PSYCHOSOCIAL HEALING

A Guide for Practitioners

Based on programs of the
Medical Network
for Social Reconstruction
in the Former Yugoslavia

May 2003

edited by **Paula Gutlove and Gordon Thompson**
Institute for Resource and Security Studies

Psychosocial Trauma Healing for Post-Conflict Social Reconstruction
A Health Bridges for Peace Guide for Practitioners, based on programs of the Medical Network for Social Reconstruction in the Former Yugoslavia

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About the Organizations that Contributed to this Guide

The Medical Network

The Medical Network for Social Reconstruction (Medical Network) is a network of health-care professionals drawn from all parts of the former Yugoslavia. Having existed informally since 1991, the Medical Network assumed its present structure in 1997. It aimed to facilitate healing processes that promote individual and community health and empowerment and the prevention of future conflicts in the Balkans region. Its programs are founded upon two major beliefs. First, violent conflict and war are the ultimate threat to public health. Second, the health community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and psychological wounds of individuals but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation. To these ends, the Medical Network promotes dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in the region of the former Yugoslavia. Programs for training and implementation of psychosocial healing for social reconstruction have been one of the Medical Network's primary activities.

Two member organizations of the Medical Network have played key roles in the development and implementation of the Network's psychosocial-healing programs, and have contributed greatly to the development of this guide for practitioners. These organizations are the Society for Psychological Assistance and the Regional Center "Together".

The Society for Psychological Assistance (SPA) is a registered non-profit, non-governmental mental-health organization based in Zagreb, Croatia. Founded in 1993, its mission is to help alleviate the suffering of traumatic stress by trauma survivors and to provide psychological and psychosocial assistance to individuals, families, groups and communities in distress. SPA has been an international leader in trauma healing and the provision of training and support to healing professionals, as illustrated by numerous contributions in this guide. (Web site: www.dpp.hr)

The Regional Center "Together" was established in Ljubljana, Slovenia, in 2002 by the Slovene Government, the City of Ljubljana and the Slovene Philanthropy (an NGO whose international activities the Center continues). The Center aims to protect and improve the psychosocial well-being of children affected by war and social adversity in South-Eastern Europe, by strengthening local structures (institutions, organizations and NGOs) and developing models of psychosocial protection and empowerment for children. (Web site: www.together-foundation.si)

International Partners of the Medical Network

Two organizations that are not based in the former Yugoslavia have been working with the Medical Network since its inception. These are the Institute for Resource and Security Studies and the OMEGA Health Care Center. Directors of these organizations serve as international, at-large members of the Medical Network Contact Group and are members of the Medical Network's Executive Committee.

The Institute for Resource and Security Studies (IRSS) was founded in 1984 to promote international security and sustainable use of natural resources. As part of its work on international security, IRSS engages in conflict management and social reconstruction. Over the last decade IRSS has developed and demonstrated a strategic approach to conflict management, featuring "integrated action," the deliberate integration of conflict management with selected social activities. This approach allows conflict management to have sustainable application by using it to help strengthen civil society. IRSS utilizes an integrated-action approach in several field programs. One of IRSS' largest integrated action projects -- the Health Bridges for Peace (HBP) project -- utilizes a shared concern for public health as a vehicle to convene, train, and engage health-care professionals in conflict management and community-reconstruction programs. Through the HBP project, IRSS helped to develop the Medical Network. (Web site: www.irss-usa.org)

OMEGA Health Care Center, based in Graz, Austria, is an independent, non-governmental organization. OMEGA engages in local and international activities that aim to assist populations at risk from war and other social stresses. Local activities are primarily related to refugee care, including medical and psychological assistance and a range of social-rehabilitation and integration projects. International projects include relief and humanitarian assistance, human-rights education and awareness, psychological assistance and social reconstruction. (Web site: www.omega-graz.at)

How this Guide was Developed

IRSS has been working in the former Yugoslavia since 1992, and with the Medical Network since 1997. During this time we have seen the aftermath of war in the form of destroyed buildings and physically and spiritually wounded survivors. We have learned that rebuilding a society depends upon the healing, reconnection and empowerment of the survivors.

Development of the Medical Network has depended upon the courage, willingness and ability of its leading members—in particular, the Network's Contact Group—to work together, in the long term, to rebuild their society and their region. Using their unique position as healers, Network members have sought to promote social reconstruction across the former Yugoslavia.

The Contact Group has come together repeatedly over the last 6 years, in a facilitated dialogue, to explore the needs within each region and the indigenous capacities to meet those needs. The Slovene Philanthropy, later the Together Center, pioneered the development of volunteer action, promoting training for local community leaders, teachers, health-care providers, and social workers. The Society for Psychological Assistance offered training in trauma healing, together with training of trainers and provision of support services to healers ("help to the helpers"). The OMEGA Health Care Center took on the tremendous task of bringing together Medical Network participants each year, while conducting its own programs on community integration, refugee support and psychosocial research. Each year Network conferences or meetings have been hosted by a different member organization. Conferences have been organized in Slovenia, Bosnia (Sarajevo, Gracanica and Neum), Macedonia, Montenegro and Serbia. These conferences provided opportunities to showcase local programs, and to enhance local capabilities through training, collaboration and material support.

In this guide, we explain the theoretical base for the steps we have taken, offer exercises we have used, and share lessons we have learned from a range of Medical Network programs. We hope that our experience will help others who seek to re-knit the fabric of society after it has been torn asunder by the destructive effects of violent conflict.

Acknowledgments

We thank the United States Institute of Peace, the William and Flora Hewlett Foundation, and members of the Rockefeller family for support that has made possible the production of this practitioners' guide.

We also acknowledge the members of the Medical Network for their unflagging commitment to collaborative action to promote social reconstruction in the region. The Medical Network was conceived at a time when the level of violence in parts of former Yugoslavia made the need for healing and social reconstruction urgent, but also difficult to carry out. Members of the Medical Network have had the vision, courage, spirit and sensitivity to work together for a better future despite these difficulties. Their work has been made possible by support from a range of international and indigenous, government and private sources. This support has allowed the Medical Network to develop and implement its programs, and to hold meetings, training workshops and seminars.

Finally, we thank our families, our colleagues and our friends, who have encouraged us, advised us, listened patiently, and supported our efforts in countless ways.

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Appendices

1. Introduction

This guide for practitioners describes the use of trauma healing and related psychological and social-support activities as contributors to the development of a stable, peaceful and functional society in a post-conflict environment. We describe this type of work as "psychosocial trauma healing for post-conflict social reconstruction." For convenience, in this guide we generally use the shorter term "psychosocial healing."

Psychosocial healing, while not the only instrument that can be used to promote social reconstruction, can make an important contribution to this task. The importance of psychosocial healing has been demonstrated by experience in the former Yugoslavia and in other post-conflict settings.

Understanding of trauma and trauma treatment has evolved greatly during the last century. A significant step in this evolution occurred in 1980, when, amid much controversy, the American Psychiatric Association added "Post Traumatic Stress Disorder" to its manual of recognized mental-health disorders. Along with growing recognition of the effects of traumatic events on individuals has come a growing awareness of the effects of traumatic events, including violent conflict and war, on groups, communities and societies. As a result, mental-health practitioners and others who work with traumatized groups have seen a need for new treatment options and modalities, and a growing awareness of the need for societal healing approaches in addition to individual therapeutic approaches. Especially important has been a new understanding that trauma does not occur in a social vacuum, and cannot heal without supportive social interactions. The Medical Network has been a pioneer in this area. It has integrated creative trauma-healing modalities with social-support activities in order to provide psychosocial healing throughout a society that has been torn apart by violence.

Although trauma healing is often referred to as trauma recovery, in this guide we refer only to trauma healing.[1] We do this for two major reasons. First, recovery implies a return to a place that one has been to before. However, in the case of trauma it is not possible to return to the pre-trauma state, because traumatic events forge an indelible imprint on those who are traumatized. The goal of trauma healing is to acknowledge and integrate the traumatic experience, to mourn the old self that the trauma destroyed and create a new self with new beliefs and new meaning.[2] Second, a post-war society can find in trauma healing an opportunity to recreate itself, replacing pre-war ways of interacting and pre-war belief systems. A post-war society has the opportunity to recreate itself as a healthy, peaceful sustainable society, with appropriate psychosocial healing as a component of social-reconstruction activities.

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[1] The term trauma recovery is used extensively in the relevant literature and by members of the Medical Network. Our emphasis on trauma healing is not intended as a criticism of this usage. Instead, it reflects the ongoing development of this field and the different perspectives within it.

[2] Herman, Judith. *Trauma and Recovery*. New York: Basic Books, 1992, page 196.

Section 2 of this guide outlines the context within which psychosocial healing occurs. At the broadest level, this context is framed by the concept of human security. Then, Section 3 provides some general background on stress and trauma as experienced by individuals and societies. Section 4 discusses the implementation of psychosocial healing, and Section 5 describes selected tools that can be used in the implementation process. A bibliography is provided in Section 6. Appendices contain supporting information.

2. The Context for Psychosocial Healing

Psychosocial healing can make a central contribution to social reconstruction in a post-conflict setting. In turn, social reconstruction is one of the essential requirements for rebuilding a conflict-ravaged society. Thus, psychosocial healing occurs within a broader context. Human security, as discussed below, provides a framework for activities that occur within this context. Within the sphere of social reconstruction and related activities, one encounters processes such as community reconciliation, conflict management, integrated action and health bridges for peace, which are described below.

Human Security

An overall framework for planning and implementing social-reconstruction programs can be provided by human-security principles. Human security is an evolving concept for organizing humanitarian endeavors. It places the welfare of people at the core of programs and policies, is community oriented and seeks to prevent harm. Also, it recognizes the mutual vulnerability of all people and the growing global interdependence that mark the current era. By combining these features in one concept, human security facilitates the organizing of humanitarian initiatives that require cooperation by a variety of actors working in multiple sectors. Human-security principles are especially applicable to the reconstruction of post-conflict societies. For more information, with a focus on the connections between health and human security, see Appendix 1, **Human Security: Expanding the Scope of Public Health,** by Paula Gutlove and Gordon Thompson.

The concept of human security adds value when it assists the planning and implementation of practical programs of action. A human-security approach can add value in the health sector by linking health with related objectives such as prevention of violent conflict, improvement of governance, and post-conflict reconstruction. In situations of conflict, shared health concerns can create neutral ground for collaboration and a basis for addressing fundamental obstacles to peace, such as discrimination, polarization and manipulation of information. Health care that features cooperation between professionals from different sides of a conflict can be a model for collaborative action, and can help to create the community infrastructure that is essential for an enduring peace. In post-conflict situations, health programs can be a crucial, unifying influence.

Social Reconstruction, Community Reconciliation, and Conflict Management

Social reconstruction is a strand of humanitarian activity that complements physical reconstruction and political reconstruction. It seeks to gradually rebuild the intangible but crucial fabric of human interactions that allow a society to function, while also meeting the immediate psychosocial needs of a society that has been ravaged by violence. A key component of social reconstruction is community reconciliation, a process involving the restoration of trust and hope within a community, a rise in cooperative behavior, and the development of shared values and expectations. Another key component is conflict management, a set of processes that allow conflicts to be managed productively and non-violently. Conflict management includes processes that promote dialogue, cooperation, problem-solving and reconciliation, with the objective of preventing the escalation of conflict and promoting its de-escalation. These processes are necessary for social reconstruction and all other areas of productive human activity.

Integrated Action

"Integrated action" is a strategy for spreading and strengthening conflict management, particularly within societies undergoing transition. Integrated action seeks to integrate conflict management with existing societal functions (e.g., health care, education), providing an effective, sustainable way to incorporate conflict-management practices into the fabric of the society. Integrated action weaves together conflict management with other humanitarian activities for several purposes. The humanitarian action is an incentive for parties to come together and provides a basis for continued engagement of indigenous parties. As parties work together they create a context for training in conflict-management skills, which can be applied on many levels, promoting community reconciliation among ever-larger circles. The first circle encompasses the providers of a humanitarian action, the second circle encompasses people directly reached by the humanitarian action, and the third circle encompasses the surrounding community. Other, wider circles will be reached by replication of this process in other locations. Finally, the conscious integration of conflict management with humanitarian actions can provide a sustainable structure for long-term cooperation and community reconciliation.

Implementing an integrated-action strategy can involve decades of work, building networks of social actors, training them in conflict-management theory and practice, and developing liaisons between the networks and a wide range of non-government, government and inter-governmental organizations.

Health Bridges for Peace

Health care is a social function that lends itself well to an integrated-action strategy. Health professionals have a special role to play in healing violence-ravaged communities. They have an intimate association with people who have suffered mentally and physically, are often well educated, have public stature and have access throughout a community. They can create a "bridge of peace" between conflicting communities, whereby delivery of

health care can become a common objective and a binding commitment for continued cooperation. Finally, they can assist reconciliation after the trauma of war, through a healing process that restores relationships at individual and community levels.

In 1996 the Institute for Resource and Security Studies (IRSS) founded the Health Bridges for Peace project (HBP) to promote the integration of health care with social reconstruction and conflict management. The project utilizes a shared concern for the restoration of public health as a vehicle to convene, engage, and train health-care professionals in conflict management and community reconciliation techniques. Also, once these professionals are trained, they are assisted in designing and implementing inter-communal activities that integrate community-reconciliation and conflict-prevention strategies into health-care delivery.

During the past seven years the project has worked with health professionals in a range of conflict and post-conflict situations. Our experience has taught us that social reconstruction, the healing of inter-communal relationships, and the transformation of violence-habituated systems can be significantly enhanced by training and assistance in trauma healing, psychosocial support, and conflict management. It is through the Health Bridges for Peace Project that IRSS has worked with the Medical Network. For more information see Appendix 2, **Health as a Bridge to Peace**, by Paula Gutlove.

Table 2.1 summarizes the contextual elements that are described above.

Table 2.1 Elements of the Context for Psychosocial Healing

Human security is an evolving principle for organizing humanitarian endeavors. It places the welfare of people at the core of programs and policies, is community oriented and seeks to prevent harm.
Social reconstruction seeks to rebuild the crucial fabric of human interactions that allow a society to function, while also meeting the immediate psychosocial needs of a society that has been ravaged by violence.
Community reconciliation is a process involving the restoration of trust and hope within a community, a rise in cooperative behavior, and the development of shared values and expectations.
Conflict management is a set of processes that allow conflicts to be managed productively and non-violently.
Integrated action is a strategy for spreading and strengthening conflict management, particularly within societies undergoing transition, through the integration of conflict management with existing societal functions.
Health Bridges for Peace is an international integrated-action project that seeks to promote the integration of health care with social reconstruction and conflict management.

3. Stress and Trauma

What is Stress and Trauma?

Everyone experiences stress. **Stress** is a human physical and psychological response to outside forces that disturb the normal equilibrium of everyday life. More precisely, stress is a pattern of physical, emotional, psychological and/or behavioral reactions to a threatening, outside event. The outside event, or series of events, are called the **stressor(s)**. An individual's response to a stressor is determined by that person's assessment of the stress and a range of personal characteristics including gender, personality, age, etc.[3]

Traumatic stress is an extreme response to outside stressors termed **traumatic events.** Traumatic events differ from ordinary stressors by their intensity and tendency to cause helplessness, terror and suffering in most people, regardless of personal characteristics. Although debilitating, these symptoms can be a normal response to an abnormal, traumatic event.

Ordinary stress and traumatic stress could be described as regions of a continuum of experience that includes both the severity of the outside stressor and the ability of the individual to cope. Nancy Good Sider of the Eastern Mennonite University in the USA provides the following chart to lay out the difference between ordinary stress and traumatic stress:[4]

Ordinary Stress	***Traumatic Stress***
Slow or gradual change	*Sudden, significant loss*
Wearing down over time	*Piercing intensity; shock to system*
Able to plan and problem-solve	*Overwhelming sense of helplessness*
People are affected differently	*Terror; frightens almost anyone*

Clearly, a traumatic event is an extreme situation causing profound effects. One of the most debilitating aspects of a traumatic event is the inability of the victim to cope with the situation. The lasting psychological impact of this helplessness is a hallmark of victims of violence, including the violence of war. Judith Herman, a renowned psychiatrist, author, and expert on trauma, has described the pain of psychological trauma in moving terms:

> "Psychological trauma is an affliction of the powerless. At the moment of trauma the victim is rendered helpless by overwhelming force…..traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning."[5]

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[3] Arambasic, Lidija. "Stress and Trauma." In: Ajdukovic, Dean, and Marina Ajdukovic, eds. *Mental Health Care of Helpers*. Zagreb, Croatia: Society for Psychological Assistance, 2000.

[4] Sider, Nancy Good. "At the Fork in the Road." In: *Conciliation Quarterly*, Mennonite Conciliation Services. Vol. 20, No. 2, Spring 2001.

[5] Herman (1997). *Trauma and Recovery*, page 34.

Reactions to Traumatic Stress

The human responses to traumatic events are called **traumatic stress reactions**, which are a complex set of interacting physical and emotional responses.

At the onset of a traumatic event the sympathetic nervous system is alerted. Nerve cells in the brain release potent hormones that increase heart rate and metabolism. Adrenal glands release adrenaline, causing the "flight or fight" response — and signal the amygdala, the "fear center" of the brain. The amygdala signals memory and emotional centers. Feelings of fear and anger are aroused, visual perception is altered, and memories can become snapshots of the event, images indelibly frozen into the brain.

After the traumatic event, the traumatic stress reactions can continue and be manifested as behavioral, cognitive, emotional and physical responses in the individual, called **post-traumatic stress reactions**. When the traumatic event overwhelms the individual's ability to respond — for example, when it is not possible to flee or fight back — the altered, aroused state can continue even after the danger is over.

Over time, a traumatic event can produce a range of cognitive, emotional, physical and behavioral responses. **Cognitive responses** include memory difficulties, lack of concentration, poor judgement, inability to discriminate, and inability to make choices. **Emotional responses** include depression, withdrawal, excitability, flashbacks, intense fear, feelings of helplessness, loss of control, loss of connection and meaning, generalized anxiety, and specific fears. **Physical responses** include stomach pains, tightness of the chest, headaches, perspiration, and psychosomatic complaints. **Behavioral responses** include irritability, startling easily, hyper-alertness, insomnia, communication difficulties, and drug, cigarette, or alcohol use.

The wide array of symptoms of post-traumatic stress has been conceptually organized in a variety of different ways. For our purposes, it is most helpful to use the three main categories put forward by Judith Herman: hyperarousal; intrusion; and constriction. These categories are described by Herman as follows:[6]

Hyperarousal is what happens when the individual is in a permanent state of alertness, fearing that danger could recur at any time. The individual tends to startle easily, be irritable, and have trouble sleeping. When he does sleep he is plagued by nightmares. Nowhere does he feel safe and secure. He is hyper-vigilant in his search for security, seeing danger everywhere.

Intrusion refers to the inescapable presence of the traumatic memory in the mind of the traumatized person. The snapshot that was frozen into the brain during the traumatic event recurs unbidden, intruding as a flashback over and over again. The traumatic memory is not a "normal" memory that one remembers as a story line unfolding logically. Instead, it is a static, wordless memory. The memory will have vivid sensations and images but no context. This memory is unrelated to time, so that the traumatized individual will relive

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6 Herman (1997). *Trauma and Recovery*, page 35.

the traumatic event as though it were happening in the present. Flashbacks can occur at any time, when the individual is awake, asleep, driving, or engaged in other activities.

Constriction refers to a shutdown of emotion, whereby the traumatized individual responds to overwhelming feelings of helplessness and powerlessness by appearing to be indifferent. It is as though the individual's system of self defense has been turned off. The person appears detached and calm. His perceptions are numbed and/or distorted. The person might appear to be in a trance-like state, indifferent, emotionally detached, and passive. He may have a distorted sense of time or reality.

People exhibiting post-traumatic stress reactions usually exhibit all three categories of response, moving from one to another, unable to find comfort or balance.

Clearly, post-traumatic stress reactions can be debilitating, inhibiting a person's ability to function and decreasing the quality of life. When the clinical picture is characterized by an extreme quality and quantity of traumatic stress reactions, clinicians may offer a diagnosis of **post-traumatic stress disorder** (PTSD).[7] However, it is important to remember that these reactions may be natural responses to abnormal situations. Thus, many people, both clinicians and humanitarian-assistance providers, are uncomfortable using the label "disorder". There is a concern about pathologizing a normal response, because this could stigmatize people and inhibit them from seeking assistance. As a result, application of the PTSD diagnosis is controversial.

In this guide we discuss psychosocial healing in the context of a wide range of post-traumatic stress reactions. However, we do not address healing of PTSD. We acknowledge that a percentage of post-traumatic stress reactions can be extremely severe and warrant professional intervention beyond the scope of the professionally-supervised but often lay-implemented interventions discussed in this guide. It is our belief that the majority of cases are amenable to psychosocial-support interventions as described here. Nonetheless, it is important to have professional expertise available to assist the non-psychological professionals who work on the front line with traumatized people, to determine if a case should be referred to a specialist for assistance.

Table 3.1 summarizes the concepts described above.

[7] Arambasic (2000). "Stress and Trauma."

Table 3.1 A Glossary of Stress and Trauma

Stress is a set of physical, emotional, psychological and /or behavioral reactions that happen when an event is assessed as threatening or disturbing.
A stressor is an outside event or series of events that are assessed as threatening to one's security, self-respect, etc.
Consequences of stress depend upon: the situation and what can be done about it; personal characteristics (e.g., gender, age, personality); and external factors (e.g., social support).
A traumatic event is an event beyond the boundaries of ordinary human experience, overwhelming normal adaptive responses, so that people lose their sense of control and connection. This event differs from normal stress in its intensity and type; everyone reacts to a traumatic event.
Traumatic stress reactions are responses during or immediately after a traumatic event.
Post-traumatic stress reactions are delayed responses.
Post traumatic stress "disorder" is a set of delayed responses of such high severity (the dividing line is controversial) that professional help is needed.
Symptoms of post-traumatic stress are cognitive, emotional, physical, and behavioral.
Categories of post-traumatic stress symptoms are (according to Judith Herman) hyperarousal, intrusion, and constriction.

Societal Trauma and its Sequelae

(Discussion here is based on Appendix 4, **Post-Traumatic States: Beyond Individual PTSD In Societies Ravaged By Ethnic Conflict,** by Vamik D. Volkan.)

Just as individuals are susceptible to stress and trauma, societies are similarly susceptible. Societal trauma can cause psychosocial changes in individuals or current society, or in a future society through what is termed transgenerational transmission. The individual response to trauma has been described above. Here, we explore the effects of trauma on present and future societies.

Societal trauma can be caused by natural disasters, man-made disasters, symbolic loss, social revolution or violent conflict. When a natural disaster takes place, shock, chaos and physical hunger can occur. The survivors need to mourn their losses even as they clean up their environment. For months, or even years, their minds may be preoccupied with images of death and destruction. They may exhibit what is known in psychiatry as "survivors' guilt," condemning themselves for having lived while others perished. A shared anxiety may also linger because the people lose their trust in "mother nature."

Even though natural or accidental disasters may cause massive environmental destruction, societal grief, anxiety and change, they should be differentiated from situations in which massive trauma is caused by ethnic or other large-group conflicts. When nature shows its fury and people suffer, people ultimately accept the event as part of their fate. In man-made accidental disasters, survivors may blame a small number of individuals or governmental organizations for carelessness. Even when this happens, there are no "others" who had deliberately sought to hurt people. By contrast, when massive trauma is due to ethnic, national or religious conflicts and wars, the situation becomes more complicated because of the presence of enemies who deliberately inflicted pain and suffering on the victims. The psychology of individuals and societies traumatized due to ethnic or other large-group conflicts and hostilities should be considered a unique category, quite distinct from the situation of people devastated by natural or accidental man-made disasters.

A traumatized society can undergo "psychosocial degeneration", in which a large fraction of the society loses its sense of basic trust, or faith, in their society or the wider world. Feelings of rage and revenge often oscillate with feelings of helplessness, humiliation, and victimization. The sense of societal shame, humiliation, and helplessness may become internalized, and may complicate the already-existing survivors' guilt. There may be a development of new, maladaptive social patterns, such as prostitution, domestic violence or organized crime. There is often a destruction of the natural environment, with massive pollution of air, water and soil. Psychosocial regeneration is possible if a society can regain the basic trust that has been lost, and can undergo a psychosocial trauma-healing process. Often, the ability of a society to regenerate depends on the resources available to the society to restore basic needs, such as safety and order, and on the willingness and capability of the society to undergo a process of psychosocial trauma healing.

One of the most striking and significant societal responses to violent conflict is the increased sense of large-group identity that occurs. When a large group's conflict with a neighboring large group becomes inflamed, the bonding between members of each large group increases. Under stressful conditions, people may feel a greater psychological investment in their large group than in their individual identity. This can lead to further differentiation between two opposing groups. Under such a circumstance, a person who was not directly affected by violence nevertheless feels the impact of large-group feelings, ranging from ethnic pride and a sense of revenge to ethnic shame and humiliation and helplessness. Thus, a loss of people, land, and prestige affects everyone in an ethnic group victimized by a neighbor. The gulf between one's own group and the "other" grows, as does the tendency to idealize one's own group and dehumanize the other. Efforts are made to differentiate one's own group from the enemy group, rejecting similarities in languages or cultural habits the groups may have shared in the past.

Trauma within a society can be passed along from one generation to another, in what is called transgenerational transmission of trauma. This process can have significant impact on the psychosocial health of future generations. There are various forms of transgenerational transmission. Mothers and fathers can pass on anxiety, depression or elation, as well as unspoken thoughts and fantasies, to their children. Adults who are drastically traumatized may "deposit" their traumatized self-images into the developing identities of their children. A Holocaust victim who appears well adjusted may be behaving in this way because he has deposited different aspects of his traumatized "self-image" into his children's selves. The children now are responding to the horror of the Holocaust, "freeing" the older victim from his burden.

After a shared massive trauma, affected individuals' traumatized self-images are linked by this trauma. When hundreds, thousands, or millions of individuals deposit their traumatized images into their children after a massive shared trauma, this process affects the large-group identity. While each child has his or her individualized personality, they all share similar links to the "memory" (the mental representation) of the trauma and a similar unconscious obligation to perform tasks to deal with this "memory." Therefore, under such a situation, an unseen network among hundreds, thousands or millions of people is created. Usually, the shared task is to keep the "memory" of the parents' trauma alive and to mourn their losses, revere their humiliation, or take revenge. If the next generation cannot effectively deal with their shared tasks—this is usually the case—they will pass such "tasks" to the third generation, and so on.

Depending upon societal and political conditions, shared tasks may change function from generation to generation. For example, in one generation the shared task is to grieve the ancestors' loss and feel their victimization. In the following generation the shared task may be to express a sense of revenge. But, keeping alive the mental representation of the ancestor's trauma remains the primary task. Since it is shared, the new generation's burden also supports the large-group identity. These "memories" (mental representations) are called by Volkan the large group's "chosen trauma." In either an open or dormant fashion, a chosen trauma can continue to exist across generations over periods of decades or centuries. When there is a new ethnic, national, or religious crisis in the large group, leaders of the group often re-kindle memories of past chosen traumas. Feelings,

perceptions, and anxieties about the past event can be transferred into feelings, perceptions, and anxieties pertaining to current events. In this way, societal response to shared trauma after a war or violent conflict may occur years after the trauma, when the connection to its cause has been forgotten. The society is puzzled by its feelings or creates incorrect and inadequate explanations. Since the actual cause remains unknown, attempts to counter it are easily frustrated or may even worsen the situation.

Table 3.2 summarizes the concepts described above.

Table 3.2 Societal Trauma and its Sequelae: A Conceptual Summary

Causes of societal trauma: • Natural disasters • Man-made disasters • Symbolic losses • Social revolutions • Violent conflict
Societal trauma can cause change on three different levels: • Individual • Current society • Future society, via transgenerational transmission
Psychosocial regeneration is possible if society can: • Regain basic trust • Undergo a psychosocial trauma-healing process
Trauma caused by ethnic conflict: • Psychosocial degeneration • Transgenerational transmission
Psychosocial degeneration: • Loss of basic trust • Difficulty in mourning • Sense of helplessness and humiliation • New social patterns • Destruction of the natural environment • Increased sense of large-group identity
Trans-generational transmission: • Myths and chosen traumas

4. Implementing Psychosocial Healing as a Contribution to Social Reconstruction

4.1 Introduction

This guide is intended to help practitioners of psychosocial healing to make a central contribution to social reconstruction in a post-conflict setting. Section 2 describes the context within which psychosocial healing occurs. The individual and societal trauma that must be healed is described in Section 3. Here, we discuss the implementation of psychosocial healing. This can occur in three major stages, which are articulated in Section 4.2. Methods for implementation are described in Section 4.3. Then Section 4.4 sets forth a community-based process whereby psychosocial healing can contribute to social reconstruction.

4.2 Stages of Psychosocial Healing

> "Rebuilding society implies a restoration of the people in social, psychological and spiritual ways. If these forces are not a part of the rebuilding of society at the end of war and in the post-war context, we just put the lid on a boiling cauldron that will eventually blow off because the pain, anger and fear of war were never dealt with." [8]

Trauma healing is closely related to peacebuilding efforts; both are ultimately about developing or restoring healthy human relationships. Trauma healing implies the decrease of loneliness, mood improvement, a sense of inner peace, a decrease in isolation, anger and bitterness, and a decrease in feelings of animosity and hatred toward others. This can only take place in the context of relationships. Healing cannot occur in isolation because it is necessary to heal the psychological faculties that were damaged by the trauma, and this healing can only occur in connection with other people. Healing societal trauma involves the development of support groups that employ a facilitated process to heal individuals in the context of a group.

Judith Herman discusses three stages through which patients move as they heal from a traumatic experience.[9] These stages are safety, acknowledgement, and reconnection. Herman states that, while it is not necessary or even expected that patients will move from one stage to another in a linear fashion, healing from trauma is predicated upon the patient's psychological state moving in three respects: from a feeling of unpredictable danger to one of reliable safety and security; from a sense of dissociated trauma to acknowledged memory; and from feeling isolated and stigmatized to restoring meaningful social connections.

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[8] Hart, Barrett. "Transforming conflict through trauma recovery training." In: Ajdukovic, Dean, ed. *Trauma Recovery Training: Lessons Learned*. Zagreb, Croatia: Society for Psychological Assistance, 1997, page 199.

[9] Herman (1997). *Trauma and Recovery.*

Safety

In an evaluation of psychosocial-assistance programs during and immediately after the Croatian and Bosnian wars in former Yugoslavia, it was noted that the most important benefit these programs could provide was a safe space psychologically and physically, in which people could rebuild their previous social contacts and make new contacts. The safe space was more important than any particular type of psychological intervention or therapy.[10]

Safety also refers to a feeling of safety within a group. This means that all group members will be treated with respect, that their confidences will be respected and that no one will engage in verbal or physical abuse. It also means that participants do not feel pressure to discuss matters beyond their personal comfort zone. Having the facilitator start each meeting by getting agreement among the group members on some simple ground rules can be very helpful in fostering a safe atmosphere of mutual respect. Similarly, the respect with which the facilitator treats participants sets a standard of behavior for all to uphold. Participants find that a facilitator who functions as a trusted third party, especially if she has a long-standing relationship with the group, helps to promote a sense of safety for all parties. Individually, participants want to maintain with the facilitator a relationship of mutual respect. They are aware that in order to do this they must behave in a way that is respectful of all participants.

Acknowledgement

> "Reconciliation is to understand both sides, to go to one side and describe the suffering being endured by the other side, and then to the other side, and describe the suffering being endured by the first side."
>
> Thich Nhat Hanh, Vietnamese Zen master [11]

Judith Herman states that when a survivor tells the story of her trauma, in detail and depth, this action can transform the traumatic memory so that the survivor can then integrate the memory into her life story. This stage of healing is known as acknowledgement. As with other types of psychosocial healing, acknowledgement can only occur in the context of renewed human relationships, because survivors need to recreate the psychological faculties damaged by the trauma, including trust, autonomy, initiative, competence, identity and intimacy.[12]

Looking at how groups recover from the trauma of war, one finds that the traumatic events of the past must be discussed, acknowledged, and mourned within and between communities if there is to be successful reconciliation between them. According to Joseph Montville, "Storytelling is an essential part of the process, not only for the victim

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[10] Mimica, Jadranka, and Inger Agger. "NGO perspectives: an evaluation of psychosocial projects and a retrospective." In: Ajdukovic (1997). *Trauma Recovery Training,* pages 251-259.

[11] Cited in Montville, Joseph. "The Healing Function in Political Conflict Resolution." In: Sandole, Dennis J.D. and Hugo van der Merwe, eds. *Conflict Resolution Theory and Practice: Integration and Application*. Manchester, UK: Manchester University Press, 1993, page 115.

[12] Herman (1997). *Trauma and Recovery*, page 175.

reconstructing the story, but also for the persons representing the aggressor group."[13] There is within individuals and groups a tremendous need to grieve and to mourn the losses that they have suffered themselves and that they have inflicted upon others. Acknowledgement of the past could include acknowledging the roles of bystanders, active and passive, individuals and nations, as well as the roles of victims and perpetrators.

This type of story-telling must be facilitated in a safe and carefully-structured environment, so that it does not rekindle conflict or deteriorate into a competition for the greatest "victimhood." Instead, the objective is to unify previously divided communities with a collective acknowledgement of the past.

To create the most helpful environment for the telling of personal stories, thereby promoting acknowledgement, the Health Bridges for Peace project has developed a specific facilitation process. The process begins with discussion about "constructive communication", an activity that is marked by: curiosity and interest among the parties; listening with an open mind; empathy; compassion; honesty; and humility. Then participants discuss the differences between debate -- which is a frequent but often non-productive mode of exchange between adversaries -- and dialogue.[14] Finally, participants are trained in active listening, an activity that serves two functions simultaneously. First, it allows the listener to understand and empathize with the speaker. Second, the speaker is better able to articulate what he or she is thinking and feeling.

In order to achieve the intimacy and safety required for people to tell their personal story, the HBP project has designed an active-listening exercise in which a larger group is divided into small sub-groups. Each member of a sub-group takes turns listening, facilitating and answering questions that explore different aspects of her experience as a health-care provider during war conditions. Using the questions as a jumping-off point, participants can talk about their traumatic experience and then acknowledge, grieve and mourn together. This exercise is described in some detail in Section 5.

Reconnection

Reconnection with society is described by Judith Herman as the final stage of trauma healing. A survivor of trauma finds that the beliefs that gave meaning to her life before the traumatic event have been challenged, and so she must find a new sustaining creed through which to live her life. This need is even more acute for an individual whose personality was formed in a traumatic environment. Such a person lacks experience of normal life. For any survivor, relationships have been challenged, severed or made difficult by the trauma, and it is only through rebuilding relationships or establishing new ones that the survivor is empowered and can reclaim her psychological health and social role.

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[13] Montville, Joseph, "Peace, Justice and the Burdens of History." In: Abu-Nimer, Mohammed, ed, *Reconciliation, Justice, and Coexistence: Theory and Practice.* Lanham, Maryland: Lexington Books, 2001, page 119.

[14] A useful teaching tool is "Distinguishing Debate from Dialogue," a chart produced by the Public Conversations Project of the Family Institute of Cambridge, 51 Kondazian Street, Watertown, Massachusetts 02172, USA.

Such reconnection is also crucial to reconciliation within a violence-ravaged community, where the ultimate goal is the restoration of healthy human relationships and the building of trust, hope and mutuality. The objective of reconciliation is to establish mutual respect and acceptance, with a longer-term objective of spontaneous cooperation.

Empowerment is an important by-product of reconnection. Through reconnection and the rebuilding of relationships, the survivor is empowered to reclaim her place in the world. In the work of the HBP project it has been found extremely empowering for individuals in a group to feel that their collective actions can effect societal change. Before participating in the HBP integrated-action program, many participants were embittered by the human and physical destruction they had experienced. Their work together provided new opportunities, a new vision, and a new role in their community and in the world. It demonstrated the potential of healing and collaborative action, and built bridges between colleagues who thought they could never again work together.

Experience in the Medical Network shows that people feel good when they are in productive relationships with colleagues. Engaging in cooperative actions that have the power to change the course of events feels even better. Thus, empowerment and reconnection can operate in a healthy cycle, each building on the other.

4.3 Methods for Implementing Psychosocial Healing

In conducting programs for psychosocial healing, the Medical Network has viewed safety, acknowledgement and reconnection as the three essential stages of the healing process. Network caregivers work with war-traumatized parties to help them move through these three stages, both as individuals and as members of conflict-divided communities. This work has evolved in four areas: community integration; volunteer action; training, and training of trainers; and help to helpers.

Community Integration

(For more information on community integration, see Appendix 5: **Community Integration for Psychosocial Assistance,** by Anne Marie Miorner Wagner, Paula Gutlove and Jacob Hale Russell.)

Community integration is a process to integrate vulnerable or marginalized groups — such as refugees — into a community, while strengthening the overall social fabric of that community. Resources needed for this task are found largely within the community, by identifying and developing the capabilities of its members. Integration is achieved through local-level psychosocial projects that empower members of the target groups and help them adapt to new environments.

Psychosocial projects of this kind are especially useful in helping immigrants and refugees adapt to a new culture. The challenges of adapting to a host country are typically a source of stress to these groups that is exceeded only by trauma that was experienced in their region of origin. In order to make the process of adaptation proceed smoothly, community integration promotes contact with the new environment, which might otherwise be strange

or hostile, in a way that is safe and supported. Fundamental goals of community integration are to establish a strong social network and to create strong, independent individuals who are able to function freely in their new environment.

Community-integration projects are marked by psychological planning, documentation and supervision. Wherever possible, professionals — including health workers, psychiatrists and psychologists, social workers, and teachers — should be used to design and support an approach that addresses problems of trauma, marginalization, and child and adolescent development. In addition, community-integration programs should involve individuals familiar with the cultures of both the original and host countries.

Community-level psychosocial projects can be used to support a wide range of individuals who are dealing with trauma and adapting to a new culture. In illustration, Appendix 5 describes the work of the OMEGA Health Care Center to integrate refugee women and children, two especially vulnerable groups.

Projects for children or youth attempt to fit into the normal framework of children's lives. Thus, they often feature support groups and other projects in local schools, as well as spare-time activities like artistic and athletic workshops.

Psychosocial assistance for women recognizes the traditional role that women play in supporting the family and raising children, and the difficulty that migration can create for family patterns. It is often difficult to convince women to accept help from an outside institution, because their need is often viewed as a psychological handicap. Thus, projects for women must establish a sense of safety and community. Once clients find the courage to talk and share their experience in a group setting, program activities such as workshops will seek to enable their capacities, maximize their talents in the new society, and develop skills for employment.

An advantage of focusing on support of women and children is that these groups have the ability to link community-integration projects with their own families. Men and fathers are harder to reach and less likely to seek out assistance from a psychosocial center, for fear of seeming weak. When a community-integration program helps mothers, the experiences of these women often build trust on the part of her husband and children. Similarly, outreach to children can be an enabler in providing help to an entire family. Refugees often say that they fled their country to provide a better future for their children. Thus, parents and grandparents will show gratitude towards, and develop trust in, an institution that helps their children. While no group should be excluded from a community-integration program, it may be easier to reach out to an entire community by targeting specific groups.

Volunteer Action

(For more information about volunteer action, see Appendix 6: The **Theory and Practice of Volunteer Action**, by Anica Mikus Kos, Paula Gutlove and Jacob Hale Russell.)

In the face of war, civil strife or other tragedy, ordinary citizens can demonstrate solidarity in remarkable ways. Individuals in difficult or traumatic situations frequently derive

satisfaction from helping fellow sufferers. Yet, since people will instinctively first provide for their own safety and welfare, this sort of spontaneous volunteer activity often extends only to one's own family and closest friends. Therefore, a more systematic means of providing consistent and organized volunteer aid is required. The objective is to harness the full capacity of humankind's instinct to help fellow citizens, while directing this help where it is most needed.

Volunteer action is a strategy to train and empower individuals to provide volunteer aid in post-conflict reconstruction. Selected from diverse backgrounds, volunteers collaborate with professionals to reassure victims of trauma that their plight has not gone unheard, to provide practical assistance to refugees in adapting to new environments, and to help reconcile communities during a post-conflict transition.

In post-conflict situations, volunteers can help combat the effects of poverty, unemployment, social inequities, disintegration of families, and the corruption and associated challenges that may characterize public institutions. Particularly if they are chosen from diverse backgrounds, volunteers' activity may create a sense of "togetherness" between two otherwise opposing sides, building trust and dispelling notions of segregation or antagonism.

Volunteers come from diverse backgrounds ranging from local community members to international volunteers. Their assistance to communities in need reassures victims of armed conflict — especially refugees — that their plight has not gone unheard. Volunteer actions can send a message of caring that counters the negative perceptions victims often develop in times of terror and violence. Volunteers play an invaluable role in helping refugees who have fled from zones of conflict. Moreover, volunteers can help to rebuild and reconcile communities during a post-conflict transition. Through a variety of functions — such as providing psychosocial assistance, practical aid, or education — volunteers can exert a positive influence on society and public attitudes, thereby assisting and expediting the process of social reconstruction.

In refugee communities, volunteers provide moral and psychological support, as well as practical assistance, that can help bridge the gap between refugees and the local population. They can provide a critical social network, send a message of caring and sympathy, organize leisure-time activities, conduct training and language lessons, provide practical assistance, and serve as role models in learning about an otherwise unfamiliar environment.

Children and adolescents, in particular, stand to gain from volunteers in the protection and promotion of their mental health. Because volunteers will frequently come into contact with youth and families, they can complement the services already provided by professionals in schools, foster homes, hospitals, and other institutions for children. Many countries — particularly, as discussed later, post-socialist states such as Bosnia–Herzegovina and Chechnya — lack the human resources necessary to provide adequate support and education for children living in poverty and violence. Bosnia, for instance, is home to a tremendous number of traumatized, displaced, and orphaned children. In such countries, the development of volunteer-action programs designed

primarily to benefit children can be extremely beneficial in protecting the emotional and psychosocial development of youth.

In fact, one of the most beneficial elements of volunteer action for children occurs when youths themselves serve as volunteer helpers. Youths can play a unique and important role in volunteer efforts. In addition to receiving aid themselves, they can be employed as effective volunteers to the benefit of themselves and their communities. The energy, enthusiasm and schedule availability of youths can suit them ideally for volunteer roles. Moreover, volunteer activities can be an excellent training ground for developing social responsibility, which will be an important asset to youths when they assume leadership positions later in life. Finally, volunteering may enhance their quality of life because of volunteerism's positive impact on psychosocial development. Volunteering has been shown to prevent delinquency and reduce drug abuse because it can give youths a sense of dignity, empowerment, and importance.

Training, and Training of Trainers

(For more information about trauma training see Appendix 7, **Challenges of Training for Trauma Recovery,** by Dean Ajdukovic.)

Most post-conflict societies do not have enough trained professionals to respond to the need for psychosocial healing. Even when there is a large mental-health infrastructure, the severity of the trauma combined with the large number of people involved will strain the ability of providers to give adequate assistance. Moreover, those professionals who are present generally are not experienced in large-scale trauma healing, nor are they equipped to work in a society that has experienced destruction of multiple social-support systems. Thus, training of large numbers of health professionals and lay helpers is crucial. The training process encompasses the identification, empowerment and activation of large cadres of health professionals and volunteers. This can be can be the cornerstone of a social-reconstruction program for a post-conflict society. As was demonstrated in the former Yugoslavia, development of a psychosocial-training process has numerous challenges, but also carries with it many rewards for the trainees, their clients, and the society as a whole.[15]

Before the war, many parts of former Yugoslavia had a well-developed mental health infrastructure, so it was often possible to find care providers from the affected community. This was difficult for the care providers as most were themselves traumatized, having been affected by the destruction of their countries and personal loss. They had to develop coping skills in order to continue providing effective services to the many people in need of psychological assistance. Their ability and willingness to do this was important because they understood the socio-cultural context and processes in which the traumatization was occurring. They knew which resources to search for on behalf of their clients, and became aware of the advantages and limits of available services. Above all, they had remarkable motivation to go beyond normal professional obligations.

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15 A comprehensive review and excellent analysis of the lessons of trauma-healing training in the former Yugoslavia can be found in: Ajdukovic (1997). *Trauma Recovery Training*.

The post-war situation demanded of healers new and creative skills, including but not limited to specific knowledge about trauma and how to treat it. Traditional, long-term, individual-oriented psychotherapy approaches were often inappropriate to the needs and logistics of the post-war community. It became apparent that training was needed to prepare helpers to deliver psychological services and to ensure that social-support structures were in place for sustainable societal regeneration. Many lessons were learned as training programs evolved to meet these needs.

One of the major lessons that was learned is that trauma does not happen in a social vacuum, nor does it heal apart from ongoing social processes. An approach that integrates psychological healing with social healing is required. This contrasts with the traditional medical model that focuses on treating trauma as an individual disorder. The psychosocial approach integrates healing the individual with healing the community. In this way, new opportunities were created for the development of a diversity of innovative trauma-assistance programs that sought to strengthen the remaining healthy resources in individuals, families and communities. The more local professionals learned about the essence of trauma healing, the more they appreciated the psychosocial component. The concept of psychosocial assistance was defined for the first time, and many practitioners recognized that its utility extends beyond war-related trauma. Psychosocial assistance may be the most effective way to heal post-conflict societal trauma and rebuild a society with a vastly improved quality of life.

Another lesson was that training programs were most effective when they were designed with particular attention to the needs of the trainees. An important part of this lesson was the realization that trainees' needs were constantly changing. In fact, it was discovered that criteria for the training of care-providers can never be definitively met. The more people put their training into practice, the more they identify new training needs. The training loop must, therefore, include both initial and follow-up assessment of need.

An important component of successful training efforts was the building of mutual-support networks among the trainees. Support networks have improved the mental health of the population and significantly increased the potential for peace in the region. Also important is that the professional self-esteem of many health providers in former Yugoslavia grew as they tested their new skills and knowledge in practice, and later became trainers themselves.

One final lesson was that the gains from training in the psychosocial model extend far beyond the initial focus of trauma healing, and involve positive changes within the professional community and at the societal level. Notably, building a community-based psychosocial-assistance program has typically opened the way for the growth of the non-governmental sector. This is an important spin-off effect of trauma-relief efforts, whose long-term impact upon democratization and the development of civil society will be fully appreciated only in the future. Thus, ongoing support to the professionals and para-professionals who are engaged in psychosocial healing should be viewed as an important long-term social investment. In illustration, the support that has been provided to such

care providers through the Medical Network has made a major contribution to the development of social capital across former Yugoslavia.

Help to Helpers

(For more information about help to helpers see Appendix 8, **Why Is The Mental Health Of Helpers At Risk?** by Marina Ajdukovic and Dean Ajdukovic.)

In the last decade there has been a growing awareness that providers of care to traumatized populations are themselves at great risk of stress and trauma. Care providers, or "helpers," include: professional care givers (e.g., psychologists, physicians, mental health professionals, social workers, etc.); para-professional helpers (who are not care givers by profession but who have some training in psychosocial healing); and volunteers (lay people, without training in the mental-health field, who are unpaid, part-time healing assistants). All categories of helpers are at risk. Helpers in a post-war situation are particularly vulnerable, as demonstrated in the former Yugoslavia. In the post-war period, the need for helpers in the former Yugoslavia was vast but the resources available to them were unreliable and support systems were minimal. Moreover, there was little understanding within the mental-health profession of the need to support helpers, and no experience providing the type of support they require. From this experience it has become clear that a psychosocial-healing program must recognize the risk to helpers and must build in a range of modalities to support them.

Helpers are highly vulnerable to stress for a variety of reasons. They are in direct communication with people in need of their help, people who are stressed and suffering. Their work demands empathy and caring. They may themselves be exposed to violence, destruction and loss. Often their resources, material and professional, are insufficient to meet the needs of the population they are trying to serve. All of these features are especially prominent in a post-war situation.

In Appendix 8, Ajdukovic and Ajdukovic describe three psychological consequences for helpers engaged in psychosocial healing: burnout syndrome; countertransference reactions; and indirect traumatization of helpers.

Burnout syndrome occurs when helpers become depressed, unmotivated, and discouraged. They may appear cynical or indifferent when once they were enthusiastic and motivated. One important cause of burnout is the gap between resources (material, professional and social) and expectations (personal, professional and societal). Helpers often have too much to do, too little time to do it, few vacations and little assistance.

Countertransference is the activation of strong emotions in a helper by circumstances in the helping situation. A helper can experience strong emotional reactions when she is reminded of some of her own unresolved difficulties by the experiences of the person she is trying to help. Rather than allowing the helper to better understand the people she is trying to help, these strong emotions can be an impediment to creative assistance.

Indirect traumatization occurs when helpers show the same symptoms of trauma as are manifested by the people they are trying to help. The helpers may have nightmares, depression, irritability, exhaustion, etc. Indirect traumatization can inhibit the productive, functioning of helpers.

Ajdukovic and Ajdukovic recommend three levels of assistance for helpers: training; structured support; and self help.

Ongoing training programs, as discussed earlier in Section 4.3, are essential features of a psychosocial-healing process. There should be an ongoing assessment of the training needs for care givers, and every effort should be made to provide training designed to meet these needs. Appropriate training will provide preparation for helpers, increase their professional competence, and provide a network for peer and consultative support.

Structured support should be instituted so that debriefing and supervision are integrated into the program, not scheduled as an emergency procedure or an afterthought. A regularly-scheduled debriefing/support group will help helpers to understand their experiences by discussing their feelings, fears, frustrations and successes. Supportive review from a peer or a more experienced colleague can also provide crucial help to helpers in stressed situations.

Self-help skills will give helpers an understanding of their own mental health, a sense of responsibility to take care of themselves, and tools to help them provide this care. Part of self help is learning to "read" one's own stress reactions, to learn what causes stress and how that stress is manifested. Another aspect of self-help is learning to encourage oneself when this is needed, and to set limits so that one's expectations are realistic. Relaxation techniques, including yoga, meditation and exercise provide another important aspect of self help.

Summary

The stages of psychosocial healing that are described in Section 4.2, and the methods of implementation that are articulated in Section 4.3, are summarized in Table 4.1.

**Table 4.1. Implementing Psychosocial Healing:
A Summary of Stages and Methods**

Stages of Psychosocial Healing
A Healing Relationship: • Establishment of facilitated support group or network to engage in a psychosocial healing process of integrated action
Safety: • Moving from a feeling of unpredictable danger toward one of reliable safety and security
Acknowledgement: • Moving from a sense of dissociated trauma to acknowledged memory
Reconnection: • Moving from feeling isolated, helpless and stigmatized to restoring meaningful social connections and empowerment
Methods for Implementing Psychosocial Healing
Community integration: • Reconstruction of the social infrastructure of society by integration of vulnerable groups
Volunteer action: • Training and empowerment of individuals to engage in unpaid public service and social reconstruction.
Training, and training of trainers: • Identification, empowerment and activation of large cadres of health professionals and volunteers through capacity-building processes designed to meet assessed needs
Help to helpers: • Assistance to professional and lay people who are working to help others in distress and who themselves suffer stress, burnout, and/or indirect trauma

4.4 A Community-Based Process of Psychosocial Healing

The preceding parts of Section 4 have described the stages of psychosocial healing and the methods that have evolved to implement this healing. Now, we discuss the development of a process whereby these methods are applied to psychosocial healing in a particular community setting. That setting could vary in scale from a small village or a group of refugees up to a province or even an entire country. However, if the setting were large the process would be initiated in selected locations and expanded incrementally. In any setting the process would proceed through successive cycles that reach progressively larger numbers of people, as explained below.

Each community setting will have some unique features, requiring the development of a psychosocial-healing process that is appropriate for the setting. Nevertheless, there will be many common features between settings, and many transferable lessons. Learning from experience will always be crucial, whether the experience is gained locally or in other settings.

General Lessons from the Experience of the Medical Network

The Medical Network's experience with psychosocial-support programs for social reconstruction provides general lessons that can be useful in other post-conflict situations, as follows:

• A program should be guided by a broadly-representative group of indigenous personnel. Only local people can identify the crucial health needs of their communities. Moreover, important resources for understanding and transforming conflict can be found within the culture from which the conflict has emerged.

• International assistance is best offered in the spirit of partnership rather than patronage. Only those international professionals who come to a post-conflict situation with cultural sensitivity and a willingness to learn will be truly welcome and effective.

• Healing trauma can be an essential aspect of social reconstruction, but is often overlooked. Trauma does not occur in a vacuum, nor does it heal apart from ongoing social processes. Therefore, trauma must not be treated only as an individual disorder but one that requires a psychosocial approach. Moreover, community-based psychosocial support can provide the foundation for social reconstruction, while promoting the growth of the NGO sector and improving the quality of life.[16]

• The greater the ownership local groups have of any program, the greater is the likelihood that they will find ways to use and sustain it.

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16 Ajdukovic, Dean. "Challenges of Training for Trauma Recovery." In: Ajdukovic (1997). *Trauma Recovery Training*.

• In order for a program to have long-term impact, it must be embedded in a structure that has the potential for long-term sustainability. Thus, the development of local NGOs can be crucial to the success of a program.

• Setting up channels for ongoing communication and information exchange among a range of parties is essential, and may be one of the most important roles of the international community in the social-reconstruction process. Acts of communication and information exchange have symbolic value, acknowledging the gains in trust and human connection that a program achieves, and practical value, allowing lessons to be learned and put to use.

• A social-reconstruction program is not sustainable or maximally effective unless it establishes links with other actors. In illustration, the Medical Network was able to grow and gain stability by maintaining communication links with, and developing cooperative projects with, a range of humanitarian and development agencies and NGOs.

• A social-reconstruction program in one sector (e.g., health) is not sustainable or maximally effective unless it actively seeks synergy with other sectors, including water and sanitation, education and internal security.

• Ongoing program evaluation and willingness to change goals and methods in response to the findings (i.e., a structured-learning approach) are essential to the efficiency and sustainability of any program. Also, a program must be able to adapt to a changing political landscape.

• It is most efficient and effective to utilize and build upon existing initiatives whenever possible.

• Experience of NGOs and inter-governmental agencies demonstrates that integrated-action programs in the health sector and other sectors can function even in difficult times and under unstable conditions. However, some minimum level of stability, security and external support is required for any program.

Structured Learning

A method is needed for capturing and implementing the lessons learned from experience with psychosocial-healing programs. An appropriate method is structured learning, which is an ongoing process of monitoring, assessment and adaptation. It involves a cycle of planning, evaluating, learning and responding to an evolving situation. The cycle consists of the following sequence of actions:

- Formulate objectives and timeline
- Formulate evaluation criteria
- Apply the evaluation criteria
- Adjust implementation
- Repeat the learning cycle

As applied to a psychosocial-healing project, structured learning is an ongoing collaborative approach to evaluation, in which objectives and evaluation criteria are developed jointly among the project's major stakeholders. These criteria are applied at predetermined intervals and the implementation of the project is adjusted in light of its performance in the prior period.

The guiding principle of structured learning is that evaluation should not occur only after completion of a project, but at intervals during the life of the project, so that the findings from the evaluation can guide the project's implementation. Structured learning can be a valuable mode of evaluation for many types of projects, but it is particularly useful when operating in uncertain, changing circumstances.

A Process of Expanding Cycles

The Medical Network's experience demonstrates that psychosocial healing can contribute significantly to social reconstruction. In the former Yugoslavia, Medical Network psychosocial-support programs have incorporated an estimated 4,000 volunteers over a three-year period, bringing together Serb, Muslim, Bosnian, Kosovar and Croat participants for a wide range of social-reconstruction projects.

In a post-conflict community, the process begins with initial training and ongoing support provided by a partnership of indigenous and external actors. Then, psychosocial support develops through a series of steps, in a cycle that begins with training in trauma healing and psychosocial assistance, and ends with the training of additional trainers. Each repetition of the cycle reaches a larger number of people, until a broad and varied community is engaged in social-reconstruction activities. These activities vary depending on the needs of the community and the capacities within it, and can include: planting gardens; repairing public buildings; hospital or school assistance; restoring public spaces; day-care assistance; assistance to the elderly; and suicide hotlines. Figure 4.1 illustrates this process, showing how its scope can expand through successive cycles of activity.

During this process the community acquires knowledge and capacity, is increasingly able to meet its own social and psychological needs, becomes progressively less reliant on external support, and can eventually contribute to meeting the needs of other, less fortunate communities. There is also a substantial "spillover effect" as the psychosocial-support program expands its reach to include, for example, school personnel, police, religious leaders, local businesses and local politicians in an array of new community programs staffed largely by supervised volunteers. Programs of this kind can directly rebuild a violence-ravaged community through assisting in repatriation of refugees, reintegration of former combatants and the reconciliation of divided communities.[17]

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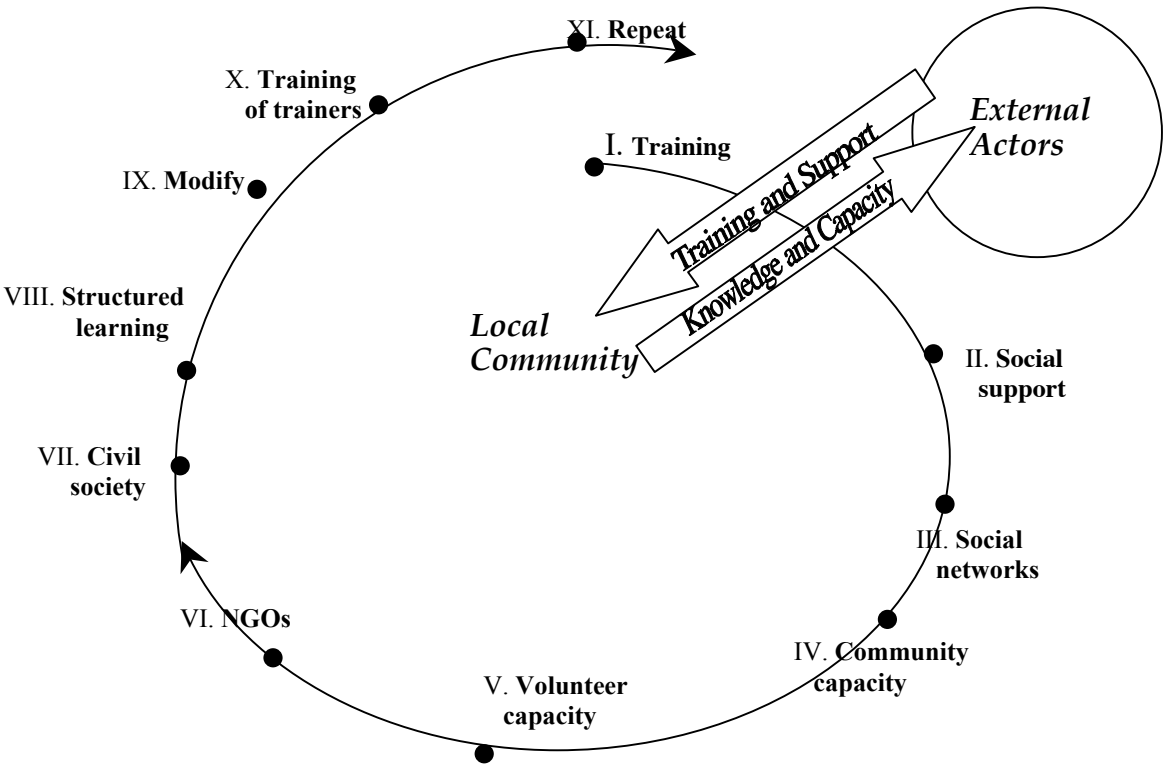
17 OMEGA Health Care Center and Society for Victims of Organized Violence and Human Rights Violation. *European Guidelines on Empowerment and Integration Programs for Refugee Children and Adolescents*. Graz, Austria: Omega Health Care Center, 2000.

Figure 4.1. A Community-Based Process of Psychosocial Healing

I. Provide training in trauma healing and psychosocial assistance
II. Identify existing social support capacity within the community
III. Strengthen existing social networks
IV. Develop community capacity for psychosocial support
V. Develop volunteer capacity for psychosocial support
VI. Develop local organizations (NGOs)
VII. Develop civil society
VIII. Engage in structured learning
IX. Modify goals and methods according to lessons learned
X. Provide training of trainers and help to helpers
XI. Repeat cycle and extend program to larger community



Goals for Social Reconstruction

- gradually rebuild human interactions that allow a society to function
- meet the immediate psychosocial needs of a violence-ravaged society
- promote community reconciliation, a process involving:
  - the restoration of trust and hope,
  - a rise in cooperative behavior, and
  - development of shared values and expectations

5.Tools For Psychosocial Healing

5.1 Introduction

This section describes selected tools for use in psychosocial healing within an integrated-action context. These selected descriptions are intended to give the practitioner a sense of the kinds of tools that could be used in a psychosocial-healing process. First, we describe the development of a facilitated network to engage in integrated action. Such a network provides a context in which to use the tools described here. Then, we describe tools for addressing issues of safety, acknowledgement and reconnection. These descriptions include information about group processes, practice exercises, simulations and role-plays.

No single psychosocial-healing program will be universally applicable across circumstances, sectors or cultures. Instead, each field project must be developed in partnership with the local participants. The tools provided here are a sample of the types of work that can be done, and should be seen as a glimpse into the wide vista of potential activities that can be created to respond to the needs and capacities of local participants.

We have found that for some activities, especially those dealing with safety and storytelling, it is recommended that trained psychological assistance is available, either on call or for referral. This is particularly important when working with a group that may have participants for whom it is determined that individual attention may be required.

5.2 Establishing a Facilitated Integrated-Action Network

The integrated-action approach starts with a diverse group of people who share a common goal and are interested in working together to achieve that goal. In the Health Bridges for Peace project the common goal is always a humanitarian action related to public health. The common goal provides an incentive for people to come together and a basis for them to continue working together in spite of social or political deterrents. As people work together they create a context for developing and implementing a psychosocial-healing process that can be applied on many levels, promoting social reconstruction among ever-larger groups or networks. The first circle of affected people encompasses the providers of the public-health action, the second circle encompasses people directly affected by this action, and the third circle encompasses the surrounding community. Other, wider circles can be reached by replication of the process in other locations.

We use the term “network” to indicate that members of a group comprise a web, or a net, that makes connections across different sectors. In illustration, the Medical Network’s Contact Group, consisting of representatives from 12 geographically and ethnically diverse areas within former Yugoslavia, has become a highly-successful integrated-action network. Through a process of facilitated dialogue, the Contact Group decides upon and then implements a range of integrated-action programs. To identify opportunities for action, the Contact Group engages in a dialogue about needs and available resources, in which participants discuss the public-health needs in their communities and offer to contribute

resources that might fill needs in other communities. These resources mostly take the form of expertise, but can also be material resources such as supplies or books. Increasingly, participant offer to collaborate on joint projects, and to jointly pursue joint funding opportunities.

Roles and Functions of a Facilitator

Productive communication within a network is fostered by careful facilitation by a third party. The facilitator seeks to create a safe space and to lead a process in which new information about the interests, needs and capabilities of all members of the group can be expressed and heard. In this process, complexities are explored, participants listen in order to understand each other, and issues are looked at from new perspectives.

When network participants meet, the facilitator will strive to: help the group to agree upon procedures to follow; maintain a focus on the agenda; and create an atmosphere in which the participants feel they can express their points of view, their needs and their concerns. The facilitator creates this kind of atmosphere by paying careful attention to the following six points:

1. The facilitator is responsible for the logistics of the meeting. The facilitator does not necessarily handle personally all the logistics of the meeting, but does need to ensure that they have been handled. This includes such things as ensuring that the meeting places and times are agreed upon by the parties involved, that the meeting space is arranged, that translation is provided, that minutes are taken, etc. The facilitator may also work with the group to clarify the purpose and goals of the meeting, including what type of meeting the group wants, how large it should be, and who should be there.

2. The facilitator acts as a moderator to promote effective communication among the parties. In her role as moderator, the facilitator may clarify, rephrase, reformulate, and reframe the dialogue, but will not offer his/her own opinion. The facilitator's interventions should help the participants to express their ideas, interests, concerns, and emotions. Frequently, the facilitator's interventions are in the form of questions designed to enhance communication and understanding. Examples of such 'open' questions are: "Could you explain the ideas that have just been stated?" or "Could you please tell us again what you are really concerned about here?" Such questions are in contrast to 'closed' questions, such as yes-or-no questions that can polarize parties and cut off discussion (e.g., "Are you for or against repatriation?").

3. The facilitator avoids bias. A facilitator must work to avoid showing bias. This requires the facilitator to pay respectful attention to all the beliefs expressed by the group. When a facilitator listens to all parties with care and empathy, she not only earns trust, but models behavior that contributes to effective dialogue and creative problem solving. The participants' trust can be undermined if a facilitator shows bias. This does not mean that if the facilitator has an opinion on the content of the meeting he cannot be a facilitator. No one is unbiased. However, the facilitator must be able to put aside personal thoughts and feelings about the content of the meeting when acting as the facilitator. If an individual feels unable to do this, then that person should not

offer to facilitate. The facilitator must guide the process of the meeting without contributing her own opinions, otherwise, she can lose credibility as an unbiased third party, or worse, be drawn into power struggles with participants.

4. The facilitator works with the group to set ground rules and agreements for the process of a meeting. The facilitator works with the group to reach agreement about how a meeting will proceed, creating a framework for the group's interactions. Subjects requiring agreement usually include ground rules to provide a structure within which participants feel safe while interacting. Some potential process-oriented ground rules include:

    - Maintain confidentiality
    - Ensure voluntary participation
    - Use respectful language
    - No interruptions of others who are speaking
    - Speak from personal experience
    - Avoid making attributions to people outside the room

    The facilitator must make it clear that the group's agreements are taken seriously. If a change in the ground rules or format appears appropriate as a meeting progresses, the facilitator should suggest and get agreement on such change, rather than simply allowing the change to occur.

5. The facilitator points out for the group when old patterns are being broken. A meeting that allows participants to express their needs, concerns and interests, when they are not accustomed to such communication, will need to break with some old patterns of interaction. A facilitator can help a group make the transition from stalemated to effective communication by highlighting and encouraging these departures from old, ineffective patterns of interaction.

6. The facilitator must incorporate some support for him/herself. It is hard work to facilitate communication between parties who have been divided by conflict. Facilitators should try to work with a team when possible, and use members of the team for observation, feedback, assistance, and relief. In setting the agenda for a meeting, the facilitator should try to think about the needs of the facilitation team in addition to the needs of the group.

These points are summarized in Table 5.1.

Table 5.1 Roles and Functions of the Facilitator

The facilitator is responsible for the logistics of the meeting
The facilitator acts as a moderator to promote effective communication among the parties
The facilitator maintains a neutral role and avoids bias
The facilitator works with the group to set ground rules and agreements for the process of a meeting
The facilitator points out for the group when old patterns are being broken
The facilitator must incorporate some support for him/herself

5.3 Safety Tools

A safety exercise is described here, whose purpose is to allow participants engaged in an ongoing group process to explore the concept of safety both in the context of their own lives and in the context of the group process. It can used as a training exercise when training practitioners who will be engaging in integrated action. Note that there are two alternative sets of questions to use in this exercise. The facilitator will need to decide, based on the needs and capacities of the group, which set of questions to use. This exercise works best with a group of 12 to 30 people. Allow a minimum of 2 hours for a smaller group and 3 hours for a larger group.

Instructions for the facilitator(s) are as follows:

1. Visualizing safety (5 minutes)
   Ask the group to consider the words "safety" and "security." Ask them to consider what these words mean to them personally. Give them five minutes to spend in silent meditation.

2. Writing an anonymous letter (20 minutes)
   Distribute blank paper and envelopes and ask the participants to write, individually, an anonymous letter addressing the following questions:
   - What does "safety" mean to you?
   - What does "security" mean?
   - If they are different, how so?
   - What do you need (in general terms) to feel safe and secure?
   - What do you need in the context of this group to feel safe and secure?
   - What can you do to help others feel safe and secure in the context of this group?

   Invite each participant to seal her letter in the envelope provided.
   Invite participants to put their anonymous letters into a hat and inform them that at the end of the exercise they will have an opportunity to pick a random letter out of the hat.

3. Discussing situations of safety (60 –90 minutes)

   Divide the group into sub-groups of three to four people.
   Pose the first set of discussion questions. Allow 4 minutes of silence for people to contemplate their answers. They can make notes if they wish. Then each person will be asked to speak for 3-5 minutes while the others listen. After each question/discussion the members of the group can rotate into other sub-groups to allow maximum interaction within the larger group.

   The facilitator should use his discretion in deciding on the discussion questions. If the participants in the group are relatively new to each other and the external situation has not been stable, then the questions for the small group discussion should repeat those of the anonymous letter:

- What does "safety" mean to you?
- What does "security" mean?
- If they are different, how so?
- What do you need (in general terms) to feel safe and secure?
- What do you need in the context of this group to feel safe and secure?
- What can you do to help others feel safe and secure in the context of this group?

Alternatively, if the group has been together for some time and has participated in psychosocial-healing processes, a more advanced set of questions can be explored. These questions move from the realm of safety to story-telling. (A story-telling exercise is provided in Section 5.4 below.) Also, a group that has gone through this exercise using the first set of questions may choose to repeat the exercise using a second set of questions, as follows:

- Describe a situation in which you felt safe and secure. What happened? How did you feel? What did you do?
- Describe a situation in which you did not feel safe and/or secure. What happened? How did you feel? What did you do?
- Describe a situation in which you feel you made other people feel unsafe or insecure. What happened? How did you feel? What did you do?
- Describe a situation in which you feel you made other people feel safe or secure

4. Silent reading of the anonymous letters (5 minutes)
   Participants can select a letter out of the hat and read it in silence before the debriefing.

5. Debriefing (30- 60 minutes)
   This is an opportunity for the full group to discuss safety and security. Some questions to pose to the group include:
   - What was easy?
   - What was hard?
   - What new information surfaced for you about safety and security?
   - Identify any safety concerns that might be relevant to the group.
   - Is there anything that the group wants to consider doing (e.g., change the ground rules, have further discussion) in acknowledgement of these concerns?

5.4 Acknowledgement Tools

The Need to Listen and to be Heard

If relationships within a conflict-ravaged community are to be rebuilt, the traumas of the past must be acknowledged. There is within individuals and groups a tremendous need to tell their story, to have their story acknowledged, and to grieve and mourn the losses that they have suffered themselves and that they have inflicted upon others. For people who suffer loss or trauma, telling stories of their experiences helps them make sense of the past, restores a sense of identity, and makes it possible to create a future. Furthermore, being

listened to reduces each individual's sense of being alone with her thoughts and feelings. Thus, people gain a sense that others are with them.

Many organizations in the former Yugoslavia are working with people to help them to tell their stories. Psychosocial specialists do this to help people heal from the trauma of violence. In many cases this means creating a safe "talking space" where people can tell their stories while feeling that they are heard and understood. In an exhaustive evaluation of psychosocial NGO projects executed in the former Yugoslavia during the period 1993-1997 it was determined that establishing a safe place for communication, caring and empathic exchange was more important than the specific therapeutic treatment that was executed.[18] Being able to tell their stories and make social connections was therapeutic for individuals and benefited the wider community.

Telling stories of the past should be facilitated in a safe and carefully-structured environment so that it does not rekindle conflict but unifies divided communities through a collective acknowledgement of the past. This is sometimes done through a process of constructive communication facilitated by a third party. The facilitated communication may begin by teaching parties how to "actively listen" to each other, a process which allows the listener to understand and empathize with the speaker, while also allowing the speaker to achieve a clearer idea of what he or she is thinking and feeling.

Active Listening

Active listening is a particular type of listening skill.[19] It is a mindful skill that improves with practice. It asks the listener to seek the total message, including content and feelings, from the words and body language of the speaker. The listener has a responsibility to actively grasp the facts and feelings that she is hearing, and to help the speaker to better understand her own thinking. The "active listener" acknowledges the speaker's words and sentiments, shows empathy and demonstrates a desire to help.

Active listening can bring about changes in people's attitudes towards themselves and others. It can help to bring about changes in basic values and personal philosophy in both the speaker and the listener. People who have been listened to with sensitivity tend to listen to themselves with more care, and then work harder to make clear exactly what they are thinking and feeling. Through active listening, the speaker will learn that the listener is interested in him as a person, and in what he thinks and feels is important. Through active listening, the listener conveys the message: " I respect your thoughts even if I may not agree with them. I know they are valid for you. I am not trying to evaluate or change you. I want to understand you."

For the listener, active listening requires an honest interest in the thoughts and feelings of the speaker. This sincere interest can only be developed by being willing to risk seeing the

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18 Agger, Inger, presentation at a meeting of the Medical Network for Social Reconstruction, Bled, Slovenia, 22 November 1997.

19 Rogers, Carl R. and R.E. Farson. *Active Listening.* Chicago, Illinois: University of Chicago, Industrial Relations Center, 1957.

world from the speaker's point of view. This act has the potential to change the listener, because in order to sense deeply the feelings of another person, to understand the meaning his experiences have for him, to see the world as he sees it, the listener's own basic attitudes may have to change.

When active listening is used within a group, the group's members tend to become less argumentative, more ready to work collaboratively, and more understanding of the diversity of opinions and views amongst them. Because active listening reduces the threat of having one's ideas criticized, the group members are better able to present their ideas and more likely to feel their contribution will be both respected and worthwhile. When group members see that individuals are being listened to with concern and sensitivity, they feel more secure in the group. They feel that they can contribute more freely and spontaneously to the group. Within a group, over time and with practice, listening will become reciprocated. Just as anger is met with anger, and argument with argument, so listening will be met with listening.

How to Engage in an Active-Listening Process

Participants in an active-listening process should be aware of eight points as follows:

1. Active listening is an acquired skill that improves with practice.

2. The setting must be safe enough to allow both speaker and listener to incorporate new experiences and new values. There must be a climate that is not critical evaluative or moralizing, but is instead characterized by equality and freedom, permissiveness and understanding, acceptance and warmth. The foundation for such a setting can be laid down by getting agreement among the parties on a set of ground rules, and by appointing an outside facilitator to ensure that the ground rules are respected and to assist the speaker and the listener in their tasks.

3. A listener should try to capture the total meaning of the speaker's message. Messages usually have two components, the content of the message and the feelings or attitudes underlying this content. To be sensitive to the underlying feelings, the listener must try to note all cues. This includes verbal cues, such as what words are stressed or mumbled, and nonverbal cues, such as facial expression, body posture, eye movements, and breathing.

4. A listener should avoid responding to questions that are really demands for a decision, evaluation or judgement. Instead, the listener should try to reframe the question so that the speaker must thoughtfully answer it himself. In illustration:
   Speaker: "Don't you think they could have given me better supplies to work with?
   Listener: "Do you feel they could have given you better supplies?"
   (Instead of "Well they were probably doing the best they could," or, "of course they should have given you X and Y.")

5. The listener's own emotions can be a barrier to active listening. The more involved the listener is in a situation, the harder it is for that person to put aside his own feelings and

listen to the feelings of the speaker. The more the listener's own needs come up, the less able the listener is to respond to the needs of the speaker. The listener should try to sense when he is feeling defensive, resentful, threatened or hostile. The more the listener can differentiate his own needs from the needs of the speaker, and can focus on the speaker's needs, the better able he will be to hear and understand the feelings of the speaker. In a group where active listening is an accepted mode of interaction, where listening promotes listening, it will be possible for the listener and speaker to change roles, so that each person has the opportunity to express his needs, thoughts and feelings, with the knowledge that his message will be heard with respect, sensitivity and understanding.

6. Speakers need to be encouraged by the listener that they are being heard. The way the listener sits and his body language are important indications of his attention. The listener must be truly attentive, empowering the speaker by being fully present with empathy and openness. The most important aspect of good listening is the genuine desire of the listener to understand and support the speaker in articulating what he/she has to say. If the listener is not interested, the speaker will know this. The listener can encourage the speaker nonverbally through eye contact and facial expressions.

7. The listener can encourage the speaker by asking simple questions that prompt the speaker to continue with her story. Typical questions might be: "What happened next? What did you do? Would you like to tell me more?"

8. The listener can verify his understand by reflecting and reframing what the speaker has said. When the listener wants to verify that he has understood what the speaker has told him, he can do so by reflecting back what the speaker has said. This reflection can consist of the listener simply repeating what was said in the speaker's words. However, in situations that are emotionally charged and/or where the potential for misunderstanding is great, it is more effective if the speaker can reframe in his own words the total message (words and actions) that the speaker is conveying. In complex situations it is safest for the listener to assume he hasn't understood the speaker until he can communicate this understanding back to the speaker to the latter’s satisfaction.

These points are summarized in Table 5.2.

Table 5.2 Key Elements of Active Listening

Active Listening is a skill that improves with practice
Good communication demands a safe setting
Seek the total message, content and feelings
Do not offer your own opinions (even when asked)
Differentiate your own feelings from those of the speaker
Display attention, empathy and interest
Ask simple questions
Use reflecting and reframing to achieve understanding

A Story-Telling Exercise

A story-telling exercise was designed for Health Bridges for Peace project participants, to give health providers in a difficult post-conflict setting an opportunity to tell their stories. Effort was made to frame the conversation within the parameters of a common concern for public health. This exercise can be adapted to other contexts as needed.

Experience shows that the effectiveness of storytelling depends on the preparation of the group to listen and the skill of the facilitator to maintain a context of safety for the participants. The broader the questions that are asked, the more the group will depend on the leadership of a trusted facilitator and a feeling of safety within which to work. Key features of the exercise are as follows:

1. Ground rules

   Ground rules serve the purpose of defining how the group will conduct itself during the listening session. These rules may alleviate some anxieties among participants, especially if they come from groups that are engaged in conflict. Some possible ground rules include:

   - Listen respectfully to each other
   - Don't interrupt when someone is speaking
   - You may disagree with the substance of what someone is saying, but no personal verbal attacks are permitted
   - Begin and end each session on time, and all participants are to observe the time constraints
   - Speak from personal experience
   - Avoid making attributions to people outside the room

   Other ground rules can be added or substituted to meet the needs of the particular group and the conditions under which it is working.

2. Format

   The group is split into sub-groups of three people each. In the sub-groups each person will have a turn to be the listener, the speaker and the observer (or facilitator). A question is posed, and the first speaker has 5 minutes to speak. Then the roles rotate and the next speaker addresses that question for 5 minutes. The roles rotate one last time and the third speaker addresses the question. After each person has had an opportunity to be a speaker, a listener and a facilitator, the sub-group members will have 15 minutes to discuss the stories they have heard and reflect on the experience. The sub-group then disbands and a new sub-group of three people forms for the second question. The process is repeated for the second question. The sub-group again disbands and a new sub-group forms for the third question. The process is repeated for the third question.

After the third question the participants return to a plenary for discussion and reflection. The total time required depends upon the size of the group and the number of questions addressed. For a group of 18 people addressing 3 questions, one should allow at least 2 hours.

3. Questions for sub-group discussion

Sample questions:

- What are some of the greatest obstacles you faced as a health-care provider during the last 7 years?
- Describe something you did in the past that you wish you would have done differently. What was it, what were your alternatives, what do you wish you had done instead?
- Describe something you did in the past that you are proud of, what was it?

Additional or alternative questions:

- How did you maintain your commitment to the health-care profession in the face of the conditions under which you were forced to work?
- How did you maintain your self-respect as a professional in spite of the obstacles you had to overcome?

4. Debriefing

After discussion in the sub-groups, the participants return to a plenary and discuss the exercise. Depending upon the size of the group this could take 30 minutes to one hour. Some questions for reflection by the group could include:

(a) Reflect on the process of the workshop:
- How did it feel to tell your story?
- How did the listener respond?
- How did it feel to be the listener?
- How did it feel to be the facilitator?
- Overall, what worked, what did not work, what should be done differently and why?

(b) Reflect on the substance of the stories that were told:
- What have you learned from each other about events?
- What have you learned about how people were affected by events?
- Have you learned anything that you were not expecting to learn?

5.4 Reconnection Tools

During the reconnection stage of psychosocial healing, the survivor mourns the old self, the old life, the old values, and the old relationships that the trauma destroyed, and looks to the future to establish a new life with new relationships and new beliefs. It is only through rebuilding relationships or establishing new ones that the survivor is empowered and can reclaim her psychological health and social role. Judith Herman refers to this stage as follows: "Survivors whose personality has been shaped in the traumatic environment often feel at this stage of recovery as though they are refugees entering a new country."[20] For refugees this is true both figuratively and literally. In this stage, survivors move from feelings of helplessness and isolation to feelings of empowerment and reconnection.

A Simulation for Demonstrating Reconnection

A simulation has been developed to demonstrate the potential for facilitated reconnection of traumatized people. This simulation is based on a true story of interactions among war refugees in former Yugoslavia.[21] Some participants role-play the refugees and others the facilitators who have been asked to help them. The objective is to demonstrate the role of the facilitator and the survivor in moving through stages of safety, storytelling, apology, mourning and forgiveness to achieve empowerment and reconnection. The role-play is a teaching tool to demonstrate both how healing can be facilitated and the importance of healing in a social context.

A review of the stages of psychosocial healing and the role of a facilitator should be presented before the role play begins.

Roles:	Sonja	
	Vesna	
	Facilitator #1 (Jan)	
	Facilitator #2 (Tanja)	
Timing:	Instructions	- 10 min.
	Reading material	- 15 min.
	Small group meetings	- 60 min.
	Debriefing	- 45 min.

The simulation is run as follows:

1. Divide the group into sub-groups of four people, giving each sub-group a number to identify itself. Assign one person in each sub-group to be Sonja, one to be Vesna, and two to be facilitators. Instruct the facilitators that they can work as a team

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20 Herman (1997). *Trauma and Recovery,* page 196.

21 Based on a simulation in: Babbitt, Gutlove and Jones. *Handbook of Basic Conflict Resolution Skills*. Cambridge, Massachusetts: The Balkans Peace Project, 1994.

serving both parties together, or one can serve one party and the other can serve the other party. You may want to think ahead of time about the composition of the groups, making sure that men and women are evenly distributed and that people from the same organization or place are in different groups. You may also want to assign the facilitator role to people who have experience working with groups or whom you think may have good intuition about how to work as a facilitator.

2. Pass out the scenario information and the role-specific instructions, which are provided below. Give everyone 15 minutes to read the material. Briefly review the scenario for everyone and ask if there are any questions about the scenario. Explain that the role-specific instructions are confidential and that participants should not share them directly with others in their group. If participants have questions about the role-specific instructions, they should ask the trainers.

3. Begin the sub-group meetings, reminding everyone that they have 60 minutes to work within their sub-group. At the end of that time, all of the sub-groups return to a plenary session for debriefing. Remind the sub-groups that the facilitators can work cooperatively or separately as they choose.

The debriefing occurs as follows:

1. Ask the sub-groups if they felt they achieved reconnection between Sonja and Vesna, or not.

2. Begin with the sub-groups that achieved reconnection. Ask the facilitators in each of these sub-groups to briefly describe what happened. Ask the participants if they agree with the facilitators' description.

3. In the sub-groups that achieved reconnection, ask the facilitators and the parties what they think contributed to their success. What stages of healing did facilitators and participants address and how? When and how did the parties come together? What made it possible to achieve reconnection?

4. Ask the facilitators in the sub-groups that did not achieve reconnection to briefly describe what happened. Ask the participants in these sub-groups to comment also and describe their experience.

5. In the sub-groups that did not achieved reconnection, ask the facilitators and the parties what stage of healing they did achieve. Sometimes group argue that the time was not right for reconnection because, in their group, more work was needed to achieve safety or more work and more time was needed to address mourning before forgiveness was possible. Discuss how to make space for participants to address these needs productively.

6. Ask the facilitators what they thought was most difficult for them. Is there anything that they would do differently the next time?

7. Ask the participants to describe anything the facilitators did that they didn't like. Ask the participants to describe the most effective interventions by the facilitators.

RECONNECTION SIMULATION
[Scenario Information to be distributed to all participants]

Vesna and Sonja came at the same time to the camp in Ljubljana from Srebrenica and live next door to each other. In fact, Vesna often stays late in Sonja's room and sometimes sleeps there. Sonja never had problems with her child care, as Vesna was always there and happy to watch her two daughters.

The conflict happened several days ago when Vesna heard from another neighbor that she saw Sonja's husband's name on the list of residents killed in Srebrenica. Since that information was not confirmed and was not common knowledge, Vesna decided not to say anything to Sonja until it was confirmed by ham radio operators from Srebrenica.

In the meantime, some other women who saw the list went to Sonja and told her the news. It was a great shock to her, and it never occurred to her that it might not be true. She accepted it as final, and lost with it any hope that she would someday return to Srebrenica. The shock was even greater when she discovered that Vesna had this information all along. And it was worse because they had spent the last two days together.

So Sonja stopped talking to Vesna. Vesna was in a dilemma—how could she resolve this misunderstanding? Sonja had withdrawn and was not willing to work through her feelings with anyone. Vesna had, in her anger, quarreled with the women who had behaved so foolishly in running to Sonja to tell her about her husband, even though she knew that it was no solution to sink into further conflict with these women. She knew that she and Sonja had to repair and save their friendship themselves. In fact, Sonja needed her now more than ever.

The status of Sonja's husband is still not known, although some time has passed since the first word. But now, Sonja understands that it is unconfirmed. She says she doesn't know if it is easier because her hope has returned or whether she feels numb and doesn't know what to hope for.

Sonja is getting more and more withdrawn and quiet, spending most of her time with her children or by herself.

Vesna has approached one of the volunteers at the camp, who knows her and also knows Sonja, to see if she can help to mend their friendship.

RECONNECTION SIMULATION
[Confidential Instructions for Facilitator #1, Jan]

You are a volunteer in the refugee camp, where you have been working primarily in resource distribution and management for about two months. You have gotten to know Vesna quite well and know she has been a close friend of Sonja. Recently, you heard about an angry confrontation between Sonja and Vesna, in which Sonja accused Vesna of betraying her and lying to her. The whole camp knows of this and some of the women have been taking Vesna's side in the quarrel. You're not sure what has happened, but you have seen Sonja become more and more withdrawn from everyone. You are acquainted with Tanja, another volunteer who works in the health sector, whom Vesna tells you has been supportive of Sonja.

Vesna has talked with you briefly about whether you would help her mend the friendship. You have not done this before, but want to be helpful if you can.

RECONNECTION SIMULATION
[Confidential Instructions for Facilitator #2, Tanya]

You are a nurse from Ljubljana who has who has been working as a volunteer in the camp clinic for about six months. You have gotten to know Sonja because she has brought her young children into the clinic quite often. Vesna has come in often with Sonja, and you are aware of the important role that Vesna has played in Sonja's life at the camp. Recently, you heard about an angry confrontation between Sonja and Vesna, in which Sonja accused Vesna of betraying her and lying to her. The whole camp knows of this and some of the women have been taking Vesna's side in the quarrel. You're not sure what has happened, but you have seen Sonja become more and more withdrawn from everyone. You are acquainted with Jan, another volunteer who works at the camp, and know that Jan knows Vesna quite well.

Sonja has talked with you briefly saying she feels helpless and alone. You are concerned that she may not be able to take care of herself or her two young children outside a larger social network. You want to be helpful if you can.

RECONNECTION SIMULATION
Confidential Instructions for Vesna

You are in your late 20s, not married and without children. You came to the camp from Srebrenica some months ago, with your older sister. She has two children, and her husband is away working in Germany. Your older brother is there also. Sonja is your closest friend, or used to be. You went to school together back before the camp, and you think of her and her children as family.

When you heard from the other women that Sonja's husband was possibly dead, you wanted to protect her from the news, because it was just a rumor and not confirmed. The women like to gossip, and you didn't want Sonja to be hurt. Now you are hurt because she thinks you have lied to her. How could she feel this way? What have you done except try and protect her?

She confronted you in an angry way about this, and was more aggressive than you have ever seen her. Everyone knows that this happened, and some of the women have come to you with sympathy for the way Sonja has treated you.

You want to be friends again, but are not sure it is possible. You have talked with one of the volunteers to see if s/he can help. Sonja will not even speak to you, and it is very painful.

RECONNECTION SIMULATION
Confidential Instructions for Sonja

You are 28 years old, with two daughters aged 2 years and 6 months, respectively. The youngest was born here in the camp in Ljubljana. You are well educated, and you like to write stories and poems. You came here from Srebrenica with many others, including Vesna. You and she have been friends for a long time, even before the camp, and you used to think of Vesna as a sister. In fact, you even thought that, if something happened to your husband, you could depend on Vesna to be there with you and start to build a new life with you and your children.

But now you feel hurt and betrayed by Vesna. She knew about the rumors of your husband's death, and she kept it from you. She has been spending more time these last weeks with the other women in the camp, and you are sure she has decided to be friends with them and not with you. Vesna is not married and so enjoys going out with the other women to socialize. You can't do that because you have to take care of your children. She is deserting you to spend time with the others, and you feel abandoned and alone.

You used to be a very happy person, laughing a lot and eager to talk with others, although Vesna has been your only real friend. Now you don't want to be with anyone, especially Vesna. She has betrayed you, and you are not sure you can ever trust her again. You don't think you can be friends with her after this.

You've told Vesna how angry and upset you are, and now you aren't certain if you ever want to speak with her again. But you are very lonely and you miss her very much.

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Appendix 1.

Human Security: Expanding the Scope of Public Health

by Paula Gutlove and Gordon Thompson

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Human security is an evolving principle for organizing humanitarian endeavours in the tradition of public health. It places the welfare of people at the core of programmes and policies, is community oriented and preventive, and recognizes the mutual vulnerability of all people and the growing global interdependence that mark the current era. Health is a crucial domain of human security, providing a context within which to build partnerships across disciplines, sectors and agencies. These principles have been demonstrated in field programmes in which health-care delivery featuring multi-sectoral co-operation across conflict lines has been used to enhance human security. Such programmes can be a model for collaborative action, and can create the sustainable community infrastructure that is essential for human security.

KEYWORDS: Conflict management Health Bridges for Peace
Human security Public health Social justice

Introduction

> In an increasingly interdependent world, nations and peoples must think afresh about how we manage our joint activities, advance our shared interests, and confront our common threats. No shift in the way we think or act is more critical than that of putting people at the centre of everything we do. That is the essence of human security. That is something that all people -- in rich and poor countries alike, in civil society or the precincts of officialdom -- can agree on. And it is something that, with political will, can be placed at the heart of the work of the UN -- our work to create security where it has been lost, where it is under threat, or where it has never existed.
> Kofi Annan [1]

In his statement the United Nations Secretary-General offers the concept of 'human security' as an organizing principle that can be placed at the heart of the work of the UN. Many other world leaders have endorsed the concept with similar enthusiasm. Human security has been part of the discourse of diplomacy and international humanitarian work for only a decade, still has varying interpretations and has not yet entered public discourse. Nevertheless, this concept offers particular promise as a framework for debating and acting upon humanity's shared interests and mutual vulnerabilities.

Supporters of the concept argue that human security will broaden the scope of policy debates and create new opportunities for addressing humanitarian concerns. Others argue that it is simply a re-packaging of old ideas. However, even the critics agree that the

lives of millions of people are plagued by insecurity, and that future events could undermine the security of many more people. Similarly, there is now broad agreement that security concerns should not be framed solely in terms of the interests of states or of powerful non-state actors. The concept of human security thus deserves careful attention. At present, there is no competing principle for comprehensively addressing humanitarian needs.

Public health has always been guided by a broad vision of human needs. For example, one of the pioneers of public health, the 19th-Century German pathologist Rudolf Virchow, fought for recognition of medicine as a social science. Virchow also called upon physicians to be the "apostles of peace and reconciliation". [2a] Human security offers a framework for applying this vision to contemporary needs, thereby creating new opportunities to expand the scope of public health. A human-security framework recognises humanity's global interdependence and mutual vulnerability to a range of old and new threats. Proven principles of public health can, with some expansion of their traditional scope of application, make major contributions to mitigating these threats.

This paper begins with a broad discussion of human security, addressing contemporary threats to individuals and societies, evolution and definition of the concept of human security, and application of the concept to practical programmes. It then focusses on the role of health as a crucial domain of human security, describes the benefits that can arise if public health activities are pursued within the context of human security, and offers a comprehensive strategy for enhancing health within a human-security framework.

Present and Potential Threats to Individuals and Societies

Millions of people around the world live in conditions of chronic insecurity, mostly because they are poor. As the World Bank has said:

> Poor people live without fundamental freedoms of action and choice that the better-off take for granted. They often lack adequate food and shelter, education and health, deprivations that keep them from leading the kind of life that everyone values. They also face extreme vulnerability to ill health, economic dislocation, and natural disasters. And they are often exposed to ill treatment by institutions of the state and society and are powerless to influence key decisions affecting their lives. These are all dimensions of poverty. [2]

The effect of poverty on health is readily apparent from global data. For example, the mortality rate of children under five years of age is 120 per 1,000 or greater for the 40 per cent of the world's people who reside in low-income countries, 35-39 per 1,000 for the 45 per cent in middle-income countries and 6 per 1,000 for the 15 per cent in high-income countries. [3]

Although the populations of richer countries enjoy better health than those of poorer countries, they are potentially susceptible to infectious diseases, which account for a quarter to a third of deaths worldwide and could spread rapidly in the modern era. About 2 million people cross international borders each day, including about one million who pass between developed and developing countries each week. As a result of this interchange and the high level of international trade, no population can be completely shielded from infection. In the United States, annual deaths from infectious disease have doubled to 170,000 after reaching a historic low in 1980. Epidemics of new diseases or drug-resistant

forms of familiar diseases could dramatically accelerate this trend. Such epidemics are especially likely to begin in populations that suffer from poverty, social breakdown and insecurity. [4] Richer populations therefore have a direct interest in ensuring that poorer populations enjoy basic health security.

Linked with the threat of infectious disease is the threat of bioterrorism. Many nations and sub-national groups now have the capability to prepare and disseminate pathogenic microbes, and this capability will become even more widespread in the future. The propensity of a group to apply this capability for a malicious purpose will be influenced by a variety of factors, one of which will be the group's perception of social injustice. While it would be foolish to attribute the entire threat of bioterrorism to social injustice, it would be equally foolish to ignore the potential for poverty, insecurity and injustice to motivate terrorists or provide a rationale for their actions.

Moreover, social justice can improve a society's capability to defend itself against bioterrorism. For example, it has become clear that the US government's ability to detect and respond to disease outbreaks at home is handicapped by two forms of social injustice: more than 40 million US citizens lack health insurance, and the numerous illegal immigrants are denied access to federally-funded medical clinics.[5] The limited contact of these populations with the health-care system could allow an undetected epidemic to begin within their ranks.

Violent conflict has always been a threat to the security of individuals and societies. Recently, violent conflict has tended to occur in lower-income countries, but higher-income countries are not exempt, as residents of the former Yugoslavia discovered in the 1990s. Wherever violent conflict occurs, it has significant direct and indirect costs. [6] Collateral impacts – including economic dislocation and the degradation of public health infrastructure - remain evident for years after violence has ceased.

The ultimate level of violent conflict is nuclear war, a potential catastrophe that is, for most people, difficult to imagine. However, the threat is real, and it can be analysed. The consequences of a global nuclear war were examined in a special issue of *Ambio* in 1982:

> In such a war no nation on earth will remain undamaged. The industrialized societies of the Northern Hemisphere will be totally destroyed, and hundreds of millions of people will die, either directly or from the delayed effects of radiation. Even greater numbers may ultimately perish there and in Third World countries as a result of the collapse of their societies and of the international exchange of food, fertilizers, fuel and economic aid. The environmental support system on which man is dependent will suffer massive damage. [7]

These findings illustrate the interdependence and mutual vulnerability of all people, both rich and poor, in the modern world. However, political leaders sometimes seem unaware of the extent of our interdependence and mutual vulnerability, and of factors including economic inequality, poverty, political grievances, nationalism, environmental degradation and the weakening of international institutions that could destabilise the present international order. Military strategists, who are obliged to consider a range of contingencies, have considered factors of this kind and concluded that the future will not necessarily be benign. [8]

Over the coming decades, human society will be vulnerable to a variety of threats that are complex, inter-related and potentially additive, leaving but a short window of opportunity to reverse trends and improve the quality of human life. The Stockholm Environment Institute (SEI) has identified a range of scenarios for the future of the world over the coming decades, and has studied the policies and actions that will tend to make each scenario come true, concluding:

> In the critical years ahead, if destabilizing social, political and environmental stresses are addressed, the dream of a culturally rich, inclusive and sustainable world civilization becomes plausible. If they are not, the nightmare of an impoverished, mean and destructive future looms. The rapidity of the planetary transition increases the urgency for vision and action lest we cross thresholds that irreversibly reduce options -- a climate discontinuity, locking-in to unsustainable technological choices, and the loss of cultural and biological diversity. [9]

Thorough, objective consideration of potential threats to individuals and societies is needed for a productive discussion of human security. Careful analyses, such as that by SEI, show clearly that the security of the world's people is, ultimately, indivisible. We all share a fragile ecosystem and a range of vulnerabilities, including potential susceptibility to new types of infectious disease. None of us can be fully secure unless all of us have at least some minimal level of security.

Evolution and Interpretation of the Concept of Human Security

There is an extensive literature on human security, including documents that review the evolution and interpretation of the concept. [10 – 12] Authors agree that human security refers to the security of people as individuals or in small communities, in contrast with security concepts that focus on the security of nations or other large entities. This is not a totally new concept:

> While the term ‘human security’ may be of recent origin, the ideas that underpin the concept are far from new. For more than a century -- at least since the founding of the International Committee of the Red Cross in the 1860s -- a doctrine based on the security of people has been gathering momentum. Core elements of this doctrine were formalized in the 1940s in the UN Charter, the Universal Declaration of Human Rights, and the Geneva Conventions. [13]

During the 1980s, these ideas were further developed through debates that centred on disarmament issues. One strand of thinking about human security can be traced to a debate about ‘common security’ that occurred during the final decade of the Cold War. [14] Common security offered an alternative vision to the Cold War confrontation, a vision in which nations co-operated to prevent conflict and to enhance the well-being of humanity. This vision found expression at the governmental level in the work of the Conference on Security and Co-operation in Europe (CSCE), which addressed issues ranging from multilateral arms control to human rights. The vision also nurtured a wide variety of non-governmental initiatives. For example, health professionals worked through the International Physicians for the Prevention of Nuclear War (IPPNW), not only to end the

East-West nuclear confrontation but also to promote humanitarian objectives such as improved health care in poorer nations. [15]

The concept of human security became widely known through the United Nations Development Programme (UNDP) Human Development Reports of 1993 and 1994. The 1994 report is said to be the first document to provide a comprehensive definition of human security. [16] The concept was described as the security of persons in seven domains: economic security (assured basic income); food security (physical and economic access to food); health security (relative freedom from disease and infection); environmental security (access to sanitary water supply, clean air and a non-degraded land system); personal security (security from physical violence and threats); community security (security of cultural identity); and political security (protection of basic human rights and freedoms). Chronic and acute threats to security were recognized. Human security was identified as a universal need, in recognition of the interdependence of people in the modern world. The preventive aspect of human security was emphasised, and a distinction was drawn between human development - which is about widening people's economic choices - and human security - which is about people being able to exercise these choices safely and freely.

The UNDP definition has not been universally employed, as illustrated by the differing interpretations of human security that have been used by the governments of Canada and Japan, which both support human-security initiatives. Canada says:

> A wide range of old and new threats can be considered challenges to human security; these range from epidemic diseases to natural disasters, from environmental change to economic upheavals. Through its foreign policy, Canada has chosen to focus its human security agenda on promoting safety for people by protecting them from threats of violence. We have chosen this focus because we believe this is where the concept of human security has the greatest value added -- where it complements existing international agendas already focussed on promoting national security, human rights and human development. [17]

Japan has adopted a broader focus for its work on human security, based on an interpretation somewhat like that of UNDP:

> Japan emphasizes 'Human Security' from the perspective of strengthening efforts to cope with threats to human lives, livelihoods and dignity [such] as poverty, environmental degradation, illicit drugs, transnational organized crime, infectious diseases such as HIV/AIDS, the outflow of refugees and anti-personnel land mines, and has taken various initiatives in this context. [18]

To some extent, differing views on human security reflect differing views on related issues of international policy. For example, the personal-security domain of human security is linked to the potentially controversial issue of 'humanitarian intervention' in the affairs of states. [19] However, differing perceptions of the utility or 'value added' of human security also play a powerful role in influencing the decision of an actor — such as a government — to emphasise one or another domain of human security.

Ultimately, as illustrated by the Canadian and Japanese positions, there is broad consensus that human security has multiple domains, but less consensus about applying the

concept. At any given time, a particular actor will choose to emphasise some domains of human security more than others.

Towards an Operational Definition of Human Security

A decision by a government or other actor to emphasise a particular domain of human security will reflect the answers to at least three questions. First, is there an existing agenda for debate and a framework for implementing practical actions? Second, will application of the human security concept provide added value? Third, can this actor make a significant contribution? Affirmative answers will encourage the actor to proceed.

These questions could be framed and answered in the absence of consensus on an operational definition of human security. However, such a consensus would facilitate the questioning process and the implementing of practical actions. A consensual definition would help to ensure that actions taken by multiple actors, across multiple domains, are synergistic. Recent analysis provides a framework that could, over time, yield an appropriate definition. This framework brings together two ideas.

The first idea is that the objective of human security should be to provide a 'vital core' or minimal set of conditions of life. [20] There is a clear implication that a person lacking these conditions deserves assistance. People whose conditions of life are above the minimal level may live in comparatively undeveloped circumstances. However, they have a basic level of security that allows them to plan and work for a better future for themselves, their families and their communities. Their progress in this respect can be described as human development. Human security, defined in this manner, is a necessary, although not sufficient, precondition for human development.

The second idea is that the minimal set of conditions for a secure life can be specified by setting thresholds in each of a number of selected domains of human security. A person is said to be secure if her conditions of life, in every domain, are above the threshold value. Conversely, falling below the threshold in any domain places the person in a state of insecurity. With this formulation, there is no need for weights to be assigned to the domains. Analysts with WHO have identified five domains of human security: income; health; education; political freedom; and democracy. For each domain, they have identified indicators that are widely used by entities such as the World Bank and UN agencies. For each indicator, a threshold value can be chosen. [12]

In combination, these two ideas provide a framework for discussions that could lead to a consensual, operational definition of human security. During these discussions, a variety of domains, indicators and thresholds could be considered. Ultimately, there could be a consensus to adopt the seven domains articulated by UNDP, or the five domains proposed by the WHO analysts, or some other set of domains. For each domain, it would be necessary to reach consensus on indicators that are measurable, consistent over time, and appropriate for worldwide application. Before the chosen domains and indicators could be employed operationally, there would need to be consensus on an initial set of thresholds. Over time, assuming that the state of human security improves, the thresholds could be raised.

Efforts to develop a consensual definition of human security should be accompanied by comparable efforts to develop a consensual analytic framework for the application of human security. In view of the preventive aspect of human security, this framework must support forward-looking assessments of potential threats to human security. The framework must also support the planning, implementation and evaluation of

actions that are taken to preserve human security. These actions will typically involve multiple actors, working across multiple domains.

Applying the Concept of Human Security to Practical Programmes

The concept of human security will demonstrate its utility when it is used to guide the planning and implementation of practical programmes of action. As a general rule these programmes will continue a pre-existing strand of activity, and must be consistent with existing strategies for humanitarian work. A notable strategy of this kind is the set of Millennium Development Goals through which the UN system is operationalising the development goals set forth in the UN Millennium Declaration of September 2000. [21]

Human security must, if it is to be a useful concept, bring added value. This can occur in at least four ways. First, human security can provide a clear and compelling objective for humanitarian work. Second, human security has a preventive aspect, which can stimulate forward-looking contingency planning. Third, human security emphasises global interdependence and can therefore mobilise additional resources and new partnerships. Fourth, human security addresses interacting threats in multiple domains and can therefore stimulate holistic, comprehensive threat assessment and programme planning.

The fourth of these points can be illustrated by the interacting threats that must be considered in connection with the health domain of human security. For example, poor economic conditions, social injustice or bad governance can undermine health care and promote political or criminal violence. Violence can have adverse effects on health, either directly or through collateral effects such as economic dislocation, food shortages or degradation of the infrastructure for public health. Adverse effects on health can have adverse implications for the economy. The potential for a downward spiral in the conditions of life is obvious. Such a spiral can be difficult to arrest or reverse.

Planning and implementing a holistic, preventive response in each relevant situation will require new mechanisms for co-operation among actors. To facilitate this enhanced co-operation, and to ensure that the lessons of experience are rapidly incorporated into programmes, new mechanisms of information exchange, organisational learning and programme evaluation will be needed. Meeting these requirements will demand additional resources. Thus, new investments will be needed to capture the value that can be added by applying the concept of human security. However, these investments could be repaid many times over through enhanced effectiveness of programmes and the mobilisation of new resources.

Health: A Crucial Domain of Human Security

As pointed out above, practical programmes that are guided by the concept of human security will generally continue a pre-existing strand of activity. This will certainly be true in the health sector, in which there is a rich body of experience and active planning of new programmes. A notable example of current planning is the action agenda that has been set forth by the WHO Commission on Macroeconomics and Health (CMH).[3] This action agenda, which complements the Millennium Development Goals, focuses on the health needs of the general population in low-income countries and the poor in middle-income countries. The financing plan for the action agenda involves a substantial increase in donor commitments above the $7 billion available in 2001, to $27 billion in 2007 and $38 billion in 2015, and calls for increased local expenditures on health. These

recommendations are predicated on the practical necessity of pursuing social justice, both within and between nations.

The concept of human security can bring added value to the CMH action agenda, in at least three ways. First, the human-security perspective can be used to mobilise new resources to support the action agenda. Second, the human-security perspective can catalyse new partnerships that recognise global interdependence and complement the action agenda; the linked threats of infectious disease and bioterrorism provide one context for such partnerships. Third, the human-security perspective can link the CMH action agenda with programmes that address related objectives — such as the prevention of violent conflict — and can thereby enhance the effectiveness of both strands of effort.

The potential for new partnerships that address the mutual threat of infectious disease — to developed and developing countries alike — was evident from discussions at a March 2002 conference on human security, held at American University in Washington, DC:

> US National Institutes of Health senior researcher Samir Khleif…. said the continuing prevalence of easily preventable diseases in developing countries demonstrates the huge disparities between developed and developing countries and has 'tremendous' implications for the security of North-South relations….
>
> 'Investing in global health is an investment in national security,' said Khleif, noting that no country is completely isolated from the diseases of the poor because of the effects of globalization, more mobile populations and migration patterns. Citing the United States as an example, Khleif said that 40 per cent of cases of tuberculosis have originated with immigrants and that the US was unable to prevent the trans-Atlantic importation of the West Nile virus. 'You can't stop TB at the border,' he said. [22]

Another illustration of the potential for new partnerships is concern about the threat of smallpox as an instrument of bioterrorism. For example, the WHO Regional Committee for the Eastern Mediterranean has requested the Regional Director to plan a strategic stock of smallpox vaccine for the region. [23] The US government has issued guidelines whereby the entire US population can be vaccinated against smallpox within a five-day period. In view of the potential for rapid spread of infectious disease in the modern world, such actions should be part of a broader effort to develop a global strategy that addresses the linked threats of infectious disease and bioterrorism. This strategy would recognise the interdependence and mutual vulnerability of all people, accept social justice as a global security measure, and catalyse a wide range of new partnerships.

There is experience with international collaboration to control infectious diseases. Nations have been willing to co-operate to a remarkable degree, and to accept the authority of international organisations, because they recognise their mutual vulnerability. WHO campaigns to address polio, malaria and TB in south-east Asia illustrate this cooperation. [24]

As noted, one way in which the human-security perspective can add value is by linking the CMH action agenda - whose focus is health - with programmes that address related objectives - such as the prevention of violent conflict, the improvement of governance, or economic development. Human security provides a perspective that can link such efforts to their mutual benefit. For example, violent conflict and bad governance are severe constraints on the effectiveness of health interventions, which are difficult to

address, [25] and programmes for the peaceful management of conflict and the promotion of social reconstruction can be successfully integrated with health interventions. [26, 27] Thus, the potential exists for mutually-beneficial linkages between health programmes and other programmes.

Experience in integrating conflict management with health care is of particular interest in the context of health and human security. In situations of conflict, shared health concerns can create neutral fora for discussion and collaboration. Furthermore, health issues can provide a useful platform to address fundamental obstacles to peace, such as discrimination, polarisation and the manipulation of information. Health-care delivery programmes that feature co-operation between health professionals from different sides of a conflict can be a model for collaborative action, helping to create the sustainable community infrastructure that is essential for enduring peace. Relevant programmes could include inoculation campaigns and public health education. [26]

Health Bridges for Peace

Much of the experience in integrating conflict management with health care has been conducted under the rubric 'Health Bridges for Peace'. This experience provides an important illustration of the benefit of pursuing health and social justice within the context of human security.

Health professionals have a special role to play in healing violence-ravaged communities and enhancing a society's potential for human security. [28] They have an intimate association with the people who have suffered mentally and physically from armed conflicts, are well-educated, and have stature and access to a wide range of community groups. They can create a 'bridge of peace' between conflicting communities, whereby delivery of health care can become a common objective and a reason for continued co-operation. They can assist reconciliation after the trauma of war, through a healing process that restores relationships at individual and community levels.

In a post-conflict community, the health sector often receives international and NGO assistance, thereby providing options for communication, transport, technology transfer, and educational support that are otherwise unavailable. [29] In complex emergencies there is often a paralysis of the state, whereas health professionals can facilitate the development of sustainable institutions that deliver health care while addressing issues of social justice and human security. International medical organisations have experience in building bridges between medical communities in developing and developed countries, North and South, East and West.

Delivery of health care has been the basis for significant co-operation between parties divided by violence, as has been documented by the War and Health Program of McMaster University. [29] UNICEF has pioneered the promotion of humanitarian cease-fires for paediatric immunisations, and the brokering of 'corridors of peace' to allow the transport of medical supplies. [30] WHO has demonstrated the potential for health to be a unifying influence through research/action programmes, sustained inoculation campaigns and health-education programmes in conflict-torn areas. [31, 32] In discussing the connection between health and peace, MacQueen et al. argue that 'there is a need for a new discipline of 'peace through health' that studies both the downward spiral of war and disease and the positive symbiosis of peace and health.' [33]

The Institute for Resource and Security Studies (IRSS) has sought to increase the potential for the health community to enhance human security by promoting the integration

of health care with conflict management in selected conflict and post-conflict situations. IRSS's experience shows that social reconstruction, the healing of inter-communal relationships, and the transformation of violence-habituated systems can be significantly enhanced by training and assistance in the concepts and skills of conflict management. In this context, the term 'inter-communal' refers to the class of racial, ethnic, religious, and ideological conflicts that involve differences between communities of people, rather than individuals or governments, regardless of whether those communities exist within or across international borders. The field of conflict management encompasses efforts to prevent violent conflict, to mediate existing conflict, and to reconcile communities in the aftermath of violent conflict. Conflict management processes that address the underlying causes of conflict and provide sustainable structures for adaptive social change can transform the ways in which groups and societies deal with differences. This transformation, away from dealing with differences through violence and destruction, and toward constructive, co-operative interaction, is essential to sustainable peace, social justice and human security.

In 1996, IRSS launched the Health Bridges for Peace (HBP) project to help health-care professionals realise their potential to heal violence-ravaged individuals and communities. The project's purpose is to utilise a shared concern, the restoration of public health, as a vehicle to convene and train health-care professionals in conflict management and community-reconciliation techniques. Once these professionals are trained, they are assisted in designing and implementing inter-communal activities that integrate community reconciliation and conflict prevention into health-care delivery. The first HBP field programme was initiated in 1997 in the former Yugoslavia, and the second in the North Caucasus in November 1998.

The programme in former Yugoslavia helped to launch the Medical Network for Social Reconstruction in the former Yugoslavia (the Medical Network). This is a network of health-care professionals, drawn from all parts of the former Yugoslavia, dedicated to facilitating healing and recovery processes that promote individual and community health and empowerment and the prevention of future conflicts in this region. It is founded upon two major beliefs:

- Violent conflict and war are the ultimate threat to public health; and
- the health community has a unique and crucial role to play in promoting a healthy society, by mending the physical and psychological wounds of individuals and communities, by rebuilding structures for public health care, and by creating bridges for community reconstruction and social reconciliation.

The Medical Network convenes conferences and engages in health-care delivery and social-reconstruction activities. It has convened nine international HBP conferences and more than thirty workshops and seminars. More than four hundred physicians, psychologists, government officials, administrators and academicians from all parts of the former Yugoslavia have participated in its conferences, seminars and meetings, exhibiting a high level of inter-ethnic co-operation. It has promoted professional exchange, training and joint humanitarian-assistance projects in a variety of areas, including: war-trauma recovery; special issues in refugee medicine; social reconstruction in co-operation with other professional groups (police, teachers, social workers); health care for the war-injured physically challenged; and special issues of war-affected children.

Training is recognised within the Medical Network as one of the most effective ways to bring together professionals from divided communities. Training programmes have been developed and taught by Medical Network members in co-operation with international experts. The training of physicians from Bosnia, Serbia and Croatia has provided a context for co-operation and the renewal of relationships. Many training programmes have involved the training of trainers, and mixed-ethnic teams of trainers have been developed.

One of the first co-operative projects of the Network was the development of a training programme for psychosocial assistance to promote trauma recovery. This is closely related to peacebuilding efforts; both are ultimately about developing or restoring healthy human relationships. Trauma recovery implies the decrease of loneliness, mood improvement, a sense of inner peace, a decrease in isolation, anger and bitterness, and a decrease in feelings of animosity and hatred toward others; it can only take place in the context of relationships. Recovery cannot occur in isolation because it is necessary to heal the psychological faculties that were damaged by the trauma, and this healing can only occur through relationships with other people.

Trauma-recovery training has both content and relational dimensions. The content of the training changes as the context evolves from basic trauma treatment to large-scale social reconstruction. The relational dimension also evolves, as trainers, caregivers and their clients all need sustainable support structures that can develop as their roles evolve. Trauma healing must, therefore, be integrated into a programme of psychosocial assistance that seeks to strengthen the remaining healthy resources within individuals, families and communities, and helps new resources evolve. In turn, psychosocial efforts must be synergistic with related humanitarian and democracy-building efforts in a region. In this way, trauma recovery can lead to an integrated process of rebuilding the social infrastructure of a violence-ravaged society while promoting reintegration, resettlement and retraining.

Building a community-based psychosocial assistance programme will open the way for the development of the NGO sector, and can lead to the development of new, community-based organisations. The Medical Network has found it valuable to mobilise large numbers of volunteers for these organisations. In all post-war situations there is widespread poverty, under-utilisation of human resources, and a lack of state-supported health services. In response, health professionals can promote volunteer action, training and empowering individuals and groups to engage in (unpaid) public-service and social-reconstruction activities. Volunteers, collaborating with the health professionals, can significantly improve the quality of life of persons with medical and psychosocial problems. Through voluntary work the values and practice of solidarity and of mutual help, regardless of religious, national or other attributes, are reinforced and promoted. In the period 1999-2002, Medical Network psychosocial-assistance programmes have incorporated an estimated 4,000 volunteers from all parts of former Yugoslavia into social-reconstruction efforts that enhance human security in the region.

The Medical Network has reached out to physicians from other war-devastated areas. In April 1998, physicians from Chechnya were guests at a Medical Network conference in Sarajevo. Later that year, IRSS convened a meeting in the North Caucasus that brought together Chechen, Ingush, North Ossetian and Russian health professionals for conflict-management training and guidance in developing collaborative public-heath activities. From this meeting the Medical Alliance for Peace through Health in the North

Caucasus (Medical Alliance) was born. Its planned co-operative public health projects, to be assisted by WHO, include: a regional network on tuberculosis control; co-operative centres for psycho-social rehabilitation; a North Caucasus inter-regional training centre for the prevention of drug addiction; and a co-operative programme for prosthetic assistance to amputees in the North Caucasus.

HBP field programmes have provided new hopes and possibilities to numerous indigenous health professionals. Many of them were in despair, and had all but given up their medical practice in the face of human and physical destruction. The HBP project has given them new opportunities, a new vision and a new role. It has demonstrated the potential of healing and collaborative action, and has built bridges between colleagues who thought they could never again work together. HBP has expanded the mission of international agency field staff and has sparked great excitement, both in the field and at headquarters.

The impact of HBP is not limited geographically to the former Yugoslavia and the North Caucasus. Health professionals from many other conflict areas (including other parts of Europe, Central Asia, South America and the Middle East) are interested in learning from, and emulating, the HBP programmes. International health and humanitarian assistance agencies have participated in IRSS's programmes or developed health-bridges programmes of their own. Some of these agencies are contracting with, or collaborating with, Medical Network personnel for trauma-recovery and peacebuilding work. At the policy level, IRSS is working with international organisations to develop policies and programmes whereby humanitarian assistance can be synergistic with the building of a healthy civil society, the enhancement of social justice and human security, and the creation of a culture of peace.

Pursuing Public Health within a Human-Security Framework

Clearly, health is a crucial domain of human security, and a human-security approach rooted in international consensus can bring added value to existing policies and programmes. Thus, the world would benefit from a comprehensive strategy for enhancing public health within a human-security framework.

An effective strategy will operate through existing institutions and promote collaboration by: national governments; international agencies; private foundations; academic institutions; professional groups; citizen organisations; and businesses, including pharmaceutical companies. Collaboration of this kind has become increasingly frequent in the modern era, but must be more intensive and must engage additional actors. It is especially important that people and institutions whose focus has been on national defence and security find a common purpose with their counterparts whose focus is health, social justice, and human security.

There needs to be a consensual definition of human security and an analytic and operational framework for the application of human security, which must support forward-looking assessments of potential threats to security and the development of plans to respond to these threats. The lessons of experience must be rapidly incorporated into programmes. This will require new mechanisms for information exchange, organisational learning and programme evaluation. These activities must proceed in a decentralised manner without any overarching authority. There is no organisation that possesses such authority and, in any event, the pursuit of social justice requires broad-based collaboration.

Given the multiple tasks that must be performed, and the diversity of actors involved, there must be some division of labour. We propose four synergistic strands of effort to refine and implement the overall strategy: policy development; specific programme opportunities; research, training and technical collaboration; and outreach and promotion.

Work on *policy development* should be informed by experience in the field, to ensure that policies have an empirical basis. Policy decisions should be iterative, so that changes can be made as lessons are learned from experience. Also, policies must account for the evolving interests of the many actors involved. These are demanding requirements.

A wide variety of *specific programme opportunities* are available. Much work will be required to identify, select, plan and implement programmes that respond to these opportunities. The geographic scope of these programmes will range from the local to the global. Each programme should follow a structured-learning model, whereby the outcomes of actions are monitored and documented, and implementation is adjusted accordingly. Findings from this experience should be widely shared, to inform policy development and other strands of effort.

Research, training and technical collaboration are inter-related. A major focus of the research effort should be on learning from experience, whether at the policy level or through work on the ground. This would be accomplished by designing structured-learning evaluation models for policy and programme initiatives, and by independently observing these initiatives. The training effort would include building human capacities for research and for implementation of human-security programmes. Training would give special attention to development of the leadership and management skills that are required when working with diverse actors, in multi-sectoral contexts, to achieve shared goals. Developing these skills would be one of the most significant value-added contributions that a human-security approach would make. The technical collaboration effort would involve the creation of professional relationships among researchers, managers, trainers and practitioners, worldwide. This effort would benefit from the establishment of an inter-university network for research and training on health, social justice and human security.

In the *outreach and promotion* strand of effort, work would be undertaken to establish and maintain relationships with relevant actors, including those who are not directly involved in human-security initiatives. One purpose of these relationships would be to propagate knowledge about human-security initiatives and their accomplishments, the second would be to obtain knowledge and other resources, including financial support.

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IRSS is an independent, non-profit corporation, founded in 1984 to promote international security and sustainable use of natural resources. Its projects range from detailed technical studies to preparing educational materials accessible to the public. Its International Conflict Management Program seeks to improve communication, build understanding, promote co-operation, and develop new models for sustainable community reconstruction and reconciliation. The Health Bridges for Peace project is developing medical networks for social reconstruction and human security in regions that have suffered violent conflict and war, including the Balkans, the North Caucasus, and the Middle East.

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Appendix 2.

Health as a Bridge to Peace:

The role of health professionals in conflict management and community reconciliation

by Paula Gutlove

Paper presented by Dr. Paula GUTLOVE at the Global Symposium on Violence and Health, 14 October 1999, WHO Centre for Health Development, Kobe, Japan

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Abstract

At the turn of the millennium, the world is plagued by seemingly intractable conflicts, marked by violence and inhumanity. Medical professionals have a special role to play in healing communities that have been ravaged by violence, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconciliation. Involvement of medical professionals from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement that is essential for sustainable peace.

The Institute for Resource and Security Studies (IRSS) launched the Health Bridges for Peace project (HBP) in 1996 to help health care professionals realize their potential to heal violence-ravaged individuals and communities. The project utilizes a shared concern, namely the restoration of public health, as a vehicle to convene, engage, and train health care professionals in conflict management and community reconciliation techniques. In 1997, IRSS initiated the first HBP field program in the former Yugoslavia. The second HBP field program was initiated in the North Caucasus in November 1998. Both field programs have enjoyed the support of WHO and other international agencies.

Health Bridges for Peace has provided new hope and possibilities to many indigenous health professionals, providing them with new opportunities, a new vision, and a new role in their community and in the world. By working and training together, health professionals are giving their communities a symbol of hope and a reason to believe that the promise of their shared future can shine brightly enough to start healing the painful memories of their shared past. Growing global interest in the use of health as a bridge to peace poses an exciting challenge which WHO is uniquely placed to meet.

About the Institute for Resource and Security Studies

The Institute for Resource and Security Studies is an independent, non-profit corporation, founded in 1984 to promote international security and sustainable use of natural resources through technical and policy analysis and public education. To complement its analytic and educational work, IRSS engages in public participation, dialogue facilitation and conflict management through its International Conflict Management Program. This

program works with people of diverse perspectives and interests, to improve communication, build understanding, promote cooperation, and develop new models for sustainable community reconstruction and reconciliation. IRSS designs and convenes workshops and training sessions to facilitate dialogue, promote collaborative problem-solving, encourage cooperative actions, and develop inter-communal networks.

Introduction

> *"Health is valued by everyone. It provides a basis for bringing people together to analyse, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict."*
>
> World Health Organization, 1995 [22]

At the turn of the millennium, the world is plagued by violence. Seemingly intractable conflicts devastate communities all over the globe. Yet, while physical and psychological health is the recognized province of health care providers, social health is often considered outside of our territory. For this reason the WHO Global Symposium on Health and Violence is a landmark event. Our traditional focus, healing physical and psychological ills, can provide an important basis for societal healing, particularly in communities traumatized by violence. By expanding the concept of healing to include the restoration of trust and confidence within a community, and by working cooperatively to help prevent future violence, the health profession can make a unique and essential contribution.

The Role of Health Professionals in Societal Healing

Health professionals have a special role to play in healing violence-ravaged communities.[23] They have an intimate association with the people who have suffered mentally and physically from armed conflicts. They are often well educated, and have stature and access to a wide range of community groups. Health professionals can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation. Reconciliation after the trauma of war requires a healing process to restore relationships, for both the individual and the community.

Involvement of health professionals from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement that is essential for sustainable peace. In a post-conflict community, the health infrastructure is often one of the few to be aided by international and NGO assistance. This can provide options for communication, transport, technology transfer and educational support that are otherwise unavailable.[24] Furthermore,

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22 "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

23 Paula Gutlove, "Health Bridges for Peace: Integrating Health Care and Community Reconciliation," in *Medicine, Conflict and Survival*, Frank Cass & Co. Ltd., London, England, Volume 14, January 1998.

24 A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996, page 5.

international medical organizations have experience in building bridges between medical communities in developing and developed countries, North and South, East and West.

Delivery of health care has been the basis for significant cooperation between parties that have been divided by violence, as has been well documented by the War and Health Program of McMaster University in Canada.[25] UNICEF has pioneered the promotion of humanitarian cease-fires for pediatric immunizations, beginning in El Salvador in 1985, and again in Lebanon in 1987. UNICEF also brokered a "corridor of peace" in 1985 between the government and the insurgent NRA in Uganda, to allow the transport of medical supplies and vaccines. In the Sudan in 1989, a corridor of peace was negotiated between the government and the SPLA to allow delivery of relief supplies to people in southern Sudan.

WHO has demonstrated the potential for health to be a unifying influence on a longer-term basis, through research/action programs, sustained inoculation campaigns and health education programs in conflict-torn areas. For example, WHO-Afghanistan and the Afghan Ministry of Public Health brokered a cease-fire in 1994 during which children throughout the country could be immunized. The two weeks of tranquillity became a two-month cease-fire during which an intensive "Mass Immunization Campaign" was carried out.[26] An important aspect of the campaign's success was the broad consensus that the organizers achieved among leaders of the warring factions and representatives of government and non-government agencies, including Afghan health officials from all parts of the country. Also cooperating in the initiative were international NGOs and UN agencies. The neighboring governments of Iran and Pakistan assisted through the donation, transport and storage of medicines. In addition to immunizing children, the campaign educated people about pediatric health needs and worked to build the health care delivery infrastructure of the country. Campaign organizers provided training to over 14,000 health workers and regional directors, and provided needed health equipment to rural centers throughout the country. Many observers felt that, until the Taliban took over in 1996, this program raised the level of respect that the health sector commanded throughout Afghanistan, and enhanced this sector's status as an impartial and neutral actor. Unfortunately, it is doubtful that the initial achievements of this program were sustained after the Taliban took over.

WHO has also organized research/action programs to integrate peacebuilding with health-related initiatives. The program, "Health and Development for Displaced Populations" (Hedip) ran from 1991 to 1995, conducting three pilot projects in Croatia, Mozambique and Sri Lanka.[27] In the three projects, Hedip addressed health problems whose solutions required actions that integrated the health sector with other sectors, and sought to use health-related actions to promote community reconciliation. The projects aimed to provide emergency humanitarian aid in such a way that it could contribute to long-term sustainable development. Participation of many sectors, including government, social services, private entrepreneurs and citizen groups, was promoted through the

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25 Mary Anne Peters, "Shots of Vaccine Instead of Shots of Artillery", in A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996.

26 "Health in Social Development", WHO Position Paper, Copenhagen, 1995.

27 Sara Swartz (Division of Emergency and Humanitarian Action of the World Health Organization), "Local Support for Peace Through Health: The Hedip Program of the World Health Organization", in A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996.

development of local committees, which directed the project on the local level. The success of the projects depended upon the development of a participatory, problem-solving process within these local committees.

The WHO office in Bosnia and Herzegovina (WHO-BiH), through the Peace through Health (PTH) strategy, has worked to integrate health and conflict resolution across a wide range of programs.[28] This integration has been based on two principles. The first principle is that common health issues can provide neutral fora for discussion and collaboration. The second principle is that health issues can provide a valuable medium for addressing fundamental obstacles to peace such as discrimination, polarization, and manipulation of information.

WHO-BiH has implemented the PTH strategy in programs such as health system reform and reconstruction, public health, primary health care, and mental health. Some specific areas that they have worked on include: joint immunization campaigns; efforts to harmonize health data collection across BiH; joint training workshops in all parts of the country; and the initiation of an inter-faculty medical students' journal. Implementing the PTH strategy has presented crucial challenges to the health profession. A particular challenge has been the need for reform and reconstruction of the health system in BiH, requiring a fundamental and widespread recognition that responsibility for health extends far beyond the health sector.

Integrated Action

The potential for the medical community to promote communal reconciliation, to heal inter-communal[29] relationships, and to transform violence-habituated systems can be significantly enhanced with training and assistance in concepts and skills of conflict management. The field of conflict management encompasses efforts to prevent violent conflict, to mediate existing conflict, and to reconcile communities in the aftermath of violent conflict. Conflict management processes that address the underlying causes of conflict and provide sustainable structures for adaptive social change can transform the ways in which groups and societies deal with differences. This transformation, away from dealing with differences through violence and destruction, and toward an approach based on constructive, cooperative interaction, is essential to long-term, sustainable peace.

In recent years, efforts to transform inter-communal conflict have benefited from the systematic integration of humanitarian activities with conflict management expertise. This approach can be described as "integrated action".[30] Peacekeeping, famine relief, public health and other humanitarian programs have always involved some degree of conflict management work. However, this work has often been done on an ad hoc basis, without specific planning or the training of personnel in conflict management. Deliberate

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28 Gregory Hess, director of the Peace through Health Program, WHO, Sarajevo: "The WHO Peace through Health Program in Bosnia and Herzegovina", in Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals, Report on an International Conference by Paula Gutlove, 23-26 April 1998, Sarajevo, Bosnia, November 1998.

29 The term "inter-communal" is used to encompass the class of racial, ethnic, religious, and ideological conflicts that involve differences between communities of people, rather than between individuals or governments, regardless of whether those communities exist within or across international borders.

30 Paula Gutlove and Gordon Thompson, A Strategy For Conflict Management: Integrated Action in Theory and Practice**,** Cambridge, Massachusetts, USA, Institute for Resource and Security Studies, March 1999.

integration of conflict management with other humanitarian efforts, through integrated action programs, is a recent development.

Through integrated action, conflicting parties are brought together to work on a humanitarian or development program that involves super-ordinate goals, and are provided with significant, concrete incentives for cooperation. At the same time, the humanitarian program receives the benefit of conflict management expertise. Such initiatives will be more effective and sustainable if they learn from previous successes and failures. Also, each initiative must respond to its unique cultural and historical context, and be developed by indigenous talent.

Integrated action weaves together conflict management with other humanitarian activities for several purposes. The humanitarian action is an incentive for parties to come together, and provides a basis for continued engagement of indigenous parties. As parties work together, they create a context for training in conflict management skills, which can be applied on many levels, promoting community reconciliation among ever-larger circles. The first circle encompasses the providers of a humanitarian action, the second circle encompasses people directly reached by the humanitarian action, and the third circle encompasses the surrounding community. Other, wider circles will be reached by replication of this process in other locations. Finally, the conscious integration of conflict management with humanitarian actions can provide a sustainable structure for long-term cooperation and community reconciliation.

Integrated Action in Practice: The Health Bridges for Peace Project

On the eve of the nine-day war that began when Slovenia declared independence from the Yugoslav Federation in July 1991, a Slovene physician asked IRSS for help. She was aware of dialogue work that IRSS has facilitated with international groups of physicians, and she hoped IRSS could promote similar dialogue in Yugoslavia among people who were in a position to make a difference in the region. Within weeks, similar requests came from physicians and other prominent individuals and groups in Serbia and Croatia who were concerned about the violent course they saw their countries taking. Thus began a long-term commitment by IRSS to the former Yugoslavia.

Working with people from Serbia, Croatia, Slovenia, Macedonia, Montenegro and Bosnia-Herzegovina, IRSS convened numerous dialogue and training workshops for a range of professional groups, including politicians, educators, religious leaders, refugee workers and health care providers. Gradually our work came to focus on the unique and crucial role that health care professionals, primarily physicians, can play, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconciliation.

Drawing from our experience in the former Yugoslavia, IRSS launched the Health Bridges for Peace (HBP) project in 1996. The purpose of the project is to utilize a shared concern, namely the restoration of public health, as a vehicle to convene, engage, and train health care professionals in conflict management and community reconciliation techniques. Also, once these professionals are trained, they are assisted in designing and implementing inter-communal activities that integrate community reconciliation and conflict prevention strategies into health care delivery.

The first field program in the Health Bridges for Peace project, initiated in response to requests from medical professionals in the region, has operated in the former Yugoslavia since 1996. In April 1997, local physicians formed the Medical Network for Social

Reconstruction in the former Yugoslavia. (Hereafter, this body is referred to as the Medical Network.) In addition to working within the former Yugoslavia, the Medical Network has engaged in active outreach to other war-torn areas to spread the Health Bridges concept. IRSS initiated its second Health Bridges for Peace field program in the North Caucasus in November 1998, when we brought together Chechen, Ingush, Ossetian and Russian health professionals in South Russia.[31] At this meeting the Medical Alliance for Peace through Health in the North Caucasus was born.

Health Care: a Special Opportunity for Integrated Action

The Health Bridges for Peace project works with the medical profession to promote a systematic integration of public health with social reconstruction and community reconciliation. The project convenes meetings with health professionals who share a common concern for public health issues. Participants are introduced to a variety of conflict management and community reconciliation processes. They engage in facilitated dialogue about their past, their present and their potential shared future, seeking to identify common health care needs that can be addressed effectively through a cooperative approach. The HBP project then assists them in designing and implementing inter-communal programs that integrate community reconciliation and conflict management techniques into health care delivery. Some areas of common ground include re-integration of war-affected people, resettlement of refugees and displaced peoples, reconstruction of health care delivery systems, civic education for human rights protection, and the development of sustainable processes for managing community conflict.

Facilitating community reconciliation can be difficult, demanding great sensitivity, patience and courage. Many of the health practitioners involved in local Health Bridges programs have special knowledge and unique skills that have contributed to the development of a culture-specific process of acknowledgment, mourning and grieving about the past. Engaging in this process has made it possible for the HBP project to help people who are locked in polarized, painful, antagonistic relationships to engage in a collaborative problem-solving approach. Documenting this process and training others in its application has been a key factor in promoting the transformation of a community characterized by violence, mistrust, injustice and anger to one characterized by hope, trust and wholeness.

An internationally known specialist in trauma recovery, Dr. Judith Herman, describes three stages -- safety, acknowledgement, and reconnection -- through which patients must move as they recover from a traumatic experience.[32] While it is not necessary or even expected that patients will move from one stage to another in a linear fashion, recovery from trauma is predicated upon the patient's moving from a feeling of unpredictable danger to one of reliable safety and security, from a sense of dissociated trauma to acknowledged memory, and from feeling isolated and stigmatized to restoring meaningful social connections. These stages have proven to be very relevant to the recovery of communities from the trauma of war. Through a process of dialogue and

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[31] Paula Gutlove, Health as a Bridge for Peace in the North Caucasus: a Workshop for Health Professionals in Pyatigorsk, Russia, 29 October - 2 November, 1998, World Health Organization, Copenhagen and Institute for Resource and Security Studies, Cambridge, Massachusetts, December 1998.

[32] Judith Herman, MD, Trauma and Recovery, New York, Basic Books, 1992.

shared actions, the HBP project has helped to train medical professionals to address these stages as individuals, as healers and as leaders of conflict-divided groups.

Reconnection is crucial to reconciliation within a violence-ravaged community. Here, the ultimate goal is the restoration of healthy human relationships and the building of trust, hope and interdependence. The concept of trust can encompass trust in other individuals to behave with compassion, and trust that the political system will be fair and equitable. The building of hope means that people can begin to believe that the future life of their community can be better than its recent, violent past. Interdependence comes from the knowledge that values and experiences, and the desire for trust and hope, are shared throughout a community.

By identifying issues of mutual interest, in which they can work together cooperatively, the HBP project allows participants an opportunity to rebuild their relationships in a sustainable, meaningful way.

The Medical Network for Social Reconstruction in the former Yugoslavia

The Medical Network was initiated in 1997 to promote the resolution of existing conflicts and the prevention of future conflicts in the former Yugoslavia. It is founded upon two major beliefs. First, violent conflict and war are the ultimate threat to public health. Second, the medical community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and psychological wounds of individuals but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation. To these ends, the Medical Network aims to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in its region. Acting on these beliefs, the Medical Network runs periodic training workshops, conducts a range of inter-communal health care projects, and convenes annual conferences.

Medical Network conferences serve to promote professional and organizational development while promoting the social reconstruction of the region. Each conference generally consists of plenary sessions and workshops, through which participants work together to examine and advance the role of health professionals in reconciliation, reconstruction and conflict prevention in former Yugoslavia. There are opportunities for exchange of knowledge on substantive issues, development of training programs for use by medical professionals to prevent conflict and encourage reconciliation, and organizational development of the Medical Network. The exchange of knowledge on substantive issues covers practical issues facing health professionals in a post-war situation, in categories such as: health care, social reconstruction and community reconciliation; refugees and resettlement; youth and the building of hope for the future; psycho-social support; and the development of civil society.

Annual conferences provide important opportunities for relationship building, across conflict divides, among the participants. These opportunities are built upon through training workshops designed specifically to promote the role of health professionals in conflict prevention and community reconciliation. In April 1998, with assistance from the WHO office in Bosnia, the Medical Network held its annual conference in Sarajevo. More than 100 health professionals, from the former Yugoslavia and internationally, convened to explore the role of health professionals in reconciliation, social reconstruction and conflict

prevention. In April 1999 the annual conference was held in Ohrid, Macedonia.[33] In view of the violence in the region at that time, the conference focussed on training Kosovar and Macedonian health care providers in three areas: treatment of traumatic stress; the use of volunteers in social reconstruction; and the integration of conflict management and community reconciliation with trauma recovery.

In May 2000 the Network plans it most ambitious conference to date in Gracanica, Bosnia. Gracanica, in northeast Bosnia, includes both the Federation of Bosnia and Herzegovina but also the Serbian Republic. It is also part of a wider Bosnia-Croatia-Serbia triangle. Since 1998, Network members from Slovenia, Bosnia, Serbia and Croatia have cooperated on a training program in Gracanica, integrating trauma recovery with community reconciliation and developing a network of volunteers to assist in social reconstruction. The conference will provide training in: medical assistance to handicapped children; psychosocial treatment for war-affected people, including refugees and veterans; and the integration of trauma recovery with community reconciliation.

The Network has a 12-member Contact Group that serves as its steering committee. The Contact Group meets every six months, has email and fax communication on a regular basis, and leads the Network as it engages in cooperative medical projects that cross conflict lines. Examples of Network inter-communal health care programs include:

- Psychiatrists and psychologists from Slovenia, Bosnia and Croatia have helped to set up inter-ethnic counseling and reconciliation programs in their own republics and have worked together with colleagues in Bosnia, Kosovo, Montenegro and Macedonia to set up similar programs there.
- Training, in psychosocial support for traumatic stress and the use of volunteers in psychosocial programs, is being carried out throughout the region by a core of Network members from Slovenia and Croatia.
- The Network has established an electronic communications linkage that functions for long-range planning and as an emergency alert system.
- Network members from Slovenia and Croatia collected hospital equipment from West European sources and, with IFOR military escort, brought it to two hospitals, one in the Bosniac Federation and the other in the Republika Srpska.
- The Network plans to publish a bi-monthly Network Newsletter and establish a Mobile Medical Library.

Medical Alliance for Peace through Health in the North Caucasus

In April 1998, physicians from Chechnya were guests at a Medical Network conference in Sarajevo. This stirred an interest in the North Caucasus for a Health Bridges for Peace field program, and a request to IRSS for assistance. In October 1998, IRSS convened and facilitated a workshop at which the Medical Alliance for Peace through Health in the North Caucasus (Medical Alliance) was born. The five-day workshop took place in Pyatigorsk, Russia, from 29 October to 2 November 1998. The workshop brought together 21 health professionals from Chechnya, North Ossetia and the Stavropol and Krasnodar regions of Southern Russia. Health professionals from Ingushetia were

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[33] Paula Gutlove, Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals, report on an International Conference, 23-26 April, 1998, Sarajevo, Bosnia, Medical Network for Social Reconstruction, Sarajevo, November 1998.

scheduled to attend but were unable to travel into Southern Russia for political reasons at the last minute. Workshop participants included ministers of health, heads of hospitals, directors of community health facilities, and a range of clinicians and administrators with significant public health responsibilities.

The workshop was organized through local and international networking and cooperation. The primary organizers on the local level were the Netherlands Relief Committee for Chechnya (RCC) and the Association for the Protection of the Rights of Refugees and Forced Migrants (ADEPT). The OSCE Assistance Group in Chechnya provided logistical support. WHO provided information about potential participants, as well as invaluable program assistance, before and during the workshop. The workshop was a carefully facilitated mixture of lectures and small group experiential work, which sought to:

- sensitize participants to the potential, inherent in their role as healers, for promotion of public health, social reconstruction and peace;
- provide training in communication and problem-solving skills;
- address specific war-related public health issues;
- identify opportunities for cooperative actions within the health sector to promote public health and peace building; and
- explore the potential for the development of an ongoing network of health professionals who can use health as a bridge to peace in the North Caucasus.

Workshop participants unanimously agreed to continue their work together and to expand their network to include all 10 republics of the North Caucasus. To do this they decided to form the Medical Alliance for Peace through Health in the North Caucasus. The mission of the Medical Alliance is to work collaboratively in the North Caucasus to promote peace through health, engaging in collaborative initiatives that improve physical, mental and social health in the region.

In order to enhance communications within the region, the Medical Alliance made plans to publish a monthly newsletter through the WHO/EURO office in Copenhagen. The Medical Alliance also started planning on a range of cooperative public health programs, including: a regional network on tuberculosis control; cooperative centers for psycho-social rehabilitation; a North Caucasus inter-regional training center for the prevention of drug addiction; and a cooperative program for prosthetic assistance to amputees in the North Caucasus.

The Medical Alliance had plans to hold its second regional meeting in November 1999, and received support to do this through a generous gift of the Japanese government to the WHO/EURO office. Unfortunately, the escalating violence and instability in the region have caused a temporary suspension of regional program plans. Until the region is safe for a region-wide meeting, IRSS will work with WHO/EURO to define and implement cooperative programs in response to the current crisis situation.

Lessons from HBP Field Programs

Experiences in the former Yugoslavia and the North Caucasus have confirmed the enormous potential for HBP programs in post-conflict areas. They have also demonstrated important principles for integrating health initiatives with community reconciliation in a systematic and sustainable manner, as follows:

- A Health Bridges program should be guided by a broadly representative group of indigenous personnel. Only the local people can identify the crucial health needs of their communities. Moreover, important resources for understanding and transforming conflict can be found within a culture from which the conflict has emerged. Wherever possible, participants should be involved in developing their own training programs.
- The greater the ownership local groups have of a training program, the greater is the likelihood that they will find ways to use it and sustain it.
- In order for training to have a long-term impact, it must be embedded in a structure that has the potential for long-term sustainability. Thus, the organizational development of the Medical Network and the Medical Alliance is in each case crucial to the success of the program.
- Setting up channels for ongoing communication and information exchange among a range of parties is essential for preserving the gains made at meetings and training sessions. For example, at times when direct communications were impossible, members of the Medical Network have creatively sent messages and medical aid through "third" parties. These symbolic and substantive acts were crucial to maintaining the gains in trust and human connection that each meeting of the Network has achieved, and were ultimately essential to the survival of the Network.
- A Health Bridge program is not sustainable or maximally effective unless it relates to other organizations and actors. Thus, the local medical networks are able to grow and gain stability by maintaining communication links with a range of relevant humanitarian and development agencies and NGOs, and with government and intergovernmental agencies. The most important link can be the WHO.
- Ongoing program evaluation and the ability to change in response to critical evaluation are essential to the efficiency and sustainability of any training program. Also, the program must be able to adapt to a changing political landscape.

Outlook for the Health Bridges for Peace Project

Despite continuing violence in both the former Yugoslavia and the North Caucasus, the outlooks for the Medical Network and Medical Alliance are bright. These networks are growing in size and in organizational integrity. They have developed modes of communication, through email and fax, that span their regions and function notwithstanding dramatic fluctuations in the political climate. Concrete health care delivery programs have been organized across "enemy lines."

In addition to expanding and developing medical networks, the Health Bridges for Peace project seeks to broaden its collaborative and supportive ties with sympathetic international organizations. The WHO is ideally suited to be a HBP collaborative partner, and could provide opportunities for the careful expansion of HBP field programs.

Conclusions

With the support of international organizations, including WHO, and non-governmental organizations, the Health Bridges for Peace project has demonstrated that medical professionals have a special role to play in healing communities that have been devastated by violence. Their special role lies not only in mending the physical and psychological wounds of individuals but in rebuilding structures for public health care and in creating bridges for community reconciliation. Involvement of medical professionals

from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement that is essential for sustainable peace.

Furthermore, the HBP project has done more than create opportunities for integrating health care delivery with conflict management. HBP field programs have provided new hopes and possibilities to many indigenous health professionals. Many of them were in despair, and had all but given up their medical practice in the face of the human and physical destruction of their post-war situation. HBP has given them new opportunities, a new vision, and a new role in their community and in the world. It has demonstrated the potential of healing and collaborative action, and has built bridges between colleagues who thought they could never again work together. Similarly, for international collaborators such as WHO field staff, HBP has expanded their mission and has sparked great excitement.

Medical professionals in the Balkans and in the Caucasus have expressed a strong desire to strengthen the existing field programs. Interest is growing elsewhere in the establishment of new field programs. Responding to these expressions of need poses an exciting challenge, which WHO is uniquely placed to meet. Through the Global Symposium on Violence and Health, sponsored by the WHO Centre for Health Development in Kobe, Japan, WHO has taken a significant step forward in meeting this challenge. There are two important next steps that WHO could take. One is for WHO to increase its support for new and existing Health Bridges for Peace programs internationally. The second is for WHO to develop a task force to examine the needs and opportunities for WHO to lead the international community in the use of Health as a Bridge to Peace in the next millennium.

Acknowledgements

IRSS is indebted to the many individuals and organizations who have supported its work on international conflict management, especially on the development of the Health Bridges for Peace project. These supporters include: World Health Organization; William and Flora Hewlett Foundation; US Institute of Peace; members of the Rockefeller family; Winston Foundation for World Peace; the Know How Transfer Center; Open Society foundations throughout former Yugoslavia; International Physicians for the Prevention of Nuclear War - Austria; and individual donors.

Moreover, we wish to acknowledge the hard work of numerous individuals and organizations that are collaborating with IRSS to apply integrated-action strategies and to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in conflict-torn areas. These collaborators include: OMEGA Health Care Center (Graz, Austria); the Slovene Foundation (Ljubljana); HealthNet International and Moj Priatelj (Sarajevo); Netherlands Relief Committee for Chechnya; the Association for the Protection of the Rights of Refugees and Forced Migrants in the CIS; and the Organization for Security and Cooperation in Europe.

Appendix 3.
The Medical Network for Social Reconstruction in the Former Yugoslavia

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> *Health is valued by everyone. It provides a basis for bringing people together to analyse, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict.*
>
> *World Health Organization, 1995*

Mission Statement

The Medical Network for Social Reconstruction in the Former Yugoslavia (Medical Network) is a network of health-care providers drawn from all parts of the former Yugoslavia. Through the Medical Network, hundreds of health-care providers— including physicians, psychologists, university professors, teachers, volunteers and local and national government health-related ministers—work together, across disciplines and across borders, to improve the health of the community and the region.

The Medical Network is dedicated to facilitating healing and recovery processes that promote individual and community health and empowerment as well as the prevention of future conflicts in its region. It is founded upon two major beliefs. First, violent conflict and war are the ultimate threat to public health. Second, the health community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and psychological wounds of individuals but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation. To these ends, the Medical Network aims to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in the region of the former Yugoslavia.

Origins of the Medical Network

The Medical Network has evolved from its origins in 1991, when a small group met sporadically in conjunction with meetings of the International Physicians for the Prevention of Nuclear War (IPPNW). Since 1993, it has convened annual meetings and has organized projects and training programs for health-care professionals and medical students. Even during periods of extreme violence in the region, the Medical Network has orchestrated broad-based participation and has brought together polarized parties.

It was officially established in its present form in April 1997 at a conference in Graz, Austria. Since then, it has convened five international conferences: April 1998, in Sarajevo, Bosnia; May 1999, in Ohrid, Macedonia; May 2000, in Gracanica, Bosnia; June

2001, in Neum, Bosnia, and June 2002 in Igalo, Montenegro. In June 2003, an international conference is planned to take place in Rijeka, Croatia, to address "Violence, Mental Health and Society". The conferences bring together health professionals from all parts of the former Yugoslavia and from around the world, providing opportunities for professional exchange, training and organizational development of the Medical Network.

Goals of the Medical Network

The first goal of the Medical Network is to facilitate and perform inter- and intra-regional collaborative projects (involving two or more members, associates or affiliates of the Network) that encourage sustainable programs for promotion of medical, psychological and social well being and development.

The second goal is to provide a framework for ongoing productive communication among health professionals (broadly defined) within the former Yugoslavia and also beyond the region.

Guiding Principles for the Medical Network

1. Promote interregional cooperation and the reconstruction of professional relationships through mutually-empowering, action-oriented programs.
2. Work in a manner that is culturally sensitive and adapted to the social context and the current situation.
3. Work for recovery and well-being of the individual and the community.
4. Meet especially the needs that are not being met by other organizations (e.g., assisting remote and/or under-served localities).
5. Mobilize resources in communities and develop sustainable programs.
6. Engage in multisectoral cooperation with a wide range of professional groups (e.g., medical, psychological, social welfare and educational).
7. Facilitate the productive exchange of experiences and professional expertise (a) within the region of former Yugoslavia and (b) between former Yugoslavia and other regions.
8. Enhance awareness of the international community to the issues and needs in the region.
9. Respect and promote high ethical and professional standards of work.
10. Recognize that different strategies are needed within each region to reach Network-stated goals.

Programs of the Medical Network

The Medical Network runs periodic training workshops, conducts a range of inter-communal health-care projects, and convenes annual international conferences. The Medical Network's collaborative programs cover a range of content areas, including:

- health care and social reconstruction;
- programs for youth and adolescents;
- refugees and resettlement;
- professional training in trauma treatment, help to helpers and other community-based psychosocial programs;
- support of local program development, implementation and evaluation;

- development of capabilities within civil society through voluntary action programs; and
- professional training in conflict management, coexistence and community reconciliation.

The Medical Network has also reached out to physicians from other war-devastated or socially-depressed areas, including neighboring areas in the Balkans, the North Caucasus and the Middle East.

The Medical Network publishes reports and newsletters containing information about Medical Network literature and other resources, needs and capabilities throughout the region, and Medical Network conferences, workshops and meetings.

The Medical Network enjoys cooperative relationships with international medical organizations, including the World Health Organization, the International Society for Health and Human Rights, CARE, UNICEF, and the International Physicians for the Prevention of Nuclear War (IPPNW).

Organization of the Medical Network

The Medical Network functions through a "Contact Group" composed of representatives from different geopolitical points throughout the former Yugoslavia. The Contact Group meets every six months, has email and fax communication on a regular basis, and leads the Network as it engages in cooperative medical projects that cross conflict lines.

Support of the Medical Network

Grants and donations from a range of sources—international and indigenous, government and private—have supported the work of the Medical Network.

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Appendix 4.

Post-Traumatic States:

Beyond Individual PTSD in Societies Ravaged by Ethnic Conflict

by Vamik D. Volkan, M.D.

Presented by Vamik D. Volkan, M.D.,
Director, Center for the Study of Mind and Human Interaction,
at the
Eighth International Conference on Health and Environment:
Global Partners for Global Solutions
United Nations, New York
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I am deeply honored to speak at the United Nations. I would like to thank Dr. Christine Durbak for inviting me again to come to the Eighth International Conference on Health and Environment: Global Partners for Global Solutions here at the U.N. Along with many others, I appreciate your efforts in dealing with critical issues in health and the environment around the globe.

Today, I would like to focus on psychological health issues pertaining to ethnic conflicts and wars.

All of you are familiar with societies traumatized by war and ethnic, racial or religious conflict. And you are well aware of the individual suffering these tragedies inflict. Today, I would like to provide you with a new lens through which the aftermath of these devastating events can be viewed.

Though we are all familiar with the psychological state of the individual **Post-Traumatic Stress Disorder** (PTSD), we must also look closely at three other groups affected by PTSD, the first of which is composed of **indigenous caretakers** who themselves may be traumatized by or caught up in ethnic hatred. How do we help them?

Next we will look at the large group, or society, and at some of the signs and symptoms of **societal processes** which follow in the wake of these calamities. How do we diagnose post-traumatic states of societies and develop policies to combat them?

And, finally, we will look at future generations and how the legacy of trauma and hatred is passed on at both the individual and societal levels. How do we identify and intervene in these **transgenerational transmissions** of trauma?

Natural or Accidental Traumas

Before speaking of societies traumatized by ethnic, national, or religious conflicts, I wish to discuss the societal traumatization that can be caused by natural or accidental manmade disasters. A tropical storm, such as the one that devastated the Dominican Republic in 1998, or an earthquake such as the one that ruined Armenia in 1999, are natural disasters. When a natural disaster takes place, there is shock. The level of outside assistance offered

in a particular crisis depends on many conditions. Chaos and physical hunger can occur. Furthermore, the survivors need to mourn their losses as they clean up their environment. For months, or even years, their minds may be preoccupied with images of death and destruction. They may exhibit what is known in psychiatry as "survivor's guilt," condemning themselves for having lived while others perished. A shared anxiety also many linger on because the people lose their trust in "mother nature." As far back as 1954, Rangell studied the importance of our physical surroundings, and he described a phenomenon called "attachment to the ground" (p.314) as a psychic prerequisite for the maintenance of the social state of poise. Massive environmental disasters caused individuals or the society to lose their poise. In the long run, the survivors of natural disasters usually come to find comfort in ascribing an inner meaning to what has happened, declaring that it is the will of God, for example.

Massive trauma can also be brought about accidentally by humans. An example of this is the Buffalo Creek tragedy of 1972, a disaster that occurred when a slag dam collapsed in the West Virginia mountains and inundated many coal camps, and sixteen towns, with millions of gallons of black water and sludge in a seventeen-mile-long valley, killing 127 people.

Though a relatively small segment of the state of West Virginia was affected, I mention this tragedy because it was the first manmade disaster that was studied extensively by psychiatrists, psychologists, sociologists, and legal professionals (Lifton and Olson, 1976; Erikson, 1976; Rangell, 1976). When the survivors were examined thirty months after this event, their images of death and destruction were still vivid. Many of them also exhibited survivor guilt. Legal settlements in this tragedy played a crucial role in restoring normality to the Buffalo Creek society.

When a society is put on the right track after a disaster, there may occur what Williams and Parks (1975) refer to as a process of "biological regeneration" (p.304). For example in the Welsh village of Aberfan, for the five years following the engulfment there of 116 children and 28 adults by an avalanche of coal slurry, there was an increase in the birthrate.

The impact of some accidental manmade disasters is much wider. Consider the nuclear accident at Chernobyl. The anxiety of individuals and societies about contamination lasted many years, and for good reason. Thousands in Belarus, for example, considered themselves contaminated with radiation and did not wish to have children because they feared they would have birth defects. Thus, the existing norms for finding a mate, marrying and planning for a family were affected. Those who had children remained anxious that something "bad" would evolve in their offsprings' health. Here, instead of an adaptive "biological regeneration," society reacted negatively.

Traumas Caused by Others

Even though they may cause massive environmental destruction, societal grief, anxiety and change, natural or accidental disasters should be differentiated from those where massive trauma is due to ethnic or other large-group conflicts. When nature shows its fury and people suffer, people ultimately accept the event as part of their fate. In manmade accidental disasters, survivors may blame a small number of individuals or governmental organizations for carelessness. Even when this happens, there are no "others" who had deliberately sought to hurt people. When a massive trauma is due to ethnic, national or

religious conflicts and wars, the situation becomes complicated because of the presence of enemies who deliberately inflicted pain and suffering on the victims.

Ethnic or other large-group hostilities initiate a number of shared psychological processes. First of all, when a large group's conflict with a neighboring large group becomes inflamed, the bonding between members belonging to the same large group increases. There is a shift in members' investments into their large-group identity, which, under stressful conditions, may become more important than the individual identity. This movement leads to further differentiation between one's large group and its enemy group. The relationships between people in each group are now governed by rituals of large-group psychology (Volkan, 1988, 1997, 1999). In wars or warlike situations, such rituals are performed according to two obligatory principles: 1. maintaining one's large-group identity separate from the identity of the enemy; 2. keeping a psychological border between the two large groups at any cost. When two ethnic groups are in a "hot" conflict, they wish to erase any sameness between them; thus, these two principles become operational. When large groups are not the "same," they can project more effectively their unwanted aspects on the enemy, thereby dehumanizing that enemy.

Anything that disturbs these two principles brings massive anxiety, and large groups may feel entitled to do anything to protect these principles. The hostile interactions are perpetuated. When one large group victimizes another one, those who are traumatized do not turn to "Fate" or "God" to understand and assimilate the effects of the tragedy. Instead, they may increase their sense of rage and revenge.

Feelings of rage and revenge oscillate with helplessness, humiliation, and victimization. Such internal turmoil prohibits the evolution of certain psychological processes that the victims need to go through in order to assimilate and accept their tragedy. Among these psychological processes is the work of mourning (Freud, 1917). Humans are obliged to mourn their losses and changes in life. Mourning allows us to accept that a loss or a change has occurred. Without mourning we are trapped in the struggle to accept the tragedy and to adjust to life after it. If that struggle is not won, we cannot move on with our lives. We metaphorically remain hiding in the basement after the tornado has passed over and fair weather has returned. An individual, or a society, traumatized deliberately by others has a tendency to remain in the basement. The sense of shame, humiliation, and helplessness may become internalized, which consequently complicates the survivors' guilt.

The psychology of individuals and societies traumatized due to ethnic or other large-group conflicts and hostilities should be considered a unique category, quite distinct from those devastated by natural or accidental manmade disasters. What is most interesting is that the study of this psychology is relatively new and that often we still deny its horrible effects.

The survivors of the World War II German concentration camps provided psychiatrists, psychoanalysts and other mental health workers with a hitherto unprecedented opportunity to study individual and mass reactions to overwhelming stress brought about by the politically motivated cruelty of man. Persecution in its other forms—for instance, the hunting down of people in hiding, emotional and intellectual erosion, and the mass expulsion from a home—could also be studied in psychoanalytic terms. It is interesting that when the Jews were rescued from the concentration camps, no one, through an astonishing oversight, (Friedman, 1949) took into consideration the psychological plight of these victims. The naive notion that releasing the prisoners from

their confinement would end their suffering seemed to prevail. Writing in 1949, Friedman noted how incredible it seemed in retrospect that when plans were first made for the rehabilitation of the Jewish survivors of the Holocaust in Europe, no one considered how likely it was for them to have psychiatric difficulties. Instead, everyone concentrated on the alleviation of their physical suffering. However, when the first survivors of the camps reached the United States, psychiatric help was provided for them, and an understanding of their situation in psychoanalytic terms began.

The Vietnam War again brought to mental health workers' attention the fact that many individuals, even those who are active participants and not prisoners, can be psychologically traumatized. In clinical terms, such individuals suffer from Post-Traumatic Stress Disorder, a relatively new category in the classification of mental disorders. PTSD exhibits symptoms that are now well known by those who are charged with helping such sufferers. These victims continue to experience their present-day interactions with others and their environment by way of the mental images of the traumatic experiences. Present-day tasks and activities are experienced through the prism of the mental images of past trauma, which are not assimilated and worked through. These individuals' preoccupations with such images are accompanied by either paralysis of initiative and/or hyperarousal. They also distance themselves from others, wish for revenge, feel depressed and have suicidal thoughts, or feel inappropriately elated. They suffer from shame, guilt, and helplessness. Over time, their symptoms may subside or change function, but new versions of their symptoms continue to disrupt their lives.

Today, when a society is traumatized by mass cruelty to humankind, the victims' mental health is routinely considered by international and indigenous authorities. Nevertheless, a closer look suggests that a tendency to deny the mental health problems still exists. There is an extensive and rich literature covering PTSD after ethnic or other large-group conflicts. I am sure that many of you in the audience have a great deal of information about PTSD and efforts to treat it. As I stated earlier, I wish to provide an additional lens for viewing other aspects of traumatized societies.

1. How do we equip local mental health workers with the proper tools for serving the directly traumatized population?

When a massive, bloody ethnic conflict erupts, indigenous mental health workers, such as those caretakers who were in Sarajevo during the months-long bombing of this city by the Bosnian Serbs, may be directly traumatized.

One Bosnian psychiatrist, who was assigned to deal with the PTSD population after the arrival of peace, continued to have a symptom that had started three years earlier during the siege of Sarajevo. Before going to sleep or upon awakening, she would check her legs to see if they were still attached to her body. When I examined the meaning of the symptom with her, we found out that it was connected to an incident during the siege. She had rushed to the hospital one night and had witnessed the amputation of both legs of a Bosnian young man whom she had known before the ethnic troubles started. The young man's legs were smashed when a bomb exploded, and they had to be amputated. The psychiatrist unconsciously identified with this young man. After the peace arrived she kept checking to see if her own legs were intact. When the connection between her symptom and her identification with the young man was brought to her attention years later, the symptom disappeared.

Instead of recalling the tragedy through experiencing appropriate emotions, she was remembering her own horror of being under enemy attack, day after day. This psychiatrist, to a great extent, was paralyzed in dealing with her PTSD patients. Because of her unconscious fear of experiencing horrible emotions, she could not fully help her patients experience their emotions in a therapeutic setting or relieve them of the maladaptive influences of repressing or denying what had happened to them. A traumatized indigenous mental health worker herself or himself needs psychological help in order to be a more effective caretaker.

In bloody ethnic or other large-group conflicts, those who are not directly affected are also influenced psychologically. As we stated earlier, the eruption of ethnic conflicts increases the emotional links between individuals who belong to the same large group. Large-group identity in fact overshadows individual identity. Under such a circumstance, a person who is not directly affected feels the impact of large-group feelings, ranging from ethnic pride and a sense of revenge to ethnic shame and humiliation and helplessness. The loss of people, land, and prestige affects everyone in an ethnic group victimized by a neighbor, including the caretakers.

Psychiatrists, psychologists or social workers in a society traumatized by ethnic or other large-group conflict develop their own complicated psychological processes even when they are not directly traumatized. In turn, they may have difficulties in caring for patients. A young Croatian psychiatrist who was not directly traumatized during the Croatian-Serbian war was assigned to work in a hospital in Vukovar after peace was made between Croatia and Serbia. (Vukovar is a border city between today's Croatia and Serbia. During the war, when the Serbs attacked this city, they turned it into ruins as the residents of Croatian origin fled inland. Today, Vukovar is a Croatian city, but most of its residents are of Serbian origin. The story of Vukovar induces deep emotions within all Croatians.) The young Croatian psychiatrist was proud to be assigned by his Ministry of Health to work in Vukovar, and he thought it his national duty to play a role in changing the emotional atmosphere of the city so that former Croatian residents would want to return. His ethnic sentiments were highly enhanced. When he arrived in Vukovar, he was met in the hospital by colleagues who were of Serbian origin. The Serbian psychiatrists wanted to be friendly with the newcomer and, in addressing him, used his first name.

Working daily with Serbian colleagues who spoke to him as if nothing had happened infuriated the young Croatian psychiatrist. Furthermore, he believed that one of them had been involved in making an "extermination" list of Croatian hospital patients for the Serbs when Serbian forces had attacked the city. The Croatian doctor felt like a traitor for working with this Serbian. Therefore, when working with his Croatian and Serbian PTSD patients in Vukovar, he was paralyzed, to a great extent, in his function as a mental health caretaker.

I believe that the NGO can improve the caretaking skills of indigenous mental health workers in two ways; the first being an intellectual one. They can train these caretakers through lectures, seminars or workshops given by foreign experts. Through our work in traumatized societies after ethnic or national conflicts such as those in Northern Cyprus, Kuwait, the former Yugoslavia, and the Republic of Georgia, we came to the conclusion that foreign NGOs have been most useful in giving this kind of intellectual, consultative and supervisory help to local health care workers.

But while it is necessary, and most useful, often it does not deal with the local mental health workers' own needs to work out their internal conflicts concerning ethnic or

other large-group conflicts as described in the two examples above. The other way in which the NGO can help is by developing programs wherein the emotional well-being of the indigenous caretakers is considered. Up until now, much less emphasis has been placed on these kinds of programs; however, the NGO should be aware of this neglected area.

2. How do we diagnose and deal with societal processes that are initiated after bloody ethnic conflicts?

Besides an individual developing PTSD after a massive and shared traumatic event due to an ethnic, national, or religious conflict, the society in general usually exhibits a collective disorder, or at least a modification in the traditional ways of expressing the culture. Earlier I noted that such a process followed the Chernobyl accident. Following ethnic or other large-group conflicts, however, such societal changes appear more regularly. A modification of the existing societal process itself may not be dangerous, but it may create shared anxiety due to the loss of the accustomed ways of expressing cultural norms. Sometimes the societal change is clearly maladaptive.

A methodology for diagnosing societal changes after ethnic or other large-group hostilities is rather new. I (Volkan, 1976) attempted to do this in Northern Cyprus after the Turkish Army *de facto* divided the island of Cyprus into Northern Turkish and Southern Greek sectors in 1974.

Members of the University of Virginia's Center for the Study of Mind and Human Interaction also carried out more refined diagnostic work in the post-Iraqi invasion of Kuwait (Howell, 1993, 1995; Saathoff, 1995, 1996; Volkan, 1997, 1999). This work was carried out under the directorship of Ambassador W. Nathaniel Howell, who was the U.S. ambassador to Kuwait during the invasion and who kept the embassy open for seven months when Iraqis were in Kuwait city. Ambassador Howell, who is a resident diplomat at our Center, and other CSMHI faculty members made three visits to Kuwait three years after its liberation. Over 150 Kuwaitis, children and adults, men and women, rich and poor, were chosen at random and interviewed in depth. In other words, we evaluated their internal worlds psychoanalytically.

You can imagine that many of these individuals were directly affected and suffered individual PTSD, which had gone undiagnosed. Nevertheless, our emphasis was on finding out changes in the societal processes. To do so, we recorded certain repeated and shared themes from the interviews, as I had done in my study of the situation in post-1974 Northern Cyprus. We learned that perceptions of young Kuwaiti men concerning the rapes of Kuwaiti women by the Iraqi soldiers had been generalized. Because of this generalized perception and because of the traditional devaluation of raped women, young Kuwaiti men who were engaged to be married, without being aware of the cause, wanted to postpone their marriages. Those who were not engaged to be married wanted to wait a while before seriously considering finding a mate. Thus, the previous tradition concerning the age of marriage of young men and women was threatened. While this did not cause a danger, it created anxiety.

The following finding, however, is a more direct expression of a societal maladaptation following a massive traumatic event. During the invasion, many Kuwaiti fathers were humiliated in front of their children by Iraqi soldiers. When the humiliation occurred away from their children, the fathers wanted to hide what had happened to them. In either case, the fathers began distancing themselves from certain crucial emotional

interactions with their children, especially the male children, in order to hide or deny their sense of shame. This led to the initiation of a societal process. The male children who needed to identify with their fathers on the way to developing their own manhood responded to the distance between themselves and their fathers.

Many school buildings in Kuwait were used as torture chambers. After the invasion, the Kuwaitis repaired the buildings and painted over areas where tortures had taken place. Adults did not speak to the children about what had happened in the schools during the invasion, but the children knew what had happened. When they went back to their schools, the "secret" between parents and children caused psychological problems for them. In turn, the young ones, without knowing why, identified with Saddam Hussein instead of "distant" and humiliated fathers. For example, in an elementary school play where the story of the Iraqi invasion was put on the stage, children applauded most for the youngster who played the role of Saddam Hussein (Saathoff, 1996).

"Identification with the aggressor" is a psychoanalytic concept that refers to when a child identifies himself with the parent of the same sex with whom the child has been involved in a competition for the affection of the parent of the opposite sex (A. Freud, 1936). In childhood, this process results in a child's emotional growth. A little boy, for example, through identification with his father, whom he perceives as the "aggressor," makes a kind of entrance into manhood himself. But, in other situations, like those of many Kuwaiti elementary school children, we see how an identification with the aggressor, in this case, Saddam Hussein, creates difficulties in families and in the society at large.

The unconscious distancing between Kuwaiti fathers and teenage sons also resulted in gang formations among the teenagers, who were frustrated by having "distant" and humiliated fathers, and by not being able to talk to their fathers about the tragedies during the invasion. Consequently, they linked themselves together and expressed their frustrations in gangs (Howell, 1996). Such societal processes did not exist in pre-invasion Kuwait.

Societal response to a shared trauma after a war or warlike situation may occur years after the trauma, and the connection to its cause is lost. The society is puzzled or creates incorrect and inadequate explanations. Since the actual cause remains unknown, attempts to counter it are easily frustrated or worsen the situation.

NGOs who deal with traumatized societies after ethnic or other large-group conflicts need also to consider maladaptive societal changes, shared psychological problems that may even lead to political difficulties. Since we now have developed a technique to evaluate such "post-traumatic states" (Volkan, 1998, 1999)—most recently we applied our diagnostic technique with success to the evaluation of the societal processes in the Republic of Georgia after the Georgian-Abkhazian and Georgian-South Ossetian troubles—this technique can be brought to the NGOs' attention. This area is an arena in which psychodynamic insights can be useful for NGOs.

3. How do we evaluate transgenerational transmission of trauma, and how do we prevent the next generations from being carriers of the malignant effects of the tragedy that their parents, grandparents or ancestors experienced?

During the last decades, transgenerational transmission of trauma and its relation to the mental health of future generations have come to the attention of NGOs, who deal with the psychological well-being of refugees, internally displaced individuals, and others who have experienced the horrors of wars. This development owes a great deal to studies of the

second and third generations of Holocaust survivors and others who were directly traumatized during the Third Reich (see for example, Kestenberg and Brenner, 1996; Kestenberg and Cohen, 1998).

Last summer in Dubrovnik, Croatia, I conducted a small group meeting between Croatian, Serbian, and Bosnian psychiatrists and psychologists designed to explore their own ethnic sentiments and traumas in order to help them become better caretakers. This gathering was organized by Professor Eduard Klain from the University of Zagreb. With a stroke of genius, Professor Klain also had invited a group of Israeli psychoanalysts and other mental health workers to this meeting. After much discussion of Croatian, Serbian, and Bosnian PTSD patients, and after examining the indigenous caretakers' own problematic issues, the Israelis warned those present that there existed another major issue: the transgenerational transmission of trauma. It had taken the Israelis at least two decades after the end of World War II to work through their own denials and note how the second and third generations after the Holocaust needed close attention and care. The Israeli guests told the Croatians, Serbians, and Bosnians, "Let us give you advice; you do not need to wait 10 or 20 years before developing strategies to deal with the next generation." In spite of the awareness that transgenerational transmission of trauma occurs, this area requires further study.

When psychoanalysis was discovered, initially the emphasis was on study of the internal world of an individual. People and things in a child's environment were considered primarily, according to what the child projected on them. As time went on, we learned that in order to "hatch" the child's existing mental potentials, we need to consider the two-way street between the child and his or her intimate caretakers (see, for example, Mahler, 1968). There is a fluidity between a child's "psychic borders" and those of his or her caretakers. And the child-mother (caretaker) experiences function as an incubator for the child's developing mind. But the fluidity also may cause trouble, in that the person from the older generation can transmit undesirable psychological elements to the child in the next generation. Such a fluidity also occurs in drastic ways among adults under certain conditions when the adults regress.

One of the most known examples of a form of transgenerational transmission comes from World War II when the Nazis were bombing London. Anna Freud and Dorothy Burlingham (1945) noted that infants under three did not become anxious during the bombings unless their mothers were afraid.

There are various forms of transgenerational transmissions. Besides anxiety, depression, elation or other feelings, the mothers or other caretakers pass unspoken thoughts and fantasies to their children. For example, a mother's unspoken wish that her newborn daughter should be a son may play a role in the daughter's sexual life when she becomes an adult. If we examine this situation clinically we note how the mother, without actually describing her wish, had influenced her daughter in many ways (Volkan and Masri, 1987). Similarly, we note certain repeating activities in a patient who seems to be doomed to having to save someone she considers "needy." We find out that this individual had a depressed mother who unconsciously gave a task to her daughter. Thus, the daughter, as an adult, centered her activities on being a savior of "needy people" who represented the image of her depressed mother (Volkan, 1982). Among refugees, when mothers or other caretakers are under stress and regressed, such transgenerational transmissions of tasks can be observed, even when interactions take place between adults. We examined a Georgian woman in her early forties and her 16-year-old daughter. At the

time, both had been refugees from Abkhazia for over four years. They, with other family members, were living under miserable conditions. Every night, the mother went to bed worrying about how to feed her three teenage children the next day. She never spoke to her only daughter about her worries. But, the daughter sensed her mother's worries and also, unconsciously, developed a task to respond to and alleviate her mother's pain. The daughter refused to exercise, became somewhat obese and put a frozen smile on her face. When we interviewed both of them, we learned that the daughter, through her bodily symptoms, was trying to save her mother by sending her a message: "Mother, don't worry about finding food for your children. See, I am already overfed and happy!"

In order to more fully understand how the influence of a massive, shared trauma passes to the next generation, we need to consider still another form of transgenerational transmission; a type which more directly influences the individual and large-group identity of the next generation(s). This type of transgenerational transmission involves the "depositing" of an already-formed mental image into the developing identity of the child (Volkan, 1987). We know that this often occurs in some children known as "replacement children" (Poznanski, 1972; Cain and Cain, 1964). A mother's child dies. Soon after this, she gets pregnant and has a second child who lives. The mother "deposits" her image of her dead child into the developing identity of her second child who now has a task to keep this "deposited" identity, one way or another, within herself. Thus, the replacement child may have identity problems as an adult. He or she may have a "double identity" and develop what we call a "borderline personality organization." Or, the person is doomed to live up to the idealized image of the dead sibling within himself or herself and may become obsessively driven to excel.

Adults who are drastically traumatized may deposit their traumatized self-images into the developing identities of their children. A Holocaust victim who appears well adjusted may be behaving in this way because he has deposited different aspects of his traumatized self-images into his children's selves (Brenner, 1998). His children now are responding to the horror of the Holocaust, "freeing" the older victim from his burden.

After a shared massive trauma, affected individuals' traumatized self-images are linked with the same trauma. When hundreds, thousands, or millions of individuals deposit their traumatized images into their children after a massive shared trauma, this process affects the large-group identity. While each child has his or her individualized personality, they all share similar links to the "memory" (the mental representation) of the trauma and similar unconscious tasks to deal with this "memory." Therefore, under such a situation, an unseen network among hundreds, thousands or millions of people is created. Usually, the shared task is to keep the "memory" of the parents' trauma alive and to mourn their losses, revere their humiliation, or take revenge. If the next generation cannot effectively deal with their shared tasks—and this is usually the case—they will pass such "tasks" to the third generation, and so on.

According to external situations, shared tasks may change function from generation to generation (Apprey, 1987, 1993; Volkan, 1987, 1992, 1997, 1999). For example, in one generation the shared task is to grieve the ancestors' loss and feel their victimization. In the following generation the shared task may be to express a sense of revenge. But, keeping alive the mental representation of the ancestor's trauma remains the primary task. Since it is shared, the new generation's burden also supports the large-group identity. I call such "memories " (mental representations) the large group's "chosen trauma." In open or dormant fashion, a chosen trauma continues to exist within the generations throughout

years or centuries. When there is a new ethnic, national, or religious crisis in the large group, leaders intuitively re-kindle memories of past chosen traumas as Slobodan Milosévic and his entourage did before the Serbs' recent war with Bosnian Muslims. They reactivated the memory of the Battle of Kosovo, which had taken place 600 years ago when the Serbs and Ottoman Muslims fought. The "memory" of this battle had been the Serbs' "chosen trauma." The six-hundred-year-old remains of Prince Lazar, who was the Serbian leader during the Battle of Kosovo, and who was captured and killed, were put in a coffin. This coffin traveled from Serbian village to Serbian village for a year-long journey, and at each stop a kind of funeral ceremony took place. The Serbian people reacted as if Lazar had been killed just yesterday. Such a response created a "time collapse." Feelings, perceptions, and anxieties about the past event were condensed into feelings, perceptions, and anxieties pertaining to current events. Since Lazar was killed by Ottoman Muslims, present-day Bosnian Muslims—seen as an extension of the Ottomans—were killed and raped. In effect, an atmosphere was created in which the Serbian people could consider revenge a Serbian entitlement.

Time does not permit me to detail this "reenactment"of Serbia's "chosen trauma" (Volkan, 1997, 1999). I simply wanted briefly to introduce you to certain possibilities concerning the "fate" of a chosen trauma. There are, as far as I know, no established NGO methods for dealing with the transgenerational transmission of shared trauma. I am familiar with the work that is being carried out in regard to aspects of this phenomenon in Georgia and South Ossetia. But, the prevention of malignant developments due to transgenerational transmissions, for practical purposes, remains unexplored. Governmental and non-governmental organization' should note this phenomenon and help develop effective measures for dealing with it.

Summary

My aim today was to provide you with a new means of seeing the social aftermath of ethnic, national and/or religious conflicts. While ministering to individuals who suffer acutely from PTSD remains our primary task, it is important for NGOs to be aware that PTSD hinders the restoration of individual as well as societal processes. Indigenous caretakers of victims, such as mental health workers, are themselves victims and need outside intellectual, consultative and supervisory assistance, but, more importantly, they need help to work through their own emotional complications. Programs need to be developed in this regard. The effects of this disorder also permeate, distress and linger with society at large. Some diagnostic techniques are now available to NGOs. The resulting psychodynamic data should prove valuable. Lastly, I have noted that shared trauma crosses generational boundaries. As I have said, dealing with this notion by NGOs is, by and large, unexplored territory that needs further study.

Our knowledge of the legacy of ethnic wars is expanding with the effort of many disciplines. NGOs can transform this new knowledge into more effective efforts in restoring the peace, securing stable societies, and derailing the passage of ethnic hatreds to new generations.

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Appendix 5.

Community Integration for Psychosocial Assistance:

Building Confidence, Strengthening Identity, Facilitating Social Integration, and Supporting Basic Needs of Refugees Through Community Integration

by Anne Marie Miorner Wagner (OMEGA Health Care Center, Graz, Austria) with assistance from Paula Gutlove and Jacob Hale Russell (Institute for Resource and Security Studies, Cambridge, Massachusetts, USA)

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1. Overview: Why Community Integration?

The object of community integration is to integrate vulnerable or marginalized groups — such as refugees — into a community, while strengthening the overall social fabric of that community. Resources needed for this task are found largely within the community, by identifying and developing the capabilities of members of the community. Integration is achieved through local-level psychosocial projects that empower members of the target groups and help them adapt to new environments.

Psychosocial projects of this kind are especially useful in helping immigrants and refugees adapt to a new culture. The challenges of adapting to a host country are probably a source of stress to these groups that is exceeded only by trauma experienced in their region of origin. In order to make the process of adaptation proceed smoothly, community integration promotes contact with the new environment, which might otherwise be strange or hostile, in a way that is safe and supported. Fundamental goals of community integration are to establish a strong social network and to create strong, independent individuals who are able to function freely in their new environment.

Community-integration projects are marked by psychological planning, documentation and supervision. Wherever possible, professionals, including health workers, psychiatrists, psychotherapists and psychologists, social workers, and teachers, should be used to design and support an approach that addresses problems of trauma, marginalization, and development (in childhood and adolescence). In addition, community-integration programs should involve individuals familiar with the cultures of both the original and host countries.

The remainder of this paper begins with a discussion of primary target audiences for community-integration work. It then outlines principles and goals for centers that provide psychosocial support to a community, and offers guidelines for practitioners who wish to establish such a center. The entire paper draws on the experience of the OMEGA Health Care Center in Graz, Austria, and the final two sections of the paper relate lessons learned from OMEGA's work with two groups, youth and women, in Graz.

2. Target Audiences for Psychosocial Help

Community-level psychosocial projects can be used to support a wide range of individuals who are dealing with trauma and adapting to a new culture. However, OMEGA's work with community integration has focused on two specific target groups: women; and children. These two groups are relatively vulnerable groups in any society, and especially in immigrant communities.

Youth projects attempt to fit into the normal framework of children's lives. Thus, they often feature support groups and other projects in local schools, as well as spare-time activities like artistic and athletic workshops. Practical support, as in "Big Brother" / "Big Sister" programs, can provide supervision with positive effects, particularly for unaccompanied young refugees.

Psychosocial assistance for women recognizes the traditional role women play in supporting the family and raising children, and the difficulty that migration can create for family patterns. It is often difficult to convince women to accept help from outside institutions, because their need is often viewed as a psychological handicap. Thus, projects for women need to establish a sense of safety and community. Once clients find the courage to talk and share their experience in a group setting, program activities such as workshops seek to enable their capacities, maximize their talents in the new society, and develop skills for employment.

An advantage of focusing on support of women and children is that these groups have the ability to link community-integration projects with their own families. Men and fathers are harder to reach and less likely to seek out assistance from a psychosocial center, for fear of seeming weak. When a community-integration program helps mothers, the experiences of these women often build trust in her husband and children. Similarly, outreach to children can be an enabler in providing help to an entire family. Refugees often say that they fled their country to provide a better future for their children. Thus, parents and grandparents will show gratitude towards, and develop trust in, an institution that helps their children. While no group should be excluded from a community-integration program, it may be easier to reach out to an entire community by targeting specific groups.

The psychosocial projects are often located in predominantly poor or immigrant-centric communities. Needs and opportunities for positive social networking may be especially great in areas with a mixture of immigrants from multiple countries of origin. Psychosocial centers can also develop synergistic relationships with other local institutions — for instance, schools in underfunded districts — by combining the skills and specialties of each organization.

3. Key Principles and Goals of Psychosocial Community-Integration Projects

Based on OMEGA's experience in community integration, a number of primary themes and goals for community psychosocial projects have been identified:

(a) *Social integration is best served by groups that include both domestic citizens and foreigners*.

By providing forums in which individuals of different cultural backgrounds can mix, constructive dialogue and integration can take place. Part of the acculturation process for refugees and immigrants requires that they get to know residents of the host country. This simultaneously helps overcome refugees' anxieties about an otherwise strange land and combats misperceptions that locals may have about refugees.

Integration should also occur between immigrants from different countries of origin. For instance, in OMEGA's Graz-based center, refugees from the former Yugoslavia, from the Middle East, former Soviet states, and Africa interact with Austrians in a single setting. Because community integration centers are often placed in areas that may be predominantly composed of immigrants, facilitating peaceful interactions between individuals of different nationalities is as important for integration as are successful interactions with host-country citizens. Psychosocial-support projects must therefore be aware of the struggles by individuals and groups to retain their ethnic identity while becoming a part of their new community through dialogue and other social interaction.

(b) *The location in which groups meet must be designed to be a "safe place," in order to develop trust.*

Social interactions should take place in a "safe place," a room designed to help individuals work through their period of transition to a new culture, during which they must seek to adapt their old identity to new circumstances. In a psychosocial-assistance program, people should not be forced to participate. Instead of being told that they need help, people must choose to ask for help. A "safe room" helps build the trust that allows them to seek help and talk about their potentially traumatic past.

Trust is built through creating an open, nonjudgmental dialogue. Such conversations should be based on a sense of mutual respect, and should allow individuals to feel able to openly criticize either their country of origin, if they were persecuted or otherwise mistreated by their government, or their host society, if they feel mistreated as refugees. Employing a staff of diverse ethnic origin — including foreigners and other immigrants — can be helpful in creating a sense of safety. For instance, more than half of the staff of OMEGA's center in Graz is of foreign origin.

In addition to constructive, open, and respectful dialogue, a feeling of safety and trust can be built by creativity. Individuals wishing to tell their stories — which are often powerful in bringing about political change — may sometimes find it easier to use creative means of expression, including music, literature, or theater. Designing workshops and performances that promote self-expression can be a useful tool in creating a sense of safety.

(c) *Psychosocial programs promote self-confidence by supporting individual identity, and projects should seek to capitalize on clients' resources and talents.*

Participants in community-integration programs participate in workshops and work with mentors in order to gain a sense of tangible involvement in society. For example, rather than providing centers purely for recreation or therapy, OMEGA has held several cooking workshops and groups. To create a sense that these activities are "real" and important, OMEGA obtained a license from the government that allows individuals to actually sell the food they cook. For children, creative and athletic workshops allow them to unleash their individual talents, and to create their own music and performances.

As newcomers, refugees may be reluctant or feel unable to show their talents and resources to their host society. It often takes years to receive the license or approval necessary to work in whatever field they formerly practiced (e.g., as doctors or healthcare workers). This problem can be addressed by identifying and developing prominent elements of individual identity. Activities are designed to be encouraging. Thus, it may be helpful to have individuals demonstrate their individual talents or expertise to others (e.g.,

by hosting slide shows and lectures) so that they can take pride in their knowledge and so that their audience can gain a new appreciation of the immigrant's talents, which can also help dispel stereotypes.

In strengthening individual identity, psychosocial workers should focus on identifying people's strengths. Refugees should be encouraged to capitalize on the abilities they showed in their home country, and helped through workshops and practical assistance (e.g., help in applying for a license to practice in the host country). An additional goal of such programs should be to demonstrate to citizens of the host country (and other foreigners) the level and breadth of artistic, athletic, academic, or other talent coming into their country.

(d) *Community integration helps participants to learn about different cultures, and may motivate them to build community ties by learning the local language*.

Because centers designed for community integration mix individuals of many different cultures, there is a high potential for anger and conflict to emerge as people learn to interact with each other. For instance, because refugees from different countries of origin will likely not share a common language, they will often rely on non-verbal means of expression. However, such hand gestures or facial mannerisms may have offensive meanings to individuals from different cultures, and misunderstandings can emerge.

In order to confront these misunderstandings, the ideal "safe room" has an atmosphere of openness that will make participants comfortable with addressing *why* they are angry or upset. By acknowledging these differences, individuals can not only dispel the anger in the particular confrontation, but also gain a broader understanding of other cultural perspectives.

The significance of language is critical. Many refugees experience apathy about learning the local language or frustration due to difficulties in learning or speaking a new language. Yet, language skills are critical to their ability to integrate into their new environment. By bringing together individuals with no shared languages, community integration often indirectly motivates language study as the immigrants seek a common language to share their experiences. Young people are often eager to communicate with each other if placed in frequent social interaction, and will thus be stimulated to study the host country's language.

(e) *Practical help and services are a crucial component of successful programs*.

Psychosocial-assistance centers should employ a wide range of professionals, including physicians, psychologists, social workers, therapists, teachers, and lawyers. Among the difficulties in adjusting to a new environment are practical challenges, such as applying for citizenship status, finding housing, and ensuring that children are placed in classes appropriate to their abilities. To that end, refugees should have access to an individual capable of providing useful advice.

Among the biggest challenges facing practitioners is to obtain decent living conditions for the people they work with. Many refugees are uninsured, and psychosocial centers should help them to get basic medical care, dental care, and vaccinations. The asylum process, as well as the process of obtaining education for children, should be made as quick and painless as possible. Helping immigrants re-obtain their careers in a new country through professional relicensing is another critical function of such programs.

(f) *Community-integration programs should work collaboratively with other institutions*.

Unfortunately, NGOs that provide similar community-integration services often find themselves in competition for limited funding and resources, rather than working synergistically to realize their common goals. It is therefore important for psychosocial-support institutions to form ties with other local organizations to ensure that money is divided fairly, and to promote an environment where such groups work together rather than compete.

To this end, there are opportunities for collaborative projects where funding will be shared between two groups, and each NGO focuses on performing project tasks that relate to its specialty. Lobbying efforts, too, are also enhanced by collaboration. NGOs should identify measures that they want signed into law and present these to officials as unified petitions and letters. Similarly, NGOs should support each other when they face challenges or danger by showing solidarity.

Another dimension of work with other institutions involves collaboration between psychosocial-assistance centers like OMEGA and governmental organizations. Rather than creating a second layer of professional help (e.g., clinics designed specifically to serve a refugee community), community-integration programs work better when they serve as a bridge to the national infrastructure, including hospitals and schools. While it is natural and healthy for refugees to at first feel more comfortable being helped by a dedicated center or facility, integration requires refugees to learn about their rights to use the national system and not feel excluded. Creating an isolated migrant-health-care system should be avoided.

OMEGA has employed "cultural mediators," knowledgeable individuals who volunteer to go with refugees to show them how to use local resources, ranging from prenatal care facilities to local recreation centers. It is also important to use individuals as advocates for expanded rights to the host country's resources, ensuring that hospitals are providing a high level of care to immigrant communities.

4. Guidelines for Practitioners

A physical space is necessary for any practitioner wishing to establish a psychosocial-support center. Because community integration relies fundamentally on interpersonal interaction in a safe, neutral facility, there must be a room or other reliable location to hold meetings and offer workshops. Participants need to know that there is a safe space where they can consistently come for help. Sometimes space can be found at low cost through a local community center, school, or religious institution.

Of equal importance, of course, is a sustainable staff of volunteers and paid employees. Because of the difficult learning curve for such positions, and because a relationship of trust needs to be established between the practitioners and those seeking help, it is important that volunteers are able to give the center an extended time commitment of at least six months to a year.

Volunteers and paid staff should be recruited from a wide variety of sources. School teachers, doctors, and artists can all be equally helpful in providing the resources necessary to provide practical help, run workshops, and create an atmosphere of trust. Of course, the organization must still employ sufficient professional staff in the most fundamental areas, in particular physicians, psychologists, psychotherapists, social workers, etc. Volunteers should also be selected with an eye towards cultural diversity; refugees will often respond first to individuals of similar background. Even having some sense of shared experience — for instance, any foreigner who has experienced the process

of immigrating into the host country — can enhance trust and allow a bond or connection to form more easily.

Beginning with a small target group (such as women, teenagers, or young children) may make it easier to get a program off the ground. Volunteers can also be recruited out of this target group.

Practitioners need to be trained in providing help and dealing with psychosocial problems. Moreover, it is important that practitioners have help in coping with the burden of hearing other people's traumatic experiences, so that they do not wear out. Having a professional team with a wide variety of perspectives (medical, artistic, political, etc.) can be helpful in this regard, because such teams can tackle problems from a variety of angles without being overwhelmed.

5. Case Study: Youth and OMEGA

Because many refugee families say their primary goal in leaving their home was to seek a better future for their children, engaging and providing services for youth has been a critical dimension of OMEGA's work. OMEGA also devotes resources to helping unaccompanied youth, some of whom may be susceptible to crime, truancy from school, or other developmental problems. Such work requires a medical and psychological understanding of how children and adolescents develop, and how their development interacts with the challenges of acculturation. This is why OMEGA employs professionals in these fields.

OMEGA has launched a wide range of projects designed to provide psychosocial support to youth:

- *Integration through support in schools*. Because OMEGA is located in a part of Austria where there is a high concentration of foreigners, one of the easiest means of reaching the target audience is to work with local schools. Since 1997, OMEGA has worked with pupils, teachers, and parents by convening workshops and support groups. Creative workshops have been used to lessen anxiety, to combat aggression, withdrawal, and xenophobia, and to understand the effects and consequences of such anxiety.

- *Integration through spare-time activities*. OMEGA has worked with youths during their leisure time, holding dancing classes, a musical workshop, and a bicycle-repair training session. The musical workshop spawned "World Beat," a group which brings together young people of different origins — with a particular focus on unaccompanied refugees — to compose and perform musical work. In spring of 2000, a CD ("Doulinga") was recorded in four languages, and a second CD was produced in 2002. Another project, "nex:it," promoted Children's Rights through creative and emotional performances and visual art which focused on exploring international conventions and declarations for the protection of children's rights. In addition to promoting social interaction in a safe setting, such projects have increased awareness about children's rights among both participants and their audiences.

- *Support in everyday life*. Many immigrant youths are benefited by mentors who can help them with practical problems and serve as role models. For this purpose, OMEGA developed a "big brother / big sister" mentorship program, where student apprentices

counseled young people for a full year, supported and trained by OMEGA's professional staff. This is a particularly critical activity for unaccompanied young refugees, for whom the "big brother" or "big sister" provides a fundamental part of their social network.

OMEGA has counseled young people at risk, and has found that an adequate social network must provide particular support for young people who are imprisoned or are repeat offenders. Immigrant youth — and particularly unaccompanied young males — often have a high risk of recidivism, and flight and migration may push young people to slide into criminal behavior. Children are also often employed by mafia or crime rings, and may be afraid to admit their involvement because they have been threatened.

In addition to providing regular counseling services for at-risk children, OMEGA developed a collaborative project with the local court system and social welfare office, where either the court or a social worker will refer a child to OMEGA to participate in a support program. OMEGA then uses the psychosocial assistance process as previously described, trying in particular to identify special talents of which the individual is proud and then capitalizing on these abilities. OMEGA has also created support groups for these individuals, and the groups take frequent excursions including trips to the wilderness. By identifying individuals at risk as early as possible and using a preventive strategy, OMEGA has found some measure of success in reducing criminal activity and integrating youth into society.

6. Case Study: Women and OMEGA

Because of their pivotal role in the family structure, as the person primarily responsible for raising children, women have been a primary focus of OMEGA's outreach. In its "safe room," women find the courage to discuss their experiences and problems, exchange their stories, learn about the host country, and discuss practical subjects, including health, education for their children, continuing education for women, and the job market. OMEGA has tried to create a warm and relaxed environment that promotes creative activity and individual skills. Women often perceive a stigma in seeking help because their need for help can be perceived as a psychological handicap, and a safe space builds trust and reduces such anxiety.

OMEGA's psychosocial-assistance projects for women were built up gradually and focus on practical skills and social integration. Projects include:

- *Women's café and second-hand shop*. Developed in cooperation with Graz's public office for women, the "women's café" was convened weekly in the OMEGA Health Care Center and later at a neighboring second-hand shop. In the café, women of different ethnic origins meet to talk informally with each other and attend informational events, including lectures by professionals on nutrition, education, migration, and health.

- *Portobella women's project*. The café and second hand shop organized by OMEGA, building on the concept of a "safe room", quickly developed into a women's project called Portobella. This project developed a catering service (see below) in addition to offering a multicultural meeting place for women outside the café. Creative workshops

were offered, and women also met while browsing the contents of the store. Psychological counseling was offered on site by OMEGA's professionals.

- *Culinary workshops and catering service*. In keeping with the principle of providing practical training and opportunities, a "culinary cultural exchange" program was established at *Portobella* in 1998. Cooking and sharing meals is of vital importance to family life and to national culture. Women in these programs cooked buffets for public events, thus increasing awareness of national culture. As a spin-off project, a collaboratively-created cookbook, entitled *Culinary Portobella: Recipies from All Over the World,* was published in 1999.

- *Multicultural health*. A one-year project begun in late 2001 aimed to increase the health of women. This program included physical activity (a swimming course, soccer, and volleyball) and training in healthy nutrition through cooking workshops. The project also provided translators for women seeking consultations at local parents' counseling institutions.

Such projects have allowed women to hone their abilities through creative work in an atmosphere of trust, simultaneously forming social interactions and a network with each other. OMEGA also provided practical assistance to integrate women into the local job market, which was further enhanced by a "labor market qualification project," where teachers and professionals provide education in hygiene, clothing manufacture, food supplies and handling, food labeling, cleaning agents, waste separation, clean work environments, time management, and professional vocabulary. Women are also trained in the use of personal computers, with the hope of opening up doors for them in the local job market.

Appendix 6.

The Theory and Practice of Volunteer Action:

Volunteers as Helpers in Conflict and Post-Conflict Circumstances

by Anica Mikus Kos (The Together Center, Ljubljana, Slovenia) with assistance from Paula Gutlove and Jacob Hale Russell (Institute for Resource and Security Studies, Cambridge, Massachusetts, USA)

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1. Overview: Why Volunteer Action?

In the face of war, civil strife or other tragedy, ordinary citizens can demonstrate solidarity in remarkable ways. Individuals in difficult or traumatic situations frequently derive satisfaction from helping fellow sufferers. Yet, since people will instinctively first provide for their own safety and welfare, this sort of spontaneous volunteer activity often extends only to one's own family and closest friends. Therefore, a more systematic means of providing consistent and organized volunteer aid to communities at risk is required. The objective would be to harness the full capacity of humankind's instinct to help fellow citizens, while directing this help where it is most needed.

Volunteers come from diverse backgrounds ranging from local community members to international volunteers. Their assistance to communities in need reassures victims of armed conflict — especially refugees — that their plight has not gone unheard. Volunteer actions can send a message of caring that counters the negative perceptions victims often develop in times of terror and violence. Volunteers play an invaluable role in helping refugees who have fled from zones of conflict. Moreover, volunteers can help to rebuild and reconcile communities during a post-conflict transition. Through a variety of functions — such as providing psychosocial assistance, practical aid, or education — volunteers can exert a positive influence on society and public attitudes, thereby assisting and expediting the process of social reconstruction.

This paper outlines some basic principles of volunteerism, and describes the social benefits that can flow from volunteer action. It provides basic criteria for when and how volunteer action should be implemented. It also discusses the special role that youth can play in volunteer-action programs, both as recipients of assistance and as volunteers themselves. The latter role can provide to youth a unique growth experience. Throughout, the paper uses examples from experience in the former Yugoslavia, especially by the Slovene Philanthropy, an organization based in Slovenia. Slovenia was well suited to the development of volunteer-assistance programs, both during and after its war of separation from Yugoslavia. Its experience is also relevant to the application of volunteer action in other post-socialist, former-Soviet-bloc countries.

2. Selection of Volunteers

Volunteers are typically recruited from a wide variety of backgrounds, and having a diverse set of volunteers is often helpful. Sometimes, volunteers belong to the affected population and have the capability, time, or resources to help their fellow community

members. If the situation concerns refugees, displaced persons or immigrants, citizens of the host country may be best suited for volunteer work. They can utilize their local background to help the newcomers adapt to their new homes, teaching them the local language and serving as a friendship network. Host-country volunteers may also serve as catalysts for political change in their country on behalf of the refugee population. Finally, intergovernmental organizations and non-governmental organizations with international operations may play a role by bringing foreign relief workers and humanitarian aid from abroad, often resulting in more specialized assistance and greater access to resources.

Careful selection of volunteers is a critical task for those organizing volunteer-action programs. A well-reasoned selection process is beneficial both to the helpers themselves and to the intended recipients of their aid. Often, those who volunteer to help individuals dealing with significant violence and loss are not psychologically equipped to cope with the trauma they may encounter. If such people are selected for volunteer programs, or if otherwise qualified people are not properly trained, their activity may psychologically harm both themselves and those they are seeking to help.

3. Volunteerism in Post-Conflict Situations

The role of volunteers is important both during and after a conflict. In fact, volunteer action is particularly appropriate for addressing the problems faced in post-conflict reconstruction. Volunteers in such cases can help minimize the effects of poverty, unemployment, social inequalities, disintegration of families, and corruption and associated challenges in newly-rebuilt public institutions. Victims of conflict can experience new, albeit different, trauma in the aftermath of conflict. Volunteers can aid in healing both communities and individuals from a range of trauma.

Volunteer action can minimize the effects of the "egoistic" phenomenon frequently observed after a violent conflict. As individuals instinctively seek to ensure their economic well being and survival, their interests and efforts frequently narrow and they protect themselves and their immediate family first and foremost. As a consequence, the creation of a sustainable local or regional culture of volunteerism and social responsibility is difficult and requires organized and coordinated forms of pro-social activity. This effort, although difficult, will yield significant benefits. Volunteer activity will not only provide aid to individuals in the most vulnerable segments of population, but will also improve a community's quality of life.

Volunteers in post-conflict situations can expedite and facilitate the process of reconciliation. If volunteers are chosen from diverse ethnic, religious, or social backgrounds, their pro-social efforts may create a sense of "togetherness," a feeling of commonality between two sides that previously viewed each other as antagonists. Their activities serve to build confidence and tolerance and may increase community welfare and happiness. Similarly, economic and financial exchanges and interactions — such as increased trading opportunities or other business projects that transcend societal divisions — can help create unity and trust. The involvement of "outsiders" — people who have not been involved in the conflict — may also assist the process of reconciliation.

When employed effectively, the presence of volunteers — whether in a country hosting refugees during a war or in a community rebuilding after conflict — can build the momentum needed to create a pervasive ethos of voluntarism. Volunteer action, as a useful form of human capital, is critical for the well being of communities and individuals, as well as for the creation and maintenance of stability and peace.

4. Volunteer Programs in Refugee Communities

Among the many valuable roles that volunteers play, community-based action can provide essential moral and psychological support in helping refugees. Refugees can manifest a multitude of psychosocial symptoms of trauma — including dependency, passivity, and depression — as a result of prolonged exile from their homes. Support from volunteers can alleviate these concerns and ailments by easing the refugees' transition to a new home. Moreover, enlisting displaced persons and refugees themselves in volunteer activities can be beneficial. Volunteer action is a two-way street — it has positive effects not only on the community and individuals being served, but also on the psychological and social well being of the volunteers themselves.

Volunteers, when drawn from both the host country and the refugee community, can serve as bridges between refugees and the local population. In so doing, volunteers often change the attitudes and behaviors of people and politicians in the host country. They help to integrate refugee communities with the host country and, by increasing the frequency of contact between the two groups, often break down destructive assumptions and stereotypes. Furthermore, on a political level, volunteers may serve an advocacy role, and can place substantial pressure on the host country's government to make decisions and enact laws that benefit and protect the refugee community.

Voluntary-action programs of the Slovene Philanthropy, following the recent Balkan wars, have demonstrated that volunteer programs can provide a range of protective and healing functions for children. These functions of volunteers are described below:

- A new social network of individual and group relationships forms to replace the lost domestic social network.
- Volunteers connect the refugee and host communities, combating the social isolation and the sense of "life in a ghetto" that refugees may feel at first. The host community can learn about the plight of refugees.
- Because they send a message of caring, sympathy, and a desire to help, volunteers can counteract prejudices, xenophobia and the sense of rejection that refugee children may feel.
- Volunteers often organize leisure activities for children, fulfilling the need for normal childhood activities.
- Children who do not know the language of the host country can be given language lessons through formal instruction and friendly conversation with volunteers.
- Volunteers can conduct tutoring sessions to provide assistance with schoolwork and academic difficulties.
- Customs and patterns of behavior of a host country are learned by observation and association between volunteers and refugees. This social orientation helps refugee children adapt to a new, unfamiliar environment into which it would otherwise be difficult to integrate.
- Impoverished and otherwise disadvantaged refugee children may experience an improved quality of life from their association with volunteers and from the practical assistance provided by these volunteers.
- Volunteers provide crucial psychosocial support to those who may have been psychologically traumatized by war and its associated events and losses.

Volunteers can help heal and rehabilitate refugee children, and can empower them to cope with their grief.

5. The Role of Youth in Pro-Social Activities

As shown by the list of volunteer functions in the preceding discussion, the psychological benefits for recipients of volunteer aid can be vast. Children and adolescents, in particular, stand to gain from volunteers in the protection and promotion of their mental health. Because volunteers will frequently come into contact with youth and families, they can complement the services already provided by professionals in schools, foster homes, hospitals, and other institutions for children. Many countries — particularly, as discussed later, post-socialist states such as Bosnia–Herzegovina and Chechnya — lack the human resources necessary to provide adequate support and education for children living in poverty and violence. Bosnia, for instance, is home to a tremendous number of traumatized, displaced, and orphaned children. In such countries, the development of volunteer-action programs designed primarily to benefit children could be extremely beneficial in protecting the emotional and psychosocial development of youth.

In fact, one of the most beneficial elements of volunteer action for children occurs when youths themselves serve as volunteer helpers. Youths can play a unique and important role in volunteer efforts. In addition to receiving aid themselves, they can be employed as effective volunteers to the benefit of themselves and their communities. The energy, enthusiasm and schedule availability of youths can suit them ideally for volunteer roles. Moreover, volunteer activities can be an excellent training ground for developing social responsibility, which will be an important asset to youths when they assume leadership positions later in life. Finally, volunteering may enhance their quality of life because of volunteerism's positive impact on psychosocial development. Volunteering has been shown to prevent delinquency and reduce drug abuse because it can give youths a sense of dignity, empowerment, and importance.

In Slovenia, youths are included in several forms of organized pro-social activities and their role is widely recognized. Volunteer activities are well integrated into the school system at all levels, demonstrating effective cooperation between state-run education and civil society. Consequently, many young Slovenes are involved on a day-to-day basis in pro-social activities within their communities. Young volunteers work in a variety of non-governmental organizations and institutions — schools, kindergartens, homes for the elderly, and social welfare centers — and aid families, individuals, and refugees. The work of Slovene youth on behalf of refugees has had a tangible positive effect on the public's attitude toward refugees in Slovenia.

Engaging in practical activities can teach the values and principles of social activism to young volunteers. Such social learning in turn enhances their overall development. Youths learn about diversity when volunteer activities expose them to new social environments and bring them into direct contact with people from different socioeconomic, ethnic, cultural, or religious backgrounds. Such experiences help them develop tolerance and increase their sensitivity to differences. Of equal significance, contact with the institutions and organizations they work for provides training in the dynamics, rules, and strategies of organizations; this work experience will serve them in their later careers.

The psychological growth of young volunteers is improved by their increased sense of social solidarity and their development of responsible citizenship. Effects on mental

health include boosted self-esteem, increasingly-developed social links, and the feeling of belonging. Youth volunteers are very likely to be motivated to volunteer and engage in community activities later in life. The use of youth in volunteer-action programs, particularly when accompanied by opportunities for training and reflection, is a powerful means of socializing children.

6. Volunteer Action for Post-Socialist Countries

Volunteerism is particularly relevant for countries moving from a socialist to a capitalist economy, such as the former-Soviet-bloc states. Such countries often lack the resources to address their problems, which may include extreme poverty and recent or ongoing civil war. Competition, self-advancement, and greed may begin to dominate value systems. In most cases, volunteer programs have not been previously developed. However, these countries are ideally suited to volunteer action, and the period of transition between a socialist economy and a market economy is ideal for introducing the values of solidarity and the social action of volunteering.

Such activity can positively influence the attitudes and behaviors of people living in post-Soviet countries, which is crucial to political stability. In addition to providing practical benefits, volunteer activity — such as the teaching of young people — can promote ethnic, cultural and religious tolerance, can enhance respect for human rights and community responsibilities, and can promote solidarity values. These developments can bring about reconciliation and reduce hostile attitudes and prejudices. Volunteerism is, at its core, a model for the kind of behavior required of citizen participants in a democracy.

Thus, volunteerism in post-Soviet countries can: positively affect social reconstruction; help develop sustainable, community-based human resources; reconcile ethnic groups and establish stronger relationships between them; promote solidarity; enhance the socialization of youth as responsible citizens; prevent psychosocial problems in youth; and develop stable democracy with respect for human rights.

Slovenia is a relevant model for volunteer-action programs in post-socialist countries, as it shares similar historical, social, and economic background with many southeast and eastern European countries. To this end, Slovenia convened a seminar to develop models for culturally-appropriate means of organizing children for volunteer action. At this seminar, Slovene models for ideal volunteer programs in the psychosocial field were presented. In such projects, there must be adequate protection for mental health in training and project management. The institutional learning of Slovene programs that employ volunteers can provide particular insight regarding the benefits and pitfalls in organizing volunteer action in post-socialist states, as discussed in Section 8, "Lessons Learned," below.

7. Slovene Projects for Volunteer Action

Under the Slovene Philanthropy's volunteer-action program, help to Bosnian refugee children began as early as 1992. Volunteer aid was provided by both Slovenians and foreign volunteers, including university students from the United States. As a result of volunteer aid to children in refugee centers, kindergartens and primary schools, many refugee children themselves later chose to enter volunteer positions. The Bosnian model was later applied in Kosovo, which required cultural sensitivity and basic changes to adapt the system for the new location. Currently, the Together Center is developing volunteer-action projects, staffed primarily by students, throughout former Yugoslavia.

The Together Center's current volunteer activities and projects include:

Region	Activities	No. of Volunteers	Local Partner Organization
Bosnia and Herzegovina (Gracanica)	• Established center for promotion and development of voluntary work • Volunteers helping older people • Volunteers in primary and secondary schools • Volunteers in day-care centers for children with special needs	1500	OSMIJEH, Association for Psychosocial Help and Development of Voluntary Work, Gracanica
Kosovo (Ferizaj, Urocevac)	• Voluntary work of secondary school students in schools and in the community	160	Center for Promotion of Education, Ferizaj, Kosovo
Central Serbia (Krucevac, Jagodina)	• Secondary school students and university students helping children with psychosocial and learning difficulties (project in developmental phase)	About 50	DUGA - Center for help to children and development of voluntary work
Macedonia	• University student volunteers (from two universities of Tetovo) helping children with psychosocial and learning difficulties (project in developmental phase)	40	Center for education and psychosocial help to children
Slovenia	• Secondary school students and university students helping refugee children and children seeking asylum	80	Slovene Philanthropy

8. Lessons Learned

At the previously-mentioned seminar on models of volunteer action for the mental health and psychosocial well-being of children, presenters discussed a variety of lessons learned from Slovenia's experience helping Bosnian refugees, beginning in 1992. Particular lessons include:

- The development of community-based and school-based voluntary work in the post-socialist countries of south-east Europe is possible.
- Models for such volunteer-action programs should be developed in partnership with a country that has recent experience in volunteer action. Such partnerships should seek to engage local NGOs and institutions.
- Once a volunteer-action model has been developed, its application should be adapted to the culture, history, and situation of the region where it is to be applied.
- Incoming foreign volunteers should show respect for previous volunteer activity in the region or community. If they fail to do so, locals may feel that foreigners do not recognize past solidarity and pro-social activities.
- Projects should be well-prepared and realistic. If a project fails early in its formation, it is very difficult to start another one.
- Basic guidelines for volunteer action should be prepared, by both foreign experts and local activists.

- ❖ Those seeking to develop new volunteer-action programs should consider visiting countries with developed volunteer programs (eg., Slovenia) as a means of motivating and teaching.
- ❖ Regional coordination of volunteer-action programs, possibly through the development of a regionally-based development center, is highly encouraged.

One other important lesson volunteers must learn involves their attitude towards victims of war or refugees. Volunteers must not be patronizing, as this may be interpreted as disrespect for the victims' ability to cope. A patronizing tone increases the sense of helplessness that victims may experience, which decreases their ability to cope with situations. Volunteerism is a partnership with the people who are supported. Thus volunteers' behavior must be culturally sensitive and volunteers should seek to form a sense of equality or teamwork with those they help.

Appendix 7.
Challenges of Training for Trauma Recovery

by Dean Ajdukovic (Department of Psychology, University of Zagreb & Society for Psychological Assistance, Zagreb, Croatia)

(Reprinted with permission from Ajdukovic, Dean (ed.), Trauma Recovery Training: Lessons Learned, Zagreb, Croatia: Society for Psychosocial Assistance, 1997.)

Recovery from exposure to traumatizing events has traditionally been considered a natural process in which the internal resources of a trauma victim along with available support systems help people heal. Survivors of trauma cannot erase the memories of a traumatic event because of the irrevocable physiological imprint, but those that recover from trauma tend to frame it within other life experiences, many of which may also be unpleasant. A similar parallel can be drawn for the traumatized communities and societies in which the memory of traumatic events and suffering often becomes a part of history or belongs to national myths. After the wounds heal, the scars remain as a nonerasable memento, just like physiological memory traces in the amygdala of a traumatized individual.

The traditional response to individual or massive traumatization has been an attempt to forget, to put it behind, never to speak about it. Research of the third generation Holocaust survivors and the ways of dealing with trauma indicated that there is an almost universal pattern called the "conspiracy of silence". Only fairly recently has this culturally appropriate, but not helpful, conspiracy been widely questioned, not only by mental health professionals. Nowadays, there are examples of bringing together in a discussion descendants of Nazi perpetrators and Holocaust victims who work hard to heal the traumatic wounds inflicted more than 50 years ago. It took years after the Vietnam war for laypeople to understand that trauma cannot be buried under the carpet in the privacy of a bedroom. In my opinion, another significant turning point was the public outcry of Chilean refugees in Europe who had the courage to start speaking openly about their traumas and about ways to cope with them.

The international media and public attention directed at the war in Croatia and Bosnia and Herzegovina may have led to another cornerstone in raising public awareness of the ways to deal with the consequences of exposure to events beyond common human experience. But this same war has also led to new challenges regarding the training of many people who have been helping other traumatized people.

Enormous man-made traumatization generally happens in countries that lack developed mental health services, whereas societies which have sophisticated helping facilities rarely suffer this extent of traumatization. Unlike almost any other country that was devastated by war in the last few decades, except perhaps Israel, Croatia and Bosnia and Herzegovina had a developed pre-war professional mental health infrastructure. The fact that the care-providers originated from within the affected community had both disadvantages and advantages. The disadvantages seem to be more obvious: many helpers were traumatized themselves, were deeply affected emotionally by the day to day destruction of their countries, and many have suffered a variety of personal losses. As a

consequence, they had to develop coping mechanisms that helped them not only to survive, but also to keep providing effective services to hundreds of thousands of clients that needed psychological assistance. The following sentence was often heard from the care-providers: "By helping others, I was also helping myself". This sentence illustrates the mechanism well. On the other hand, these same people understood the socio-cultural context and processes in which traumatization was occurring, knew which resources to search for among the clients, and became aware of the advantages and limits of their services. But above all, they had remarkable motivation to go beyond their professional duties of helping the people in need. Many lessons have been learned along this path and many are still being learned, building one upon another.

Looking back and summarizing the lessons learned, one could identify two parallel processes. One process was providing direct helping services and the other one was meeting the emerging training needs of service-providers. These processes went through the mirroring phases of change and adjustment that I would like to share with you today.

The *first phase* was characterized by the initial, mostly spontaneous, involvement of care-providers in 1991 and early 1992. The professionals suddenly faced the specifics of trauma and refugee issues, and dealt with them using the more traditional skills which were readily available. Soon these proved to be of limited use, so that when the first group of international experts provided a short period of training under the auspices of the World Health Organization early in 1992, a new chapter in the professional lives of the participating care-providers, mostly psychiatrists and psychologists, was opened.

The *second phase*, dominating most of 1992, saw the growth of a more professional approach and refinement of programs. Professionals (psychologists, psychiatrists, social workers) recognized the importance of a supportive environment as a facilitator between traumatizing experiences and the psychological functioning of their clients and communities. The assessment of mental health needs became more clearly linked to the assessment of the resources of the clients. Concepts were clarified and there was an increasing exchange of experiences among the local care-providers. A major review of the state-of-the art was the conference "War Psychology and Psychiatry" held in Varazdin. As more foreign colleagues came and generously shared their experiences (some of these brave people are sitting here in the audience), the contacts expanded and the flow of information increased. A growing number of training opportunities became available in which the emphasis was more on specific knowledge and less on acquiring skills. Most of these were sponsored by UNICEF which was able to bring to Croatia the leading international experts in child trauma. This was of invaluable help. The local mental health professionals were by then able to integrate the knowledge which was offered, but perhaps still lacked critical distance to scrutinize what was most helpful.

In the *third phase*, mainly during 1993, several professional issues emerged as dominant ones. Among these was the importance of the grief process and its management, and the need to integrate the efforts of regular social services and the mushrooming non-governmental initiatives. At that time it became obvious that the refugee crisis was going to last and so the first collective centers were built in the country. This period also witnessed a major growth in training opportunities. One could meet the same colleagues attending different training events over and over again, searching for answers to practical questions and dilemmas. After a while, they grew more demanding and critical as they became aware that there was little new knowledge offered by the onetime training events. An awareness emerged that the training of mental health care-providers was a process in

which new professional needs surfaced. However, only a few training programs were built around this understanding. Interestingly enough, at that time, the only two training programs that acknowledged this were provided by our Danish colleagues.

The *fourth phase*, starting in 1994, saw already well-established centers and teams for trauma treatment. Refined, comprehensive programs of psychosocial assistance to refugees were operating in Croatia. The self-esteem of local professionals was well grounded and they started feeling that they were competent care-providers. They were increasingly invited to present their experiences at international forums. At that time, the need for supervision as a helping dialogue became more recognized as a legitimate request, and not as a sign of professional weakness. Another major concept focusing on the care-providers themselves was the acknowledgment of their own mental health needs. This was recognition of the consequences of prolonged exposure to high levels of professional stress, vicarious traumatization, and above all, of increased burnout among the providers. Coincidentally, in the spring of 1994, the Society for Psychological Assistance (SPA), as a local group of professionals supported by the International Rescue Committee, and a group of experts associated with Harvard University, independently offered the first training course focusing on the mental health needs of care-providers. Since then, the SPA course has been successfully completed by over 450 care-providers throughout Croatia and Bosnia Herzegovina. The effects of this particular training will be presented in another paper at this conference.

This was also the phase in which the needs of experienced professionals for more sophisticated training became very apparent. During the previous years, many of these professionals had access to a number of short training seminars that addressed a particular issue, without framing it within the broader context of theory and practice.

At the same time, a growing number of non-professionals and paraprofessionals demanded training to meet their needs. Many of them worked in teams along with mental health professionals. But, as the time passed, they discovered that the issues they were faced with were much more complex and that expectations from their clients too high for them to bear without specific training in helping skills. Alongside international experts, Croatian professionals started providing training to Bosnian colleagues. This was extremely well received because both sides shared so many common experiences.

In response to these needs, the international community, and especially the US government, provided support for the major training effort in the field trauma recovery. What became known as "Project 16" was a multi-million dollar project to train the care-providers, alleviate the suffering and war-related aftereffects. Within this framework, several projects were developed, demonstrating a range of approaches. In cooperation with Catholic Relief Services, the Society for Psychological Assistance developed the three-year "Post-trauma Recovery Training Project" which included training programs designed to meet the needs of a whole spectrum of care-providers: from nonprofessionals to highly experienced professionals. This was also an example of a training model that was based on three interrelated concepts. One was the multiplier effect achieved through the "training the trainers" approach; another was the "ladder model" in which the trainees had an opportunity to meet their training needs as they emerged; the third concept was "comprehensiveness". The latter concept integrated the years of practical experience of the local mental health professionals working in the field of trauma with training by leading international experts, and their own critical thinking. The unique feature of this project was that the trainees had an opportunity to influence the training curriculum, and in some cases

to design it themselves. This required an appropriate level of individual expertise and is an important lesson in empowering the local resources which is worth exploring further.

The *fifth phase* is the period in which we currently live and will be living for a while. It was opened by possibilities for the resettlement of the displaced, increased safety and the focus on the rebuilding of destroyed communities. The need for the social reconstruction of these communities required designing outreach community-based assistance programs. This was yet another professional challenge, requiring flexibility and extreme creativity from mental health workers. They had to demonstrate not only competence in trauma healing, but also in community social network building, reconciliation, and individual and group empowerment. This kind of work in traumatized communities is an area in which mental health providers really have to exercise their cultural sensitivity and competence. The way to ensure this is joint work with para-professionals and professionals from all significant groups from the community. As these individuals often require training, this actually opens a new round of meeting the needs for training in trauma recovery.

The huge dimension of need for services and a lack of specific prewar experience in addressing the needs of traumatized individuals, families and communities, demanded the development of innovative and creative helping approaches very early on. As in any other situation, the care-providers tried to utilize the models, methods and skills they had readily available in their professional repertoire. Some of these worked, and some did not. The situation demanded new and creative skills, specific knowledge about trauma and how to treat it. Overall, the more traditional, long-term psychotherapy approaches seemed to be less fruitful than the focused, more direct, and problem-oriented eclectic treatments. But this was precisely the area in which specific knowledge, skills and concepts were lacking and had to be provided. This was the area in which help from the international professional community was most useful.

The expatriate experts that provided trauma recovery training early on, in the first phase outlined earlier, had an extremely important, but an easier task than those that came later. The reason is that the baseline of specific knowledge in dealing with trauma was low, care-providers were confused, and were themselves traumatized. In such a situation, any new piece of information which became available was very helpful. Those who could provide training in specific techniques were the most needed and impressed local colleagues. As this training was quickly integrated within the framework of the previous knowledge of the local mental health professionals, it was adapted and further developed. The consequence was that the international experts that arrived after the first two years faced much more demanding tasks. Those that came unaware of the level of sophistication of the already-experienced care-providers either had to immediately adjust the level of training they had pre-planned, or else were not helpful. Sometimes they actually irritated local colleagues by underestimating their professionalism.

Among the foreign trauma experts, most came with an open heart and a willingness to share and teach whatever they knew from their wealth of experience in dealing with traumatized clients and communities. As most of the experts had worked with communities and individuals who had been traumatized in peace time, what they had to share had to be adjusted to our war-affected reality. The international experts also had to learn how to present their knowledge in order to reach the audience which had very high expectations and pressing needs. For some of the local trainees, examples that were presented did not correspond to the extent of the massive traumatization they had witnessed. Finding it

difficult to grasp the common issues in trauma healing, at times they felt that these examples were inapplicable and inappropriate, even to the extent of being offending. The lesson is that true experts should learn more about the situation and the culture in which they are to work with local colleagues. Building a professional partnership relation with local professionals enabled some of the international representatives to assess the needs better and to discuss the training content and formats, thus avoiding these pitfalls.

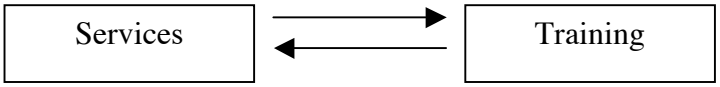
It was puzzling to see that in a number of instances it took quite a while for the international and local professionals to establish *true partnership relations*. However, those that were open for honest collaboration, who came both to teach and learn, who were genuinely intellectually curious, were most welcome and most helpful. They often took the non-expert position, displayed respect for colleagues, and searched for the positive aspects in their work. They also understood that their trainees were able to absorb only a limited quantity of information and skills at any one time, and showed respect for this pace. They exhibited patience and understanding when coming back to the same trainees and sometimes having to address the same issues again. The lesson for all of us is to be humble in respect to colleagues from another culture who are doing their best, given the circumstances and reality of their constraints. Professionals that brought this kind of attitude were most appreciated and remembered with affection and gratitude. In contrast, those that portrayed a colonial approach were seen as pursuing their own personal goals, whether for career or money, and were quickly seen through and despised. The concept of "cultural sensitivity" was too often given only lip service because it was the politically correct thing to do.

One of the major lessons learned is that *trauma does not happen in a social vacuum*. Nor does it heal apart from ongoing social processes. This notion has sometimes sharply contrasted with the dominating medical model that focuses on treating trauma-related consequences as an individual disorder or a problem. On the other side, the psychosocial approach as a genuinely community-embedded approach was discovered. This opened un-thought of opportunities for the creative development of a diversity of trauma assistance programs that sought to strengthen the remaining, healthy resources in individuals, families and communities. The more local professionals learned about the essence of trauma healing, the more they appreciated the psychosocial component in the overall treatment. The concept of psychosocial assistance was defined for the first time. The importance of its recognition extends much beyond war-related trauma. I believe that it will grow to become the dominant approach in the years to come in healing trauma and in reconstructing the social fabric, as well as in improving the quality of life of the nation.

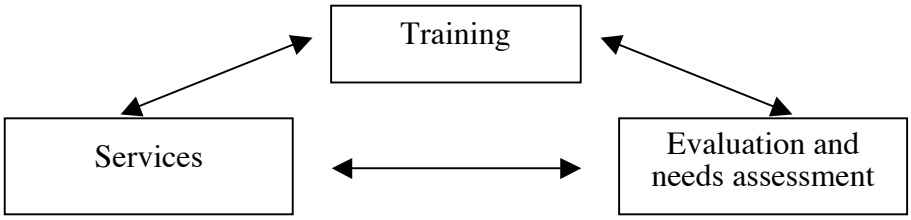
It was impressive to observe how the professional self-esteem of many providers grew as they tested the new skills and knowledge in practice, and later became trainers themselves. But not all training formats were worth the money spent. The training curricula that were built with an insight into the needs of trainees were the most helpful. The awareness that these needs were constantly changing was also an important lesson, which was reflected in the growing sophistication in the design of training curricula. In the first and second phases, services were provided within the available repertoire of skills and knowledge, but also leading to specific training requirements. This training loop (Figure lA) was later expanded to include the more formal evaluation of services and the related assessment of training needs (Figure lB). At a later stage, dissemination and publication as final components in the loop were added (Figure 1C).

Figure 1. Developmental phases in training for trauma recovery

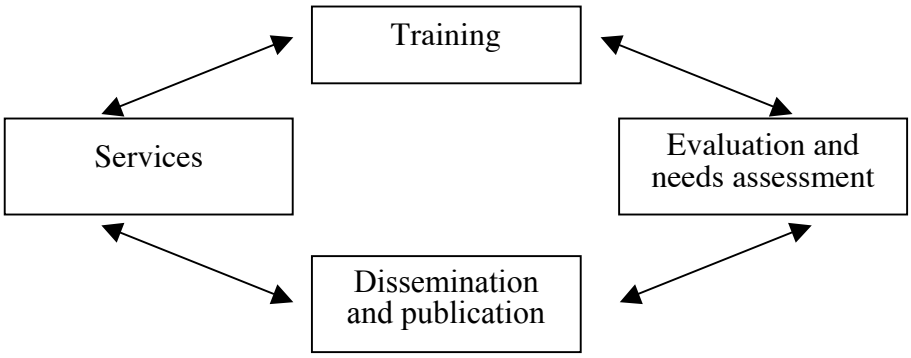
A. Early phase: Interaction between providing services and meeting the emerging needs through training



B. Developmental phase: Systematic needs assessment and evaluation enter the stage



C. Mature phase: Dissemination and publication complete the training cycle



Those who do not belong to the mental health profession often fail to understand that professional needs for the training of care-providers *cannot ever be definitively fulfilled*. The acquisition of helping skills is very different from mastering other skills, such as, for example, reading skills. In our profession, it seems that the more people practice what they have been trained for, the more they seem to identify new training needs. But this is only natural, since we deal with such a delicate subject matter: the suffering of the most complex being, a human. What we learned was that the training loop must include both the initial needs assessment and the follow-up needs assessments. Thus, a strong recommendation to those who are responsible for strategic planning of training resources is to view trauma recovery training as a process that has both content and relationship dimensions. The training projects that acknowledged this actually laid the ground for a sustainable mechanism that will be able to address the needs of recovering individuals and communities in the years to come. An important component of such training efforts was the constant building of a mutual support network among the trainees. These achievements will help improve the quality of the mental health of the population for many years to

come after the war. In this way, they might contribute to preventing the transgenerational transmission of traumatic memories and thus perhaps help the stability of peace in the region.

Evaluation is another issue that has gained increasing attention during these past few years. The need for evaluation originated from two separate starting points, but converged over time. One starting point was the intrinsic need of care-providers to monitor the effects of their own work in order to refine the program delivery and to identify elements that would increase internal gratification of the difficult work they were doing. The other starting point for stronger emphasis on evaluation was the donors' needs and requirements, linked to the overall increased demand for accountability. During this process, both the donors and care-providers have learned a lot. Among these lessons, one should be highlighted: it is essential that both donors and partners adjust their expectations according to the evaluation before the project begins. Otherwise, many frustrations, disappointments and harmful tensions can be caused.

As the resources were always limited, *competition* became apparent as was often reflected in the relations among different players. This was evident at all levels: between international relief agencies, among local non-governmental organizations, between the NGO and governmental sectors, and among different interest groups. Many political interests were also mirrored in these relations. However, an important lesson is that compassionate, yet professional and committed work in providing services with the needs of the beneficiaries always seen as the priority, is the right path to be taken, which is bound to be recognized, though it may happen later rather than sooner.

There are many lessons learned that extend beyond the immediate focus of trauma recovery and relate to changes within the professional community and at the societal level. One of these is the fact that *building a community-based psychosocial assistance program has opened the way for the growth of the non-governmental sector*. This is an important spin-off effect of the trauma relief efforts whose long-term impact upon democratization and the development of the Croatian and Bosnian civil societies will be fully appreciated only in the future. The perspective of full cooperation between the non-governmental sector and the governmental agencies is only at its beginning, but we must be optimistic. We must also hope that the care-providers, both professionals and paraprofessionals, will be supported to extend their accumulated expertise to the many people in need who will seek their help in the years to come. Only in this way will the enormous resources, both human and financial, that have been invested in training for war-related trauma recovery pay off by serving the people in peacetime and building peace in the future.

Appendix 8.
Why is the Mental Health of Helpers at Risk?
by Marine Ajdukovic and Dean Ajdukovic

(Reprinted with permission from Ajdukovic, Dean and Marina Ajdukovic (eds.), Mental Health Care of Helpers, Zagreb, Croatia: Society for Psychosocial Assistance, 2000.)

Occupational or professional stress arises from the imbalance between the requirements of a job and the working environment on the one hand, and the abilities, wishes, and expectations related to these requirements on the other. All professions are not equally exposed to professional stress. Professions which are markedly stress-exposed are those which include working with people. There are differences, however, even between these professions. A bank clerk, a teacher, and people who work with traumatized persons or persons in distress are not equally exposed to professional stress. Members of the latter group, who are usually referred to as "helpers" or "care-providers", are exposed to specific sources of professional stress. Before describing the specific sources and reactions common to the helping professions, we shall try to define the concepts of "helping profession" and "helper".

What are the helping professions? They are professions oriented towards helping other people to solve their problems. What they have in common is the personal contact between helper and person in distress.

Who are the mental health helpers? They are people who have decided to act professionally or voluntarily in situations in which usual ways of mutual help among people in distress or crisis prove to be insufficient, so that additional help is needed. They are primarily social workers, psychologists, and health workers, but also all other people of good will who are ready to help in various crisis situations. The range of needs for specific help to people in distress is huge, and this is continuously growing in the modern world. It includes work with delinquent children and young people, alcoholics and drug addicts, abused and neglected children, AIDS patients, victims of rape and violence, people who have survived major losses, victims of torture, war and refugees. The great need for additional help with psychotraumatized American soldiers from the Vietnam war led in the 1970s and 1980s to a growth of interest in conditions under which helpers become victims of their own work.

People of various professions and experience work as mental health care-providers. Some of them do so professionally, others voluntarily. In order to clarify the terms, we can speak of three categories of helpers. Professional helpers have been trained for some of the helping professions (psychologists, social workers, physicians, nurses, teachers, special needs teachers, pedagogues, etc.). In order to be able to work with traumatized persons, professionals usually undergo additional education and training. The second group consists of paraprofessionals - i.e., persons who have not been specially trained for a helping job, but who have chosen this as their vocation and have been additionally trained, gaining necessary experience in the course of their work. Like professionals, paraprofessionals help people in distress on a permanent basis, and they do this as a regular job for which

they are paid. The third group is made up of volunteers who are not paid for their work. They are usually people of good will who help individuals in distress, but who do not do this as a regular job. Of course, professionals can also be found among volunteers who do their job without being paid (their number is especially large in major crises, disasters and war). Most volunteers, however, are laymen in the field of mental health.

The helping professions are liable to stress because of their direct communication with persons who need other people's help, since this communication entails a direct relationship and empathy with the emotional states and sufferings of other persons. A gap between a helper's expectations and the actual possibilities of helping may be another source of professional stress. In the course of their work, helpers hear numerous sad and tragic life stories, descriptions of traumatic experiences, and about the tragic losses of other persons. They are often emotionally overwhelmed by these insights. At the same time, they are usually faced with limited resources and possibilities to help distressed traumatized clients.

Daily encounters with traumatized people or with clients suffering great emotional problems are a serious burden on the mental health of helpers. According to a commonly accepted definition, traumatic events are those events to which a person has been exposed which surpass the boundaries of ordinary human experience, and where he or she has felt extreme helplessness, loss of control and fear for their life. Such instances include exposure to violence and torture, being witness to scenes of violence, the sudden or violent death of other persons, the destruction of a home, etc. Everyday encounters with other people's misfortune and traumas call into question the helpers' sense of control over their own lives as a result of their contact with other people's devastating experiences. Helpers can thus become traumatized themselves and experience situations of crisis. The awareness of the threat to the mental health of helpers caused by their exposure to other people's traumas has been one of the most important insights about psychological crisis and in the treatment of trauma in the last ten years. The psychological consequences of working with people in distress and crisis are usually defined by three concepts:

1. Burnout syndrome
2. Countertransference reactions
3. Indirect traumatization of helpers

The burnout syndrome is related to the fact that some care-providers tend to become depressed, unmotivated in their work, emotionally empty, and discouraged. They manifest various types of physical symptoms of stress, a decrease in their immune defense abilities, an increase in self-inflicted injuries, etc. Cynicism or indifference can replace their previous understanding of clients in distress. Generally speaking, the burnout syndrome is among the worst consequences of dealing with people in distress and the worst outcome of professional stress experienced by a helper.

These difficulties can partly be attributed to the personality characteristics of a particular helper. Perfectionism, idealized views of helping people in distress, the need for self-affirmation, the inability to say "no", the refusal to delegate work to others and excessive expectations are the most frequent causes of this syndrome. On the other hand, burnout can originate from a number of circumstances which are not related to the helper's personal characteristics, such as the poor organization of work, the lack of professional

skills and inadequate working environment, lack of support, professional isolation, etc. (Van der Veer et al., 1992).

Countertransference can be defined as the re-emergence of the personal emotional reactions of care-providers in a helping situation, i.e., as the transfer of the helper's emotions to the person with whom he or she works. These strong emotional reactions are a result of the interaction between the experience which a person in distress is going through and the unresolved difficulties or previous life experience of the helper. Dramatic stories which the helper hears incite feelings (especially fears) which are difficult to integrate (e.g., the fear of the helper's own death and the awareness of his or her own vulnerability, the fear that something similar could happen to the helper's closest relatives and friends, etc.). Even the appearance of a client or the similarities of his or her own life story can remind a care-provider of past experiences and affect the non-conscious reactions towards a client (Klain, 1995). Countertransference is a common fact in the course of care providing. It adds color to the helping process, encourages the expression of empathy, and facilitates a helper-client relationship. At the same time, it can trigger a number of defense mechanisms such as suppression, denial, or projection. This can lead to non-functional professional behaviors and impaired relations with colleagues. These strong emotional reactions on the part of care-providers can be an obstacle to their work rather than allowing them to increase their understanding of their clients and to use their professional skills creatively.

Understanding of the countertransference process points to the inner life of the helper as a person and to the need to become aware of the emotional reactions triggered by the client. This need is most often met in the supervision process and while being trained in psychotherapy.

Indirect traumatization refers to the psychological effect that working with traumatized people has on helpers. Helpers often manifest the same signs as the traumatized persons they work with, such as nightmares, compulsive thoughts, sorrow and depression, irritability, the feeling of helplessness, chronic exhaustion, digestive problems, increased susceptibility to accidents such as cuts, sprains, etc., proneness to infections, increased consumption of alcohol, smoking, addiction to medicines, etc. (Talbot et al., 1992).

Care-providers in war situations and disasters have even greater psychological difficulties. The many direct and indirect victims of the war in Croatia, as in Bosnia and Herzegovina, "threw" helpers into a completely new field of work. The amount of work they were required to do increased because the problems of the refugees, families who had lost members, the disabled, etc., grew in scope and complexity. The systematic training of professionals and paraprofessionals for work with war victims began only at the end of 1991 and the beginning of 1992. Although full attention was directed to the negative psychological consequences of violence, war, torture, and life in exile, almost no attention was paid to the psychological challenges faced by the helpers them selves. In practice, this meant that the psychological needs of the helpers were always very low on the priority lists of the various services and organizations working with traumatized people. However, the professional difficulties of the helpers became a reality that had a growing impact on their work, diminishing their efficiency and endangering their mental health. Therefore, the care for the mental health of helpers is not a luxury, but part of the professional responsibility both of the helpers themselves and of the system they work in. Here, short and focused training programs can be very effective, with long-lasting positive consequences on both

the individual care-providers and the professional community (Ajdukovic, Ajdukovic and Ljubotina, 1997).

There are a number of specific sources of professional stress in helpers who work with direct and indirect victims of trauma.

Helpers are often not sufficiently prepared for this kind of work and for the intensity of the crisis situations they have to deal with. They have little time to adjust to a new situation before taking on their multiple responsibilities. Their working hours are usually long, while vacations are almost non-existent.

Helpers experience strong emotional reactions that change in the course of their work. They often identify with people who need help, and experience feelings of guilt and remorse because the circumstances in which they live are more favorable than those of the people they work with.

Helpers are also faced with administrative obstacles in providing help. Stearns (1993) points out that both the people who need help and the helpers are victims of an imposed structure. A helper reacts to the determining factors imposed by the situation, which is as much beyond his or her control as it is for the clients. Helpers in the field are usually not sufficiently informed and have no impact on the decisions that come from above. The expectations of the organization for which the helpers work can be different from, or even contrary to, the expectations of the people in distress and the helpers.

As a rule, the usual forms of professional help to helpers, such as supervision, mutual support, or team consultations in situations of crisis, are lacking, and they are not a regular part of the activities of these organizations. And if they do exist, they are often not accessible to the helpers in remote locations.

In the recent war, a number of helpers were not only victims of indirect traumatization, but were exposed to a number of traumatic events themselves, ranging from personal loss to bombings and life imperilment.

Although work with victims of war has highlighted the psychological needs of care-providers, the experiences and the awareness of the importance of caring for their mental health have been successfully transferred to peacetime working conditions as well. It has been proven that working with a range of other clients, such as victims of family violence, terminal patients, alcoholics, non-voluntary clients and other people in crisis, also increases the mental health risks for care-providers. Helpers are frequently unaware of the impact of their work on themselves and tend to avoid seeking help. This is not surprising if we realize that everything happens in a situation in which the victims and helpers are both part of the existing power structure. Victims are those who are "weak", "helpless", and without resources, while helpers are those who are "strong", "powerful", and can offer help from various sources. In this context, professionals can experience their own need for consultation as a personal weakness and, in order to retain their own image of self-control and invulnerability, will point out with pride that they can bear anything. Helpers, through fear of losing status, respect, and the trust of their collaborators, often refuse to admit that they have psychological difficulties. However, by refusing to seek help, they reduce their ability to do their job well and become less useful to the people they help.

What can we do in order to feel better, become more efficient in our work as helpers, and reduce negative consequences in terms of our mental and physical health? Caring for the mental health of helpers should be an indispensable part of any program of psychosocial assistance. Such a program should be carried out at three levels of intervention:

1. Prevention and training:

- Preparing helpers for situations of stress and work with people in crisis,
- Informing helpers about the effects helping can have on their own mental health,
- Ongoing improvement of their (professional) competence,
- Continuing support to helpers through supervision and consultations.

It is important to have this type of program in place before starting to work and in the course of work because of the changes in the working conditions and in clients' needs, and because of the growing professional needs of helpers.

2. Interventions directly oriented toward protecting the mental health of helpers, whether in group or individual formats (Arambasic and Ajdukovic, 1997; Ajdukovic, M. 1997):

- Debriefing after crisis situations,
- Guided support, i.e., the supportive component of supervision.

3. The development of self-help skills and awareness of the responsibility for one's own mental health.

In line with what has been said so far, it is the purpose of this manual to draw attention systematically to the consequences that working with traumatized people has on the personal and professional life of helpers, to recommend certain basic skills of self-protection and self-help, and to give advice on ways of successfully protecting the mental health of helpers within the care-providing organization.

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