceptualisation of the pathological as the norm, PTSD is made universally applicable. However, the universality of PTSD is contested by medical anthropologists, psychologists, psychiatrists, sociologists and trauma experts who highlight its culturally specific origins (Dawes, 1994; Dean, 1997; Dineen, 1999, Lee, 2001; Scott, 1993; Summerfield, 2001; Young, 1995). Nevertheless, the concept of PTSD remains relevant for policy-makers, despite doubts over its validity, because it accords with contemporary metropolitan risk consciousness and its fears of unrecognised and untreated conditions. The ethos of therapeutic governance or risk management is, as Duffield outlines, 'one of anticipatory, probalistic and preventive intervention' (Duffield, 2001).

**Mediating traumatic events**

Yet are the international projections of mass trauma borne out in practice? Although many international psychosocial programmes assume mass trauma in conflict, closer evaluation does not support such assumptions (for example, IRC, 1999; Norwegian Ministry of Foreign Affairs, 1999; Oxfam, 1999b; Summerfield, 1999; Wiles et al, 2000). The appearance of clinical conditions in war remains particular, not universal. There are manifold personal, political and social factors, as well as military circumstances, which mediate war experiences and influence whether an individual does or does not become traumatised. The international psychosocial response in Kosovo assumed the presence of mass trauma. But what grounds were there for the assumption that Kosovo Albanians, the main targets of international psychosocial

programmes in the Kosovo war, would have the same post-traumatic psychological response as defeated and demoralised US Vietnam veterans, shunned as pariahs on their return? This highlights how the psychosocial model deterministically projects metropolitan risk consciousness onto populations.

Before highlighting factors mediating distressful experiences, it should emphasised that the appearance of clinical trauma rendering people unable to function is relatively rare. The experienced trauma expert Yvonne McEwen has found this to be the case even where people have been involved in extreme situations.[3] Additionally, normal distress symptoms should not be confused with clinical conditions requiring treatment, although this is precisely what the international psychosocial model does. Warning of the 'uncritical application of diagnostic checklists for post-traumatic stress', the psychiatrist Derek Summerfield notes that, 'features of post-traumatic stress disorder are often epiphenomenal and not what survivors are attending to or consider important: most of them remain active and effective in the face of continuing hardship and threat' (Summerfield, 2000, p. 232). . This flaw is evident, for example, in a survey conducted by Médicins Sans Frontières (MSF) in Sierra Leone (de Jong et al, 2000). The survey concluded that 99 per cent of respondents had high levels of disturbances indicative of severe PTSD on the basis of firstly exposure to traumatic experiences, secondly diagnostic symptoms, and thirdly non-specific health complaints. Yet the survey confuses normal adaptive distress symptoms with clinical conditions. For example, 'avoiding situations, locations, conversations, or people' is highlighted as one of aspect of the psychological impact of the civil war. Yet surely wariness is an infinitely sensible course of action in a very dangerous situation and can hardly be categorised as a pathological response. Would the respondents identify this impact as a symptom of PTSD? Would 99 per cent of the respondents identify themselves as severe PTSD? Do their symptoms cause dysfunctionality or are they epiphenomenal without significantly affecting function? As Summerfield observes in a detailed critique of international psychological trauma programmes, 'Uncritical use of PTSD checklists generates large overestimates of the numbers needing treatment' (Summerfield, 1999, p. 1454).

The cornerstone of the international psychosocial model is its assumption of the vulnerability of the individual. Whereas earlier psychiatry assumed the general resilience of the population and sought to diagnose individual susceptibility to psychological breakdown, the PTSD assumes universal vulnerability. Assuming universal vulnerability, metropolitan actuarial risk analysis then focuses on environmental risk factors. Hence people in the South are deemed to be at greater risk of psychological dysfunctionalism because of the economic, political and social insecurities they face. However, a history of insecurity should not be equated with a history of psychological problems or greater susceptibility to psychological breakdown, a distinction that is lost in the international psychosocial model. If there is any correlation it may be the reverse of that assumed by international policy-makers, that is, the background of communities used to hardship means that they are likely to be remarkably resilient in the face of adversity. This factor helps explain why international aid workers, including trauma counsellors, appear to be more susceptible to secondary or vicarious trauma, than the recipient populations who have experienced primary trauma. It may be noted that counselling as a profession attracts a high percentage of former clients to retrain as counsellors, consequently individuals with a prehistory of psychological vulnerability. This phenomenon in turn encourages

a professional culture that tends to project its own sense of psychological vulnerability onto other people.

In so far as international aid agencies recognise different degrees of susceptibility to stress, it is typically on the basis of preconceived stereotypical notions of vulnerability. Most international trauma work is focused on women or children, rather than men. This bias has been marked irrespective of whether men in the target recipient community have actually been exposed to greater distress as soldiers on the front line or as prisoners of war. Moreover this bias ignores how women and children are usually better able to adapt to life as refugees. Women may maintain purposefulness in their traditional role as primary family carer. Children can escape into play in even the most adverse situations or, in more fortunate circumstances, may become integrated into new communities through schooling. Men, however, may find it harder to adapt if they lose their traditional status as the primary economic provider in the family. Nevertheless, although there is perhaps greater potential for male psychological vulnerability with this loss, their susceptibility to trauma too should not be exaggerated. The idea of the soldier as traumatised victim has become the norm through the concept of PTSD, but this neglects how men may gain a status and sense of purpose in the military, which they might not have enjoyed in peacetime. As Joanna Bourke's *Intimate History of Killing* (2000) documents, soldiers can be shockingly psychologically resilient in the face of appalling events.

There is a danger in the concept of PTSD that informs international psychosocial programmes of reverting to a mechanistic, deterministic model of the human psyche. So although psychosocial programmes seek to affirm the selfhood of the individual, the underlying view of the self is as a passive recipient of experience. In contrast, authoritative studies demonstrate that there is no linear relationship between experiencing distress and becoming traumatised. As the early psychiatrists documented during the First World War, 'the same exposure to a traumatic experience may result in neurosis in one person, but not in another' (Jones, 1921, p. 47). Consequently, the popular term 'shell shock', suggesting a mechanical reaction, was disliked by these psychiatrists. How people understand their experiences, as much as the severity of the experiences, influence whether individuals develop clinical conditions. Esprit de corps and comradeship militate against psychological breakdown, as do political engagement and identification with the war aims. So even where soldiers or civilians suffer the death of close family members or friends, hero status in the struggle can help them cope with their personal grief. The greater the sense of normalcy and degree of control refugees have over their daily lives, the presence of family support or community networks, the character of camp regimes are all variables that experienced field staff are familiar with. Getting the basics of food, water, shelter right is crucial for any sense of well-being, after that, the most appreciated support for refugees continues to be the message and tracing services, the medical services, and the facilitation of asylum or other practical problems. As the British Red Cross draft assessment on Kosovo observed, 'If one matches the needs expressed by refugees, host families and RC staff […] with what a PS programme could provide, there is a relatively modest role for a PS programme (British Red Cross, 1999). To reiterate, populations are generally far more resilient than the international aid workers sent in to administer to them. But resilience is effectively viewed by the psychosocial model as evidence of psychological dysfunctionalism, for PTSD has become universalised as the norm. Borrowing from therapeutic concepts,

any population resisting pathologisation of its condition is 'in denial' and thereby in need of treatment. In this way populations are caught in a double bind that does not allow escape from pathological categories. Indeed, the psychosocial model posits life-long or even multi-generational dysfunctionality as individuals who have experienced trauma are considered to merely be 'in recovery' or 'in remission', never recovered, but ever haunted by their trauma and at risk of being re-traumatised by their memories.

**Professionalising trauma responses**

What is problematic about psychosocial intervention is therefore not merely the question of the relevance of trauma counselling for people who are exhibiting rational responses to their plight and who have their own support networks and coping strategies. Reading the aid literature, understandably anxious, tired or depressed refugees in insecure situations are being pathologised as unable to function. As a consequence of the pathologisation of their condition, psychosocial intervention implicitly denies the capacity of populations for self-determination. The imperative to professionalise trauma responses irrespective of whether populations are coping with their distress is symptomatic of social risk management's mistrust of individual capacity and impulse to regulate.

In its projection of vulnerability and mass dysfunctionalism, psychosocial intervention may be contrasted to previous Western psychiatric practice in wars up to and including Vietnam, whose work presumed the general resilience of individuals. The former effectively questions the capacity of individuals, the latter forcefully emphasised their capacity, often employing harsh regimes as well as strong moral pressure to return people to their war time duties as quickly as possible. Yet for all the toughness and sometimes cruelty of past war psychiatry (Shephard, 2000), the underlying assumption of capacity and its appeal to individual's abilities is ultimately a more humanistic approach than the today's misanthropic model deterministically framing people as objects of experience. Hence, although contemporary therapists often identify themselves as radicals and view their work in terms of progressive social reform – a notable number of senior psychologists today became involved in psychology through anti-Vietnam protest movement – the political implications of their ideas are ironically more authoritarian than that of (military) clinical psychiatrists from whom they self-consciously sought to distance themselves.

While the capacity of the recipient population is mistrusted, trust in external psychosocial intervention is an article of faith. The benefits of psychosocial intervention are assumed by aid agencies rather than backed up by research. As one leading PTSD counselling book concedes, 'the jury is still out as to whether current strategies improve matters' (Scott and Stradling, 2001, p. 126). Since psychosocial programmes intervene in people's lives and intrude into individuals' intimate feelings when they are perhaps at their most insecure, the benefits of the psychosocial programmes should be unambiguous. However, recent studies even suggest that PTSD counselling or debriefing after distressful experiences may actually produce worse outcomes by unwittingly undermining people's own coping strategies (Deahl, 1998; Wessely et al, 2000). That psychosocial intervention might not promote recovery is not surprising since the psychosocial model constructs people as never recovered but ever vulnerable to relapse. Anybody who inculcated the suppositions of

psychosocial model and its cycle of trauma and violence thesis is thus likely to feel more anxious, not reassured by its thesis. Particularly disturbing for any recipient of its message would be the alarmist projection of traumatised individuals as dysfunctional, prone to aggressive or even acquiring sociopathic tendencies. But the issue is not primarily a question of efficacy in treating individual cases. As Duffield indicates (Duffield, 2001), the application of metropolitan risk management externally to whole populations has far-reaching political significance, which will be explored below.

**Psychological dysfunctionalism as the cause of conflict**

Psychological functionalism seeks the origins of ethnic conflict in the 'powerful reservoir of traumatic memory' (Norwegian Ministry of Foreign Affairs, 1999, p. 18). Trauma, international reports contend, drives victims to perpetuate the violence they have experienced (Commission on Global Governance, 1995; Mackmoud, 1994; UNESCO, 1993a, 1993b; UNICEF, 1996). The psychological functionalist approach is exemplified in a UNICEF briefing report which states, 'the world has only just begun to realise that left untreated, the psychological wounds of war can be most damaging, as children grow up unable to function normally, often driven to perpetuate the violence they have experienced' (UNICEF, 1994). A catalogue of social problems is predicted as the consequence of untreated trauma in an ECHO psychosocial manual on Bosnia-Herzegovina:

> Research on trauma responses shows that lack of attendance to these problems can impact on at least the next two generations – even if the war stopped now. The symptoms to be expected are, for example, a massive increase in alcohol and drug addiction, suicides, all kinds of violence (criminal and domestic) and psychiatric illness. Moreover, unresolved traumatic experiences are likely to be ignited by new hatred and new wars (Agger, 1995, p. 14).

This understanding of conflict and social problems as arising from trauma-induced psychological and social dysfunctionalism points to the reasons for the continuing saliency of the psychosocial intervention. The population is constructed as dysfunctional because of the very experience of war. To break the perceived cycle of trauma and violence, contemporary international policy envisages mass corrective psychosocial therapy. As one much-cited book *Trauma and Recovery* claims, re-living traumatic experiences (through therapy) 'are *prerequisites* both for *the restoration of the social order* and for the healing of individual victims' (Herman, 1992, p. 1, emphasis added). Indicative of the contemporary emphasis on psychological and moral rehabilitation, many international documents refer to the 'rehabilitation' of post-conflict societies, rather than their reconstruction. This preoccupation with re-socialisation of populations has been translated into agencies defining new policy areas: 'best practice in the context of psychosocial counselling; how to demobilize and detraumatize child soldiers; how to deal with the conditions of social breakdown in the "failed state"' (Black, 1996, p. 272). These policies are being codified in international instruments as human rights, assuming a consensus on psychological functionalism. Article 39 of the UN Convention on the Rights of the Child requires states to 'take all appropriate measures to promote the physical and psychological recovery and social reintegration of a child victim'. In this manner, the

issue of psychosocial intervention is elevated above the realm of national political contestation, restricting the latter to merely debating the merits of particular therapeutic methodologies or implementation strategies. However, although Article 39 presupposes a consensus, analysis of the specialist literature shows that this is far from the case.

There are fundamental flaws with the psychological functionalist model of conflict. Because of the limited space available, I will just highlight a couple of controversial areas raised in the passage from the ECHO psychosocial manual cited above (Agger, 1995, p. 14). A raft of assumptions is made here in blaming a multiplicity of long-term social problems on 'unresolved trauma'. Can social problems of alcohol and drug addiction, crime and violence, even psychiatric illness be attributed to war neurosis? Most symptoms arising from trauma or depression do not affect functionality (Dawes, 1994; Summerfield, 2000). Nevertheless, psychosocial policy-makers are claiming that distress can affect functionality for 'at least the next two generations', although the idea of intergenerational transmission of trauma is merely intuitive conviction, albeit strongly held, rather than a verified thesis. The idea of a causal link between trauma and violence derives from the cycles of abuse model in the family violence literature, but the validity of the concept both to explain abuse and to devise policies to tackle abuse is highly contested. Notably, the cycle of abuse is premised on contentious retrospective studies (sometimes relying on explanations involving self-justifications!), which elevate past experience of violence or trauma over a multitude of other factors that lead to abuse.

Difficult to sustain in the context of interpersonal behaviour, the trauma and violence model becomes harder to sustain when applied to social conflict. The model provides an over-socialised account of individual and collective behaviour. Trauma, as discussed above, does not necessarily result in people becoming traumatised. People may respond to adversity by becoming more resilient. Nor does the experience of violence simply lead people to become violent, more violent or indifferent to violence. So although the therapeutic paradigm elevates personal feelings, it has a crude, deterministic view of the self, which effectively reduces the human subject to the id of vulnerable inner child and its flipside of primordial violence. In the context of the North-South relations, the metropolitan construction of populations as victim/perpetrator represents the return of Rudyard Kipling's conceptualisation of the non-Westerner as 'half savage, half child' (1899).

The continuum of trauma and violence propounded by psychological functionalism ignores how individuals in violent conflict continue to make moral and political judgements about what violence they consider legitimate and illegitimate. Even in civil war, there are limits to social disintegration. The Hobbesian vision of a war of all against all is misleading. Writing on the problem of social order, the sociologist Dennis Wrong observes:

> Societies never fall apart to the extent of literally lapsing into a war of all against all. Nation-states may fragment [...] into several hostile groups controlling different localities [...] But underneath these processes social order survives at least at a micro-sociological level - the level of families, small groups, and networks of interacting individuals cooperating in the pursuit of common goals (Wrong, 1994, p. 243).

As Wrong points out, 'the very existence of organized groups mobilized for conflict indicates the achievement of consensus between them' (ibid., p. 209). Even adherents of the cycle of trauma and violence thesis have conceded the lack of research indicating that trauma or exposure to violence result in social dysfunctionalism or the legitimisation of violence per se (Goodwin-Gill and Cohn, 1994, p. 174). Nevertheless the presumption of a continuum of political and family violence remains. Evidence is rendered superfluous or superseded in the account provided by cycle of trauma and violence model. Furthermore, the ethos of 'anticipatory, probabilistic and preventive intervention' (Duffield, 2001) dictates that policy is formulated on the basis that 'at least the next two generations' may dysfunctional and that the process of rehabilitation requires an international presence to attend to the population's recovery for that period. The requirement for (life-cycle-long) psychosocial intervention demonstrates a view of recipient populations as irrational and emotionally immature and therefore implicitly incapable of determining their lives without outside professional intervention. Effectively, the psychosocial model involves both invalidation of the population's psychological responses and their invalidation as political actors, while validating the role of external actors. The psychosocial model envisages an indefinite suspension of self-government in post-conflict societies or so-called 'failed states'.

Meanwhile, psychological functionalism's belief in the essential harmony of interests under global governance denies the global constitution of the South. Furthermore, the attribution of war to 'traumatised nationalism' is reminiscent of the themes of earlier Western racist psychology with its descriptions of the damaged personality or 'pathological state of mind' of the colonial subject (Perham, 1963, p. 28). The earlier racist psychology denied the rational capacity of colonial subjects and acted as an apology for the denial of political rights. Through the psychosocial model, we are witnessing the re-institutionalisation of the idea of the pathological state of the dependent subject, condemned four decades ago by the Algerian psychiatrist Frantz Fanon in *The Wretched of the Earth* (1965). Once fashionable in aid circles, Fanon's attack on Western psychology's pathologisation of the non-Western mind and his location of pathology in the colonial or neo-colonial relationship itself are overlooked as irrelevant in today's ostensibly emancipatory social risk management model. Local professionals too have been willing to adopt the Western therapeutic framework, lacking confidence in their own populations. However, the technologies of therapeutic governance are distinct from colonial rule. International therapeutic governance does not follow the formal institutions and embedded expatriate communities of the colonial period. Analogous to the disavowed power relationship of contemporary non-directive counselling, therapeutic governance is a disavowed form of government by a transitory network of global professional consultants who seek to enable processes within societies.

## Cultivating psychological functionalism

Psychosocial emotional education programmes to cultivate psychological functionalism are an central component of the self-regulatory technologies of governance. Comprehensive socialisation programmes are being developed to tackling individual psychology, social attitudes and norms of behaviour. Programmes are not confined to changing outward conduct, but the very development of

personality. Backed up with the moral authority of the UN Convention on the Rights of Child, international programmes seek to supervise and guide the conduct of family life and change parenting practice in accordance with the contemporary Western therapeutic paradigm. Today, as in past Western anthropological national character studies, non-Western child-rearing practice and family relations are particularly singled out for fostering dysfunctional authoritarian personalities. Feminising cultures and empowering the female and child voice to counter aggressive (male) values and to promote emotional sensibility have become an integral part of conflict resolution strategies (Carnegie Commission, 1997, p. xxxii; Garbarino, 1993, p. 791; Giddens, 1994, p. 244). UNICEF advocates parental education and other counselling initiatives in all its country programmes in the region. Western therapeutic approaches are also being disseminated through the publication of books and translations such as Thomas Gordon's *P. E. T., Parent Effectiveness Training: the tested new way to raise responsible children* (1970) and *T.E.T., Teacher Effectiveness Training* (1974). Furthermore, since therapeutic policies are now part of international human rights law, states are required to adopt the psychosocial approach. The UN Committee of the Rights of the Child has criticised the post-Yugoslav states, among others, for failing to provide family counselling services, pre-marriage counselling and parental education.

International policy has taken up a key theme of psychological functionalism: the idea of low self-esteem leading to dysfunctionalism and self-esteem being necessary for being a functional personality and responsible citizen. Self-esteem has arguably been elevated to a right under the UN Convention on the Rights of the Child with its model of childhood being in 'an atmosphere of happiness, love and understanding'. As part of social risk management, UNICEF, UNESCO, the World Bank and other international organisations have been involved in education reform promoting a shift from what UNICEF policy-makers condemn as 'factology' towards educational approaches elevating emotional and social skills to ensure psychological and social functionalism. The cultivation of self-esteem now features prominently in international conflict management strategies, notably in the post-Yugoslav states. For example, *Zdravo da ste* (Hi Neighbour) has provided, 'activities designed to enable adults to re-establish their emotional stability and confidence in others as well as their own self-confidence' (Hi Neighbour, undated). It is not just the NGO sector, which has been involved. Psychologists and teachers in the state sector are also being trained to adopt self-esteem as the goal of their work. To mention just one initiative in this area, the UNICEF Self-Esteem Project in Vojvodina in 1993 involved workshops with over 400 teachers and 15,000 children in two years alone (UNICEF, 1995, p. 12). The disciplining aspect of the promotion of psychological functionalism is most apparent in the case of Iraq. International psychosocial intervention, for example, to improve child-rearing practice in Iraq, to prevent psychological dysfunctionalism in children is not unrelated to alarm that the decade of international sanctions has fostered a generation with no stake in the present international order.

Leaving aside contention over its assumptions or the Huxlian or Orwellian connotations of mass 'soma' therapy, there are evident problems with the application of psychological functionalist policies. The sum of the psychosocial initiatives represents an attempt to professionalise intimacy, but intimate feelings cannot be broken down and taught as if they were analogous to transferable employment skills, nor can intimate relationships be prescribed as if they were positions of employment.

Cultural values and self esteem cannot be treated as independent variables divorced from individual experience and the social milieu. This limitation of socialisation programmes is evident in US research on the correlation between self-esteem and performance. Despite the lack of evidence for self-esteem being a prerequisite for performance (Dawes, 1994), the link has become axiomatic in US social and educational policy and is enshrined in state statutes and regulatory codes (Nolan, 1998, p. 169). However, although US pupils appear to have assimilated the values of the self-esteem and emotional communication programmes and have high confidence in their abilities, their confidence does 'not seem to translate into actual performance' when compared to their counterparts in other countries (ibid.). Furthermore serious doubts have been raised about the efficacy of the self-esteem approach (Hewitt, 1998), as potentially being dysfunctional by fostering narcissism (Baumeister, 1996; Baumeister and Bushman, 1998; Dawes, 1998; Shanker, 1997).

Psychosocial conflict management approaches have long been criticised for concentrating on feelings to the detriment of rational thought (Scruton, 1985) and being process rich and content poor (Lister, 1987). Their preoccupation with emotional stability and role playing effectively reduces social problems to poor individual morale and bad socialisation. One pitfall of the focus on individual feelings as the reference point is that it may obscure structural sources of conflict, thereby making it harder for the warring parties to see beyond their own conflicting perspectives and overcome their mutual enmity. Another issue is that international psychosocial initiatives at the micro-sociological level may potentially erode community and family cohesion. Firstly external intervention and the professionalisation of emotional communication may unwittingly undermine the sense of intimacy necessary for communal and family bonds. Secondly such intervention encourages identification with and dependence upon the intervening bodies thereby corroding local ties and institutions. Potential problems of the therapeutic approach are evident in Western societies. It should be noted how the triumph of the therapeutic in Anglo-American education and social policy has been accompanied by an explosion of behavioural disorders being diagnosed in British and US children, tens of thousands of whom are on therapeutic programmes and prescribed behavioural drugs such as Ritalin (Nolan, 1998, pp. 12-13). It is not conclusive whether this phenomenon represents real pathologies or the pathologisation of challenging behaviour. Nevertheless, the pathologisation of a significant section of metropolitan society under social risk management underscores how merely devising more culturally sensitive therapeutic interventions that do not stigmatise the borderlands is not an adequate response to criticisms of psychosocial programmes. Fundamental questions need to be asked about the ethics and efficacy of the therapeutic model in the West too. However, the pathologisation of the borderlands has implications for self-government as well as individual rights.

**Therapeutic governance**

The imposition of the therapeutic paradigm in post-conflict societies does not just entail an attack on ethnic nationalist politics, but represents the demise of the realm of politics. Therapeutic governance is reducing democracy to a question of self-esteem (Lasch, 1995). Rights entail the recognition of competing victim statuses, but the substance of political rights is denied. Power is not exercised by the ostensible subjects of rights, but by international advocates on their behalf. Populations are de-

coupled from policy-formation. Instead of societies formulating policy, policy is being formulated for them. The characterisation of democracy as reduced to self-esteem is particularly apt in Bosnia. The substantive exercise of self-determination has been indefinitely deferred. The power of local institutions more closely resembles that of NGO children's parliament initiatives than that of government. However, even countries that are not under de facto international administrations are finding their right to determine politics is being curtailed through the codification of international social risk management policy as higher law. The role of local institutions thus becomes merely about adapting and administering externally-devised policies, whereby politics loses its *raison d'être*. Symptomatic of the problem of the de-coupling of populations from policy-formulation is the exhortations by international officials that post-conflict societies take ownership of reconstruction processes.

In the curtailment of self-determination, society and the individual citizen are effectively denied their moral capacity for the conceptualisation of the good. As a consequence, populations are also denied their moral personality and unity of the self (Rawls, 1973, p. 561). Where populations are experiencing a curtailment of self-determination and a questioning of their moral capacity, it should be no surprise if psychosocial professionals find a relatively high instance of depression - the link between a sense of control and mental health is well-established. However, the presence of depression does not vindicate therapeutic governance, rather the reverse. It is the functionalism of therapeutic governance that needs to be examined. Ironically, the unprecedented regulation of people's lives and emotions under therapeutic governance risks populations' mental health. That populations do not succumb to the pathologisation of their condition under therapeutic governance in greater numbers is testimony to people's capacity and resilience.

**Notes**

1. Research on the significance of social psychology and its therapeutic approaches is much more developed in the United States than in Britain. See, for example, Lasch, 1978, 1984; Nolan, 1998; Sennet, 1976; Sykes, 1992.

2. The concept of international community effectively refers to Western governmental, inter-governmental and non-governmental organisations. 'The very phrase "the world community", Samuel Huntington observes, 'has become the euphemistic collective noun (replacing "the free world") to give global legitimacy to actions reflecting the interests of the United States and other Western powers' (Huntington, 1993, p. 39).

3. Personal communication on forthcoming study conducted by McEwen, 1 March 2001.

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