

PSYCHOSOCIAL NOTEBOOK

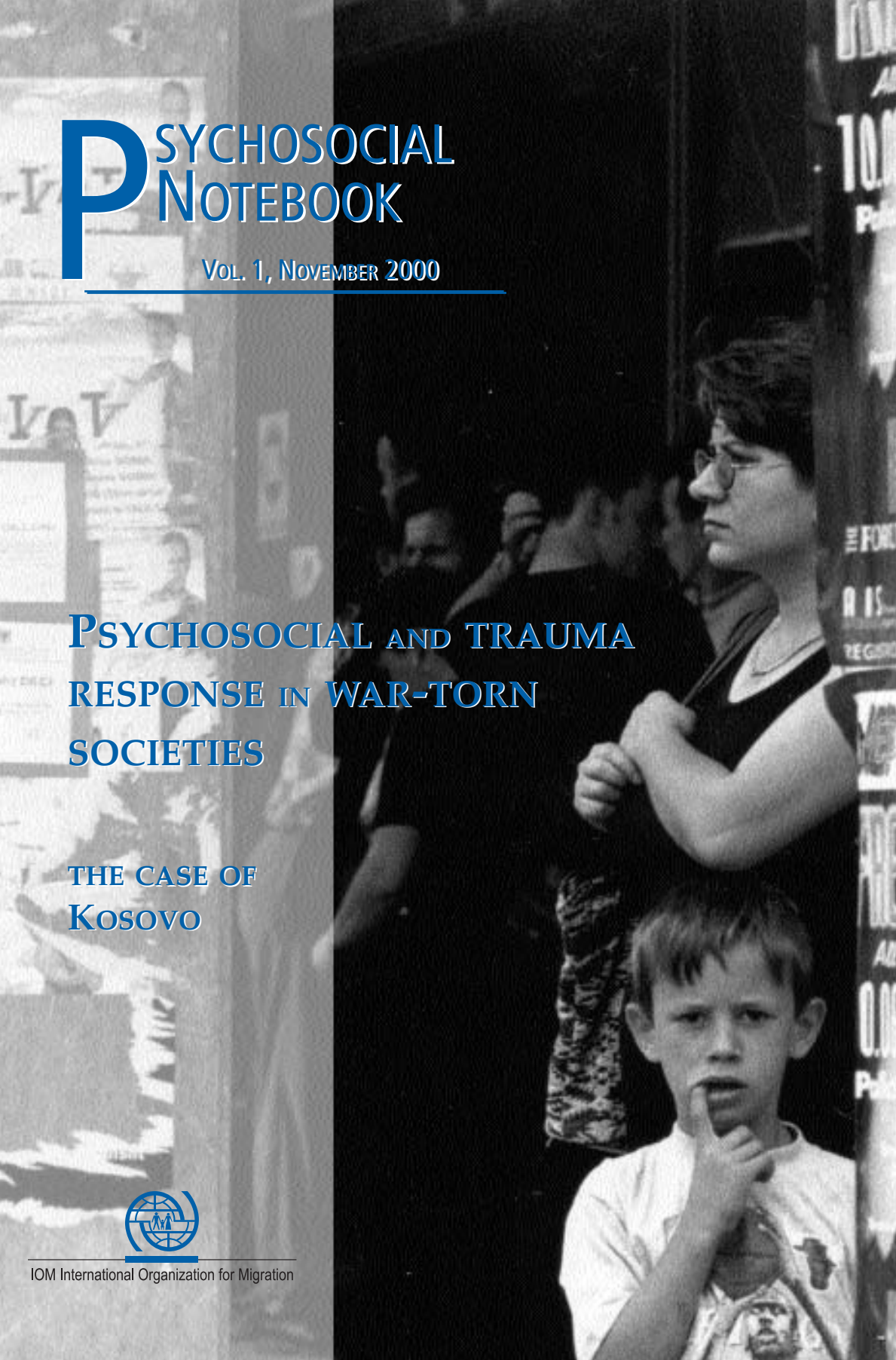
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PSYCHOSOCIAL AND TRAUMA RESPONSE IN WAR-TORN SOCIETIES

THE CASE OF
KOSOVO



IOM International Organization for Migration



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Psychosocial and Trauma Response in War-Torn Societies

The Case of Kosovo

Psychosocial Notebook
Vol. 1, November 2000

Under the direction of Natale Losi

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Preface

The end of the twentieth century continued to be marked by episodic regional conflicts, social upheaval, violence and the displacement of populations. Experience in several of these events has demonstrated that prompt and adequately coordinated interventions in the health sector can reduce the mortality and morbidity associated with complex humanitarian emergencies. The improved understanding of the health consequences of these events has been accompanied by the increasing awareness of the importance of psychosocial and mental issues in the affected populations.

It has become clear that once the major risks for mortality such as housing, nutrition and epidemic diseases are addressed in affected populations, there often remains a continuing burden of psychosocial ill health. The experiences of the affected populations in terms of exposure to trauma, violence, abuse, loss and displacement can produce long-term health problems. These problems can affect the successful resettlement and integration of displaced populations as well as impact on the rehabilitation and rebuilding of the residual society.

The increasing recognition of the importance of psychosocial health in complex emergencies has been coupled with the development of appropriate strategies to recognize and manage these issues. The resolution of community or population-based psychosocial trauma can often be facilitated by the collection of memories, support and community healing through appropriate psychosocial support.

IOM, through the delivery of immigration and transportation services to mobile populations, is often in the front line of complex emergencies involving population displacement. This was true in the south-east Balkans in the spring and summer of 1999. Capitalizing on this opportunity and recognizing the immediate and future needs of the affected population, the Organization quickly mobilized and mounted a Psychosocial Trauma Response project. Initially operating with displaced populations in Albania, the project was rapidly expanded into Kosovo, following the end of hostilities and the rapid return of the displaced.

This project has been very successful in producing adequate community-based support that will assist the population with the long-term rehabilitation and resolution of many of the traumas of the recent past. Through remembrance and recognition will come the healing that will be necessary to carry and support community health both now and in the future. This monograph describes that process and will be an important reference source for those working in other locations. Additionally, it is

hoped that this and other materials developed for the project can be used to assist in the recognition and management of psychosocial issues in migrant populations in countries of either permanent or transient resettlement. The impact of population-based consequences of psychosocial trauma can extend long beyond the immediate migration phase and the lessons from this undertaking should go a long way in supporting community-based assistance.

Brian Gushulak
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Introduction

The *Psychosocial and Trauma Response Project for the Displaced and Refugees from Kosovo* (PTR) was initially set up in the refugee camps in Albania, immediately after the outbreak of conflict in April 1999. Following the massive, spontaneous return of the refugees upon the resolution of the conflict, the project was modified and its focus was shifted from Albania to Kosovo. An assessment was therefore undertaken in the province to appreciate how to best respond to the returnees' psychosocial needs. It revealed that, while psychiatric care was available, very few psychologists were operating in Kosovo, and that there seemed to be a clear need for some sort of intermediate professionals who could give psychosocial support through counselling activities.

The revised PTR project aimed at providing a rapid and timely response to the population's emerging psychological needs, as these materialized following the conflict and the subsequent forced migration, while laying substantial ground for long-term capacity building of local educational infrastructure.

A one-year, extra-curricula, inter-faculty University training course on Psychosocial and Trauma Response was set up for newly graduates and students from the Faculties of Medicine, Philosophy and Sociology. The course consisted of four modules based on a participatory methodology. Strong emphasis was put on practical fieldwork in order to identify the immediate needs of local communities and individuals and to provide, under strict supervision, a first treatment.

In the framework of the project, The International Organization for Migration invited professors from different universities worldwide as well as international experts in this field to take part in the training modules. In addition, two seminars were held, bringing together some of the international experts with the professors from the University of Pristina involved in the training programme, to discuss methodological approaches and issues relevant to the course, and exchange views on psychosocial support in post-conflict contexts.

The present notebook is a selection of papers from the first International Seminar on Psychosocial and Trauma Response in Kosovo, held in Geneva from 8 to 10 March 2000. Despite the many changes that have occurred in the region since this meeting took place, and their effects on the PTR project, the papers compiled here have a timeless significance, which make them universally relevant.

This is not the right place to list all the activities and results achieved through the PTR project¹. Nevertheless, I would like to reiterate that the main aim of the project, which was the training of 40 psychosocial counsellors, has been achieved thanks to the implementation of a theoretical and practical work focused on the support of traumatized persons. At the end of the 1999-2000 academic year, 37 of the 40 trainees, obtained the title of Psychosocial Counsellors and were handed a joint certificate delivered by the University of Pristina, the Tavistock Clinic of London and IOM.

I am very grateful to all the professors and international experts who have participated in this seminar and to those who, later on, have brought their knowledge and expertise, by accepting to give lectures in Pristina. I am particularly grateful for the open discussions that took place during the seminar, and which brought words of criticism as well as appreciation for the efforts undertaken. All the input received has been valuable, as it made possible the necessary adjustments to the direction of the project throughout its implementation.

Taking a closer look, I can safely say that the project's innovation lies mainly in the shift of emphasis away from the individual symptoms to the collective and community experience. The activities developed in the framework of the project have therefore been carried out at both a social and a clinical level.

At the social level, they were achieved through two main tools. First, the introduction of theatre as a collective ritual rooted in the local culture and a re-discovery and enrichment of the autonomous resources with ritual, therapeutic functions². The theatrical work involved both the trainees and their tutors.

Secondly, they were expanded through the development of *The Archives of the Memory: From an Individual to a Collective Experience*, which records the complex and multifaceted experiences of the local people before, during and after the war. It was mainly through this continuous discussion, of which the theatrical work is but one part, that the reconstruction of a non-nationalistic identity has begun, through a process of "storied communities" as is very well described by Renos Papadopoulos in his intervention³. The process will obviously be a long one, and, although the PTR project is just a drop in the ocean, it tries to contribute to the global efforts to prevent the sporadic resurgence of violence.

1 A synthetic but very clear description of the activities and results achieved through the project is summarized in the booklet *Psychosocial and Trauma Response in Kosovo. Achievements and Plans 1999-2002*, IOM, Geneva.

2 See more in M Eisenbruch's intervention.

3 In addition to the interventions of S Salvatici and Altrimenti in these proceedings, both referring to *The Archives of the Memory*, this part of the project has produced videos, theatre performances, a photograph exhibition and the proceedings of a psychosocial notebook on *The Archives of the Memory* are scheduled.

At the clinical level, the activities proposed by the project aimed at developing a mixed and integrated approach composed of family and community therapy⁴ as well as ethnopsychiatry and transcultural psychiatry⁵, through the implementation of training in action.

Following the clinical part of the training, Harry Minas taught a module specifically on understanding and defining the role of counsellors in the community and mental health services being developed in Kosovo.

Greater details on the activities carried out during the first year of the project are given in the annex. From a methodological point of view, the didactic material produced through this experience could be useful, if adapted, to other realities and, in particular, to train counsellors and professionals who work with migrants, refugees and asylum seekers in resettlement countries.

At the end of the first year of work, the project has proven to be very satisfying. The outcome seems of “unexpected” quality, considering the complexity and the vastness of the task. This work is the fruit of the commitment of many persons and institutions at regional and international level.

Natale Losi

4 In particular through the training and clinical work implemented on the field after this seminar respectively by the therapeutic couples constituted by N Losi and R Papadopoulos and by V Dubois and JM Lemaire.

5 This clinical and training work has been implemented by T Nathan with his colleagues from the Centre G Devereux, F Sironi and M Pradem, and with the participation of N Losi and M Pandolfi.

Understanding the needs of the displaced: some elements on the Kosovo case

Natale Losi*

Introduction

The first project for the assessment of the psychosocial needs of Kosovar Albanian refugees was entrusted to IOM immediately after the outbreak of the conflict, in April 1999. This emergency project, called *Psychosocial Trauma and Response for Displaced and Refugees from Kosovo*, aimed to undertake a rapid assessment of Kosovo's displaced population and to begin responding to its psychosocial needs. The project was documented by a report along with a video on the life of Kosovar Albanian refugees in a number of camps and compounds throughout Albania.

From this first experience, a few points might be raised in order to review the philosophical basis of humanitarian intervention¹ and to draw expertise for the improvement of future projects.

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¹ A very interesting view on this subject is given in: Papadopoulos RK and Hilderbrand J, "Is home where the heart is? Narrative of oppositional discourses in refugee families", in Papadopoulos RK and Byng-Hall J, *Multiple Voices in Systemic Family Psychotherapy*, Duckworth, London, 1997.

Entering the field: preconceptions and their fallibility

At the origin of humanitarian intervention lies a number of basic assumptions, which find their roots in predetermined methods and, in certain cases, potentially destructive processes:

1. A reductive assessment of the refugees' plight, limiting their needs to primary necessities such as food, clean water, basic health care and restricted reparations. In contrast, any response to more complex and layered needs is delayed and dealt with only in plans for later action.
2. The victimization of refugees. The conviction that they would not be able to survive without international aid and that they should comply passively with outside assistance as homogenous "victims", leaving behind their culture and background.
3. A shift in the interpretation (and understanding) of the refugees' experiences, where the reasons for their exile no longer are sociopolitical, but belong to a more neutral, "technical" dimension. This often occurs after a decontextualisation of the refugees' experience, when the lost languages and concepts are replaced with medical jargon and obscure terms. In other words, when their experience is translated from their "lay narrative" to a dialect of narrow clinical psychiatric definitions.

One particular example of this tendency might be found in the diagnostic category Post Traumatic Stress Disorder (PTSD), which has become acceptable only because it is so widespread. In the last few years, particularly as a consequence of the wars in the former Yugoslavia, the genocide in Rwanda and the conflict in Kosovo, the term has been widely applied - often inaccurately and without judgement - to a multitude of situations.

In the last 50 years, concepts like "stress" and "trauma" have become part of a discourse that is used commonly in the media's coverage of wars, conflicts or natural disasters. Although this has brought many people to a full realization of the plight of the displaced populations and of the psychological dimension of their suffering, this designation has also transferred the responsibility and care for those suffering entirely to physical or mental healthcare professionals, reducing social problems to an individual psychological process.

The western-oriented psychiatric and medical context, which, we assume, influences the convictions of most of the international aid workers faced with the effects of migration on a population, is itself based on three fundamental presumptions. These are the egocentric self, the mind and body dualism and the conception of culture as an epiphenomenon.²

The term “egocentric self” refers to an understanding of the individual being as a self-contained, autonomous entity. Psychological normality and abnormality are therefore seen as internal processes also limited to the self. This idea disregards the social origins and path of mental illness. Most of the world’s populations, however, hold a more sociocentric conception of the self, where individuals exist within networks of social relationships from which they derive self-worth, self-fulfilment, self-control and other attributes. In this model, reciprocal and interpersonal privileges or obligations are more important than the rights of individuals.

The western notion of mind and body dualism separates uncommon events occurring in the body or in the mind into two broader psychopathological categories: organic and psychological disorders. Despite this theoretical division, most of the world’s population experiences suffering as an integrated mind and body reaction, and, for many cultures, a spiritual dimension remains of great importance to the process.

Last, the concept of culture as an epiphenomenon is also particular to western thought. In this approach, culture is interpreted as a set of beliefs, or secondary elements, which are superimposed on the tangible reality of biology. Such beliefs are often disparagingly viewed as superstitious. Conceptions of illness, experiences of affliction and healing practices specific to one culture are often discredited or dealt with as obstacles to diagnosis, treatment compliance and outcome.

Psychologically traumatized people all over the world need help. They need help in order to define and understand their trauma and to develop social and cultural-specific strategies for dealing with it. Imposing pre-packed “universal” interpretations, definitions, tools and approaches to human psychological suffering does not bring them the help they need. Moreover, by doing so, international aid workers run the involuntary risk of converting themselves into traumatizing agents, by labelling some individuals as “mentally sick” while taking others away from the potential protection of their community’s traditional means of coping with trauma.

2 See Lewis-Fernandez and Kleinman, “Culture, personality and psychotherapy”, *Journal of Abnormal Psychology*, Vol. 103 (1994).

Nowadays, people find it difficult to discuss their troubles in their own terms, and therefore resort to an alienated language. This eliminates the particular individual, social, cultural and historic characteristics of their suffering. Paradoxically, then, the magical belief in “science” and in the power of the international scientific community is so strong that it tends to marginalize local knowledge.

A community based and culturally sensitive approach

From the western perspective, trauma is viewed as highly relevant. In the context of war and persecution, however, it becomes necessary to overcome individualistic approaches to trauma and attempt to bring the problem back where it belongs, within its own social and cultural context. In order to illustrate the importance of this context, students in the first training programme of the *Psychosocial and Trauma Response* (PTR) project were asked to define trauma according to their different cultures, backgrounds and knowledge. These descriptions ranged from “a deeply spiritual disorder” to “a painful reminiscence”.

The definitions proposed by the students indicate the wide range of meanings attributed to trauma according to the culture of the individual. Behind each interpretation of trauma lie the shared experiences and different traditions of women and men who find common ground in this terminology. In contrast, and in an extremely near-sighted manner, a diagnosis of PTSD suggests a set of easily identifiable symptoms and a clear account of the development of the illness and of the circumstances under which it can disappear. None of this applies to victims of war and persecution.

Although many people present PTSD symptoms, many others are afflicted with different kinds of problems. Various types of somatic and psychosomatic illnesses, for instance, have been known to appear alongside psychological symptoms. The occurrence of these symptoms also varies in timing, appearing a few days after the traumatic experience or, in contrast, surfacing only many years later.

This “classic” symptomatology is often hidden in young people who tend, instead, to reveal their affliction through anomalies in their social behaviour. For instance, they might drop out of school, have conflicts at work, use and abuse of mind-altering substances or put themselves in situations of unnecessary risk.

In survivor families, a set of typical problems can usually be identified. These do not, however, fit the criteria for a diagnosis of PTSD. Indeed, family problems *a priori* are not even included in the notion of PTSD. To further complicate the

definition, problems at the family level tend to appear and disappear, often following patterns which are not recognizable at the individual level, but which seem to depend much more on social processes.

In other experiences³, the use of alternative concepts has proven more accurate. Among these are Bettelheim's "extreme situation", Khan's "cumulative trauma" and Keilson's "sequential trauma". Another interesting term is "extreme trauma", which is defined by Becker⁴ as:

An individual and collective process that occurs in reference and in dependency of a given social context: it is a process marked by its intensity, of extremely long duration in time, and the interdependency between the social and the psychological dimension. It exceeds the capacity of the individual and social structures to answer adequately to this process. Its aim is the destruction of the individual, his sense of belonging to the society, his social activities. Extreme trauma is characterized by a structure of power within the society that is based on the elimination of some members of this society by others of the same society. The process of extreme trauma is not limited in time and develops sequentially.

Using this concept of "extreme trauma" implies a change in focus from the symptoms to the traumatic situation itself.

At the level of treatment, the conceptual change requires a shift away from individualistic approaches towards working with the entire community. This cannot mean that we, as health professionals, forget about the individual, which would only cause a repetition of the trauma, but it implies the awareness that each of us, within our community, must constantly rediscover what constitutes trauma for the specific group, and create a strategy for treatment accordingly.

We must not try and construct institutions where multitudes of professionals treat large populations. We can learn only in the communities how each can help its members and how, in return, each individual within the group can be a "trauma specialist". "Treatment" will not occur on a couch, but in schools, families, community meetings, with employment, and through functions of the community. The basic task of professionals will then be to facilitate collective recognition of the psychosocial dimensions of the community's problems, to help overcome fragmentation and to favour communicative processes by identifying key situations. Without forgetting their specific knowledge, psychotherapists might thus leave their therapy room and work within the community, promoting processes of empowerment rather than encouraging victimization.

3 I mainly refer to experiences quoted in an unpublished document by the Instituto Latino Americano de Salud Mental (ILAS) in Chile.

4 Quoted from the same document by ILAS.

The psychosocial concept proposed here is an attempt to overcome the traditional (individualistic, psychological and PTSD-oriented) methods of assessing and dealing with the problem of trauma, and to reconsider it within its sociopolitical context. Based on our observation and experience in the field, I think that it is necessary to work within the community, viewing it as the foundation and unit model. On the other hand, this cannot be done if the complicated inter-psychoic processes at work in the event of traumatic breakdown are denied. These forces must be acknowledged and integrated within our approach.

The focus should therefore stem from a discussion on how these diagnostic categories might be used, not from their outright denial. Each of us, as we face intervention and attempt to help, must take into account these categories of diagnosis, the strictness or flexibility of their application, the process of identification and of diagnosis itself, the importance given to culture, as well as the patients' ability to explain their problems in their own words.

The status of the intervention

In my experience both in Albania and Kosovo, I was perplexed by the general context of the environment. The difficult living conditions, the tension and instability, the suffering and anguish so evident in all aspects of people's everyday life were disheartening. More striking, however, was the arrogance and thoughtlessness of most of the international experts who swarmed over the entire territory. Most of them had arrived with toolboxes of pre-packaged instruments, of which PTSD was the most popular. The acronym alone felt perturbing and invasive to me, causing internal conflict even as, during discussions, I applied the word "trauma" to the suffering of the population.

This was probably the driving force behind the decision to design a project aiming to overcome the limitations of western intervention in Kosovo. This required moving on dangerous grounds, both figuratively and literally. The project was and still is a great challenge, intensified by the fact that despite the rich range of critical literature available on humanitarian interventions in the field of psychological trauma, texts have mostly limited themselves to criticism, falling short of proposing alternative intervention constructions.

This project in Kosovo provided an opportunity to use an approach more respectful of the context and better adapted to local culture. Both the objectivization and the decontextualization of symptoms, which are obstacles to progress, were examined and rejected.

This approach, already tested in the first two phases of the first module, has exposed us to the emotions and suffering of the students. Their emotions were accepted as legitimate, their feelings were recognized and their own interpretations of events heard. As a group, we learned to value their common and unexplored resources, interpreting them as alternative means of understanding the suffering linked to their experience.

During the first months of work, apart from the shared feeling of having embarked on an important human and professional experience, we began understanding some aspects of the Kosovar experience and culture. Such an understanding has seemed to lead us towards a common ground, or to the construction of a common discourse, where exchange becomes possible. This is fundamental to the development of local resources, in this case a group of 40 counsellors. They will be crucial in helping the population face the psychological suffering as it reveals itself by providing a trans-disciplinary and a culturally appropriate perspective.

The IOM project on psychosocial trauma

During the first observations and assessments in the field, certain elements particular to the context became apparent and illustrated the specificity of the case of Kosovo:

1. The duration of the conflict, with the international attention turned almost exclusively to the refugees;
2. The transition period, with its instability due to, amongst other things, an ambiguous political situation and a lack of stable interlocutors;
3. The massive return of the population and the fact that they are now no longer refugees.

Throughout the papers presented here, experts on post-conflict and trauma situations have explored these elements and their constant influence on the project. Together with the array of definitions of trauma developed by the students, they are a first synthesis of the material gathered in Pristina.

Three axes of intervention

The project in Kosovo is built on a common methodology, based on the “learning through practice” approach inspired by Freire’s pedagogical ideas. Within this framework, there are three principal axes of intervention, each structured to hold a number of activities:

- Psycho-sociocultural
- Historical-anthropological
- Clinical

This division is not intended to be rigid. The different dimensions - psychological, social, cultural, historical, anthropological and clinical - are not separate, nor do they have a strict, temporal sequence. Moreover, partial elements of each of these dimensions mingle with different training activities. At the same time, the training activities already had some operational value: during the different periods of the fieldwork, for instance, students in each axis undertook closely supervised support activities for those in need.

The psycho-sociocultural axis

The activities that make up the psycho-sociocultural axis of the programme were undertaken at two different times, both within the context of the module *The Archives of the Memory: From an Individual to a Collective Experience*. The first series of activities began with the period of introduction to *The Archives of Memory*. The second set of activities was run parallel to the theatre project called *The Exiled Body*. These two training sessions were carried out between 6 and 17 December 1999, and 7 and 25 February 2000, respectively. In addition to this, in January 2000, the students carried out four weeks of supervised fieldwork.

The first training period of December 1999 was especially effective, in that it helped establish a relationship of trust with the students, which ensured the emergence of a community between students and trainers.

The primary objective was to show the students that the recollection and sharing of painful, sometimes traumatic experiences and the shifting of this recollection from the past of the individual to the experience and memory of the group allowed for a certain depsychiatrization. The shared experiences allowed the students to express feelings linked to possibly traumatic events of their own past within a protected situation, accompanied, led and supported by the group or its guide. With the help of role-playing and discussion of cases and fieldwork, the trainers were able to verify to what extent this exchange of intense feelings was legitimate and therapeutic. On the other hand, each of the students and trainers were given the chance to experiment with psychosocial working tools like group discussions held in a “conversational” setting.

The following part of the training programme, *The Exiled Body* theatre project, proved to be especially valuable. Besides giving the students another tool with the use of theatre and *mise-en-scène*, it strengthened the solidarity of the group and their conviction that they were doing something they believed in, something to which they were strongly committed.⁵

5 For further reference, see the paper by the association *Altrimenti*. The theatre group also produced videos and other didactic materials related to their specific intervention.

The historical-anthropological axis

Another level of the training programme, which dealt with historical and anthropological methods, was created mostly from *The Archives of Memory* module and is presented more thoroughly in Silvia Salvatici's paper. The anthropological perspective, as it relates to the Archives, is further introduced by the paper of Mariella Pandolfi.

The clinical axis

As already mentioned, the shift in attention from the individual to the community in this project has allowed us to perform a similar shift in the clinical axis, from the symptoms of the patient to their context. For this reason, our training intervention has been geared to provide clinical activities and to use therapeutic techniques that would favour this movement. Given this approach, the roles of patient and therapist must find new interpretations and schemes of interaction.

Following this approach, patients feel encouraged to refer, consciously or otherwise, to a traditional and familiar thought and understanding of the world that includes theories of illness and cure. These theories are aetiological, and the cause of the patients' confusion is often external. Their disturbance is then identified as the reflection of a rupture in their bond to their family and community.

In this type of interaction, neither the healer nor the therapist act directly on the patients. They play the role of mediators between the patients and their social and cultural group. The objectives of the care lie in the search for a traditional aetiology and an original approach of curing the patients' confusion. This intervention allows the patients to represent their illness to themselves and see it in their own way, according to their culture - already allowing for re-affiliation and a sense of belonging - and to renew family bonds, by re-entering their original family and social network.

The aim of this seminar is to review the participants' experiences in order to be able to offer the richest and most articulate vision of our next activities in Kosovo.

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The IOM psychosocial and trauma response training programme: six questions

Harry Minas*

Graduates of the IOM psychosocial and trauma response training programme will be working in very difficult circumstances. Over a period of more than a decade many people have experienced social exclusion, displacement, loss of family and friends, loss of property and livelihood, physical injury, and psychological harm. Needs in the community are extensive and diverse. Social infrastructure and essential social institutions are fragmented and there are limited material, financial and human resources. There is an enormous amount of work to be done, with many individuals, agencies and institutions contributing to the task of social and material reconstruction. The purpose of this presentation is to ask some questions that may be useful in the further development of the training programme.

1. What should be the goals of the training programme?

The broad goal of the IOM psychosocial and trauma response training programme is to enable the graduates of the programme to contribute effectively to the promotion, protection and restoration of psychological and social well-being among the

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population of Kosovo. The goals of the training programme should be clearly articulated in terms of the contribution that the psychosocial counsellors can be realistically expected to make to the health and well being of the population. The goals should be determined on the basis of an understanding of what needs to be done (the needs that exist in the population) and, in the current and foreseeable context, what can be done with the available resources. A firm commitment to equity will ensure that priority is given to those in greatest need, and a commitment of human rights will ensure that health services and other programmes of assistance will be inclusive.

2. What is the nature of the work that the counsellors should do?

The types of work that the graduates will be expected to do as psychosocial counsellors will determine the body of knowledge that they will need to acquire and the practical skills that they will need to develop during the course of training. The types of work that the graduates will have an opportunity to do will depend on many external factors. These include the structure and operation of the health, education and social welfare systems that are developed in Kosovo; the availability of positions in which the graduates may be employed in the general health, mental health and education systems; and matters such as the formal recognition of the training by appropriate bodies. Given the diversity of professional backgrounds and interests of the students, it is likely that they will wish to work, and will be most effective, in different settings. Some graduates might work with community groups and organizations, others with children in the primary and secondary schools system, some may work collaboratively with primary health care staff, and others may work in the specialist mental health system. This would ensure that, in their work as psychosocial counsellors, appropriate use is made of the knowledge and skills that were acquired in their previous professional training and work experience.

3. What should the programme graduates know and what should they be able to do?

The students have entered the programme with a variety of professional backgrounds and bring to it a wealth of knowledge and experience. They will undergo a year of intensive activity and interact with many different teachers. What new approaches should they learn? What should they be able to do differently or more effectively as a result of their training? This question is directly tied to the skills and activities that will be required of them. What will the community want of them? A one-year training programme can only focus on the core knowledge and skills that are required across settings. All graduates should know something about individual casework, working with groups and community development work.

As well as focusing on core knowledge and skills, the training programme must of course prepare the students for the particular situation of Kosovo, and develop a capacity for flexibility and responsiveness to changing circumstances. The group must be prepared to work in conditions of profound uncertainty and rapid change. The programme should prepare the students to be flexible and creative in their approach, and to be active in their own continuing education. Throughout their training, the students should be given opportunities to discuss and reflect (not only amongst themselves and with their tutors, but also with members of the community they serve) on the kind of society that is being reconstructed. In considering the characteristics of this new society as it emerges from the chaos and turmoil of recent years, it will be essential to promote discussion of human rights and their meaning in the light of recent history and current circumstances.

In order that they should be effective (and that they should do no harm) the counsellors should be able to recognize the limits of their knowledge and skills. When they confront situations that exceed their competence, they should be active in seeking supervision and assistance, and should refer to appropriately skilled professionals when this is required.

4. What should be the role of graduates in the specialist mental health system?

The World Health Organization (WHO) has assumed responsibility for the re-development of health (including mental health) services. It has identified mental health as one of the five key priority areas for health development. This is based on the current health situation and the demographic structure of the population in Kosovo. The priorities are:

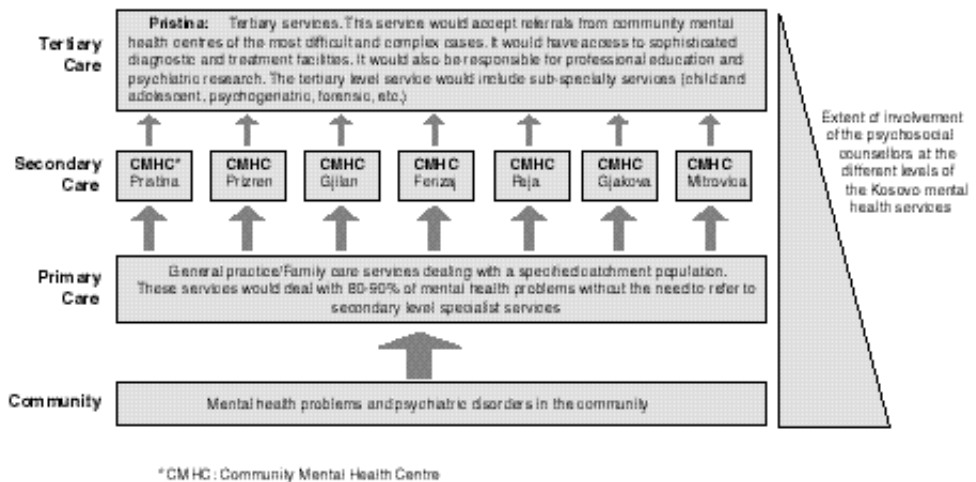
1. A healthy start in life;
2. Improved health of young people;
3. Improving mental health;
4. Managing for quality of care; and
5. Developing human resources for health.

WHO has enunciated the key principles that will underlie the health services to be developed. They will have a commitment to equity, acceptability, effectiveness, flexibility, sustainability, non-discrimination and appropriateness.

In relation to mental health, it is intended that the current hospital-based system, reliant almost entirely on a very small number of psychiatrists, will be transformed into a community-based mental health service (with community mental health centres located in six regional towns as well as in Pristina) with significant

enhancement of the capacity of the primary health care system to deal with mental health problems. Such a structure of the primary care and specialist mental health systems will create many opportunities for significant contributions by the programme graduates (see figure 1). The greatest opportunities, in my view, are at the community level, particularly in working together with schools, workplaces, village and other community associations, etc. The counsellors should also have a prominent part to play at the primary care level, assisting primary care professionals to deal with the psychosocial problems that many of the patients seen at this level will be experiencing. There is also a significant, but less prominent role, for the counsellors in the specialist mental health system, working collaboratively with psychiatrists and psychiatric nurses in assisting patients with psychiatric disorders.

Figure 1: Organization of mental health services



5. What will be the professional identity of programme graduates?

The graduates of the programme will have the opportunity to create a distinctive group identity. What should this identity be? How will the students define themselves once they have completed the programme? Will they be able to provide a clear and simple answer describing what they do, should a member of the community ask this of them? A clear sense of professional identity will be important if graduates are to be able to work confidently with the community and with professional colleagues from a variety of disciplines. How will their new role relate to their previous professional identity? How will they have changed? Some of the students are doctors, others teachers, and still others skilled in a variety of fields. Will

they enter the programme as individuals, individually skilled, and complete it as a uniform group with similar roles limited to their new training? Or will they emerge still as individuals, identified according to their initial training, as doctors, teachers or other professionals, but with a new set of perspectives and skills acquired within the programme? How will they use the additional skills in the pursuit of their primary obligations? For example, will doctors be required to diagnose severe depression, and will they have a clear procedure to follow in cases of severe distress? Will teachers have particular responsibilities, such as adapting systems of psychosocial support to school environments? Will they be assigned to work primarily with children and families who require counselling? These issues of professional identity must be clarified, and the students must be clear about who they will be, professionally, once they complete the programme.

One way of facilitating this process, and ensuring that the group has a voice in policy and planning discussions, is to establish a Kosovo Association of Psychosocial Counsellors. The establishment of such a body would have a number of benefits. It would:

- Give the group a formal, collective presence, identity and profile;
- Enable the group to collectively negotiate matters that are of collective concern to the group;
- Enable the group to promote the establishment of departments of clinical psychology and social work, and to participate in curriculum development and the teaching programmes;
- Enable the group to promote appropriate resourcing of community-based and community-orientated mental health and other psychosocial programmes;
- Enable the organization of peer support and information exchange activities;
- Enable the establishment of linkages with other organizations with similar goals internationally.

6. Human rights

Finally, a few words on the issue of human rights. I would wish again to emphasize the critical importance of incorporating extensive and continuing discussions of human rights in the programme curriculum. What is the origin of these rights? What is their nature? What is their extent and reach? Does everyone have the same rights, or is the situation of Kosovo such that some are excluded from their net? The extent of societal commitment to human rights should be a recurrent theme throughout the curriculum, because the answers and solutions that come from such discussions will have a direct impact on the society emerging from this post-war period. These

discussions should explore the social and political implications of either a full or a partial commitment to human rights. They must raise questions as to the nature of political justice, of the current nature of citizenship in Kosovo, of whom it includes, and whom it excludes. What are to be the rights and obligations of these citizens? What kind of institutions will be established to ensure observance of human rights over the next few decades? Recovery from trauma and pursuit of personal and social well being is not possible in the absence of these rights.

Disappearing boundaries: notes on Albania, Kosovo and the humanitarian agenda

Mariella Pandolfi*

On borders

P pausing between the Europes of East and West, Claudio Magris (1986), writer of frontiers and enclosures, once vividly evoked the complex importance of borders:

They die and are reborn; they shift, dissolve only to reappear unexpectedly. They leave their mark on experience, on language, on the space in which we dwell, on the body robust or ailing, on the psyche and its divisions, on politics and its absurd topography, on the self and its fragments struggling to regroup, on society and its factions.

Yet this border, the border as limit and risk, the border central to human experience, has been marginal to the history of societies and men, compared to the vivid and violent reality of complex identity: the borders of awareness that separate us from others and close us off from the risks of contamination and hybridity.

The border becomes a site of power only when it acquires material reality. Ramparts, walls and checkpoints are just tangible threats of violence, but the limit

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of a wall's power is never circumscribed to the will of those who build and maintain it. Defining a boundary also means to entrench a memory into the soil, to form time into space or, to paraphrase Braudel (1986), to eternalize the limits of a space.

Over a decade ago, the true brutality of the Berlin wall was revealed on the eve of its destruction. Trapped violence, which had been sublimated under the everyday life of the city and frozen by the tensions of the Cold War, began to erupt at night-time, tearing through the routines of Berliners with live images on television. This same energy ultimately generated and legitimized new social politics built upon memory. In a sense, the Berlin wall fell to be replaced by a new border: a wall between that past and the present of collective memory, which was also neither natural nor sustainable. The people who watched the wall crumble were seeing the sun set over nineteenth century values of citizenship. The reunited Berliners were seeing the end of "materially defined culture": culture based on self-contained nation states, territories, borders, populations, legislation and political representation. In its wake, an opposite but no less intense process is now unfolding at the peripheries of south-eastern Europe, this time without the clarity of tangible borders.

In south-east Europe, especially, efforts to erect and solidify nation states have taken shape: there have been large-scale campaigns to acquire territory, mass deportations and ethnic cleansings verging on genocide. In this new stage setting of disappearing borders, one might then ask what would be the legitimate relationship between an ethnic group as a form of social organization and the effects of its defensive territoriality? What would be defined as legitimate interactions between refugees, humanitarian interventions and this territorial democracy? How are the common intervention logics of "incorporation" and "distancing" creating refugees as opposed to citizens, while establishing and normalizing an ambiguous form of "intergovernmentality"?

Fragments of memories

The outlook offered here comes from a dual experience: on the one hand, my learning as a professional anthropologist already shaped by a previous training in psychoanalysis. On the other, my experience as a psychoanalyst anthropologist, growing again from a political atmosphere similar to that of post-war Italy.

For an anthropologist of the 1968 generation (I was born in Naples immediately after the end of the Second World War), doing fieldwork in Albania and Kosovo evoked memories of my childhood, reactivating a politics of memory that had since fallen into disuse. I had forgotten the teachings of this political climate but was brutally reminded of them when I arrived on field in the Balkans. This particular

atmosphere does not belong solely to my background, however, but is one which should influence people of all fields who work in countries termed “post-communist”, or in “post-communist transition” (Pandolfi, 1999).

In the ruins of the post-war years, amidst the destruction that had been our sacrifice for freedom from fascism and nazism, the North Atlantic Treaty Organization (NATO) had established its headquarters in the outskirts of Naples. The harbour was occupied by sailors in white uniforms who behaved, and even walked, just like their battle-fatigue-clad descendants in Tirana today. Much like their forefathers in Naples, today’s units have their shoes polished by Albanian children who look just like the Neapolitan *sciusia*.

These mirrored fragments and associations illustrate the risks inherent in the practice of anthropology in Albania or Kosovo today. To practice anthropology, and thus to attempt to recover the dimension of a people’s subjective memory, is not a matter of uncalled-for reflexivity or of fiction and creativity: the challenge of anthropology is not found in the rhetoric or in the safety of text.

On the contrary, the challenge of anthropology lies in recovering, with the help of one’s own insight, every dimension of the politics, from a people’s subjectivity and territory to the local ideas of family and gender, that the media have reduced to flat, one-dimensional, virtual spaces. This also implies reviving this science with a genealogy of experience from a landscape levelled by globalization.

The challenge lies in the ability to switch from the large, mobile scenery on the field to a subjective and emotional politics of memory, as we attempt to recover a cultural framework that would otherwise be lost. When the object of our study undergoes large-scale transformation and is thoroughly mediatized, the subjective world of anthropology can become the “operative frame”, tracing the “cultural” perimeter of the object or objects of study that the anthropologist is forced to share with others. These fragments and free associations call for another dimension of anthropological practice, where fragments of personal memories - the free associations of childhood images - work to construct a frame for the local, political dimension, protecting it from the rush of globalization and from the porosity of the fields’ borders.

The anthropologist working in the humanitarian fields in the Balkans today, however, also runs the risk of addressing these topics with the logic of perpetual retrospection, reducing the present to past experience, collapsing particular phenomena into a homogenized historical processes and thus inevitably re-enacting the creation of “imaginary communities”.

Transition and migrant sovereignties

The humanitarian war zones in the hinterlands of south-eastern Europe constitute a double risk for anthropological work. On the one hand, there is the continuous presence of the media, who with their pervasive and entertaining logic of the spectacular may lead one to find in war, chaos and opposing vendettas the same logic of the “scoop”. Or to lose oneself in labyrinthine debates on the differences between massacre and genocide, constructing the *identikit* of victim and executioner basing oneself on medieval “identities” that had been long buried and that re-emerged suddenly after the fall of the Berlin wall.

On the other, one may enter the territories crossed by the humanitarian military and civil presence and yet ignore it completely, as if the transnational peace forces had no pertinence to anthropological work. As a matter of fact, anthropologists, despite having worked in areas where, for decades, the humanitarian presence has been tangible if not oppressive, except in the case of development and cooperative projects in which they were often dogmatic protagonists, have not considered their presence and actions as an object of anthropological study.

Moreover, the theatre of humanitarian wars is pushing anthropology towards redefining a new dimension of the political or cultural nature.

Today, after the tragedy of Kosovo, Albania has become a political borderline, a land caught between the long-lasting Balkan conflicts and the multiplicity of different nation members of the newly united Europe. At last, that black hole of a region that was once depicted by the media as an alien inferno - from the boarding of ships to the naive and disastrous economy of financial pyramids and from the old traditional *Kanun* (a code newly re-ordaining its laws of vendetta and female subjugation) to a language whose origins are yet unknown - has acquired a certain legitimacy in the official transnational rhetoric. To the media, the region has been redefined as “ethnic enclave” (Martelli, 1998), i.e., a complex geography of identities reduced to transmitted sound bites. Operant throughout is the notion of “transition”, the key word of Albania’s new international and national political agenda. This transition, however, is many sided, like a *Janus* of international politics.

To speak of Albania also means discussing the “others”, that is all of the actors operating with their own logic, power, strategy, culture and authority on the Albanian territory. This implies focusing on how the political perimeter has become permeable to transnational forces, and, consequently, on how it constantly reacts and interacts with all forms of otherness (Kullashi, 1998). The region’s quest for a

post-communist and neo-democratic identity has forced their most dynamic social networks -those most sensitive to the transnational context- to negotiate with the demands of what I have called “migrant sovereignties”.

The emergent impression is that of a complex network of military forces, international organizations, Non Governmental Organizations (NGOs) and private foundations. These are only examples of the “migrant sovereignties”, authorities that exercise a strategic hold on local institutions and civil society, beyond their own legitimate borders. Ethnographic research suggests that these transnational formations impose alien institutions and notions of citizenship on territories where the state has either been eroded, destroyed or has never taken firm root. While the implications are still poorly understood, we know that at the local level, these formations mobilize transnational communities of experts and coercive power capable of uprooting previously existing networks of influence and distribution, and of weaving new alliances, blurring strategies of legitimization and authority in the process. Drawing on Appadurai’s (1996) notion of mobile sovereignty¹, we might define these transnational formations as migrant sovereignties which serve to link transnational forms of domination to local political practices.

The intricate network of the humanitarian, political, economic and military complex that is superimposed as a migrant sovereignty upon the Albanian society does not conceive of any strategy of negotiation with its political, institutional and social actors. In such a context, how could Albanian social actors pursue any form of negotiation? How could they negotiate a temporality and an urban space of their own, faced with this transnational governance of urgency and humanitarian interference, which has its own ready-made values, truths and pre-packaged institutions?

¹ The notion of “mobile sovereignties” (Appadurai 1996) can be used to analyse the new geopolitical stage in which NGOs, UN agencies, donors and transnational organizations establish implicit transnational rules constraining local institutions and governments into unidimensional negotiations. Ethnographic research suggests that these transnational formations impose alien institutions and notions of citizenship on territories where the State has either eroded, been destroyed or has never taken firm root. It appears that at the local level these formations mobilize transnational communities of experts and coercive power to disaggregate local networks of influence and distribution, configure new alliances, and blur strategies of legitimization and authority. These “mobile sovereignties” are a form of governmentality characterized by innovative forms of (de)territorialization. The robustness of these mobile sovereignties appears to derive from two phenomena: (1) the migratory fluency with which they are able to articulate local and global institutional forms and practices into new and productive relationships; (2) the ideological cloak of humanism under which they circulate and mobilize powerful constituencies in wealthy countries and recruit élites in subject territories.

The Balkans and the “West”

With the 1999 conflict in Kosovo, Albania has become the lynchpin of Balkan stability and the key site on the political cartography of post-communist transition. At its frontiers, different figures have assembled over the last decade, brandishing carrots and sticks in their quest for the ideal post-communist state. Volunteers, soldiers, peacekeeping forces, NGOs and international agencies flock in to embrace the new cause as though to evangelize this final frontier of Europe. The culture of the West is of course not homogenized, nor is it unified into a single influence. It must, however, be admitted that, in certain cases, the “occupying” humanitarian efforts run the risk of a “supra-colonialism”. In these instances, the international presence has to such an extent mediatized the country that we have no choice but to consider it almost an involuntary invasion.

This international presence has not emerged overnight, but within a context, and it belongs to a historical precedence of the West’s habitual conception of the Balkans. We must first account for this view in order to offer a political interpretation of humanitarian aid and the way it has rewritten politics and social relations in this fragile and porous territory (Chomsky, 1999).

This new dimension, a field of new experiences especially for anthropology, has been so thoroughly mediatized that it has become difficult to select a field of research in Albania, and we are thus faced with a double problem. On one hand, the anthropologist runs the risk of sinking into the interpretative logic of the media, which emphasizes violence, chaos, war and hopelessness, i.e., “Balkanization”. On the other hand, especially in Albania and Kosovo, we are confronted with other sets of people, like international workers, NGOs, the Council of Europe, NATO troops, and so on. All of these occupy the territories, usually after forgetting that they are intervening in a country at a vulnerable point and where a sovereign state (here Albania) is at a social-political impasse (in this case regarding the future of Kosovo). In these territories, where a supra colonialism wears the sheepskin of humanitarian aid, peacekeeping interventions or alternative development promoters, the anthropologist’s work is increasingly important. To him or her falls the responsibility, rather than passively reading a coherent, localized terrain, of reviving the line between what is local and what belongs to the transnational presence.

The ability of this presence to penetrate, even to permeate, a culture should be checked, especially at this fragile time when countries are busy redefining their post-communist identity. Among areas where international political scrutiny is often most intense, one might add several other countries which do not belong to the geographically defined “Balkan region”, but which are considered in the western

political discourse as “enduring Balkan instability”. The word has re-emerged, in the last four or five years, in the geopolitical discourse. Where it once defined specific south-east European countries, considered by the West like “Black Holes” on the map - or, as Bismarck used to define Albania, as “an anomaly of History” - we now speak of the Balkans not merely as a geographic designation, but as a situation. In the twentieth century, the expression “Balkanization” has connoted a situation of endemic violence and the impossibility of attaining national unity (Todorova, 1997). The term was coined under the influence of post-colonialism, and came to encompass any kind of disintegration, whether political or economic, incurred as a result of decolonization. Interestingly, however, the conflicts within Kosovo and Bosnia, along with the fragility of Albanian democracy, have repatriated the word, returning a concept to its origins on a newly politicized map, balkanizing the Balkans.

This might not yet be considered “pertinent” to the intervening psychiatrists, or indeed, to ethnopsychiatrists, but in the post-communist territories under western scrutiny, changes are occurring: politics and political influence are migrating to new arenas, raising an undeniable obstacle for the science of anthropology. One could not claim to work in Albania or Kosovo today without taking these changes into account.

Further, the “Western Culture”, differentiated and varied as it may be, also changes in these tense fields. As a unified humanitarian interference, the “Western Culture” becomes homogenous, immersing the field with a rigid, precise protocol. This protocol may or may not be American, still its influence on the field raises new questions of local identity. Often this presence alters pre-existing power relations, giving new local lobbies the opportunity to emerge, gaining control of traditional power structures and then substituting them with a flexible international social and information network.

The creation of new political planes and the emergence of new mechanisms of authority no longer contained within the borders of nation states raise questions of both political and cultural nature. From an anthropological perspective, these questions bring us to redefine notions which are becoming increasingly ambiguous, like national sovereignty, territory, humanitarian intervention or invasion, the concept of a national border and what might be referred to as “migrating sovereignties”.

These migrating sovereignties are not entirely new and have already been encountered outside Kosovo. There has been international presence in Bosnia and Iraq, United Nations observers in Cambodia, humanitarian efforts and protective interventions. Migratory sovereignties have existed with the establishment of tribunals specializing in crimes of war or crimes against humanity, the presence of

Greenpeace, and even behind the political shift which supports a distinction between civil and humanitarian warfare. In other words, the transnational organizations have become active protagonists in our field of work, and we will have to adjust to them with better-adapted procedures.

The migration of a nation's political influence into new arenas exists, concretely, as part of a fundamental alteration of the stakes and appearance of power. Though long considered apolitical, all of these intervening forces have a considerable effect upon the countries exposed to the humanitarian wave. Not everything, of course, should be criticized, but it is important to look over the scene from a political standpoint, and ask what working on any level in such a context truly means.

In territories which have become tension zones, requiring urgent intervention and stabilization, our work should be entered upon in full preparation for what we are to face. The apparent stasis of a given situation, where victims, enemies and peace-making forces appear to form a fixed scene, is actually merely a cover for an extremely porous and fragile network of interdependent social actors. Cultural influence and hybridization seep into all levels of local life and become a part of this recollection of trauma. This power of the migratory sovereignties is just as realistic as politics of national memory. It operates in the same way as a nation's political faction, when it bases its authority on discourse related to static and homogeneous aspects of cultural identity (like ethnicity, or a history of a shared language, culture, territory and tradition).

The new situation in these fields might be compared to a spider web: an invasive net of intervention that tightens or loosens according to the current strategies of the transnational forces. The web tightens to spread values of performance, productivity and efficiency. There is also a certain ambiguous notion of democracy that has come to affect all aspects of the local lifestyles. In Kosovo, for instance this international presence was both evident and massive. In every town, the field is already marred by the foreign presence with zones and barricades, controls, blockades, checkpoints and restricted access areas.

Towns and zones

The ancient boundaries of yesterday's violence now serve as fences around humanitarian and military intervention zones. In Kosovo, under the aegis of transnational politics, new boundaries are taking root. These borders entrench themselves in towns where the reconstructed local identities should be coming alive and rising as a shared discourse. Yet these borders, once positioned, infiltrate the memory of those who stayed behind with them, living upon them in the worst of times, and of

those who have left and are now returning. They sink deeper still into the memory of those who became involved with events from the distance of their Swiss, American, or German diasporas, and who had animated their mediatic debates outside Kosovo, weaving from afar their network of influence.

Everyday life and survival in Pristina entails an awareness of these borders, and an ability to move through the mists of western political influence. Crossing Pristina means walking between a massive presence of uniformed men, armed or protected by bullet-proof vehicles, and ordinary citizens. These men and women are trying hard to retrieve a routine they once had, before their world was ruptured by the deaf impatience of others, drained by pain, and darkened by the fear that the abyss of this, their past, might only be filled with that other emptiness of transnational diversity.

The barbed wire; the barrier blocking the avenue; the never-ending lines uncurling from border stations; the Guardians of Peace waiting at every intersection; the stadium vulnerable to fire and to perpetual electric failures; the blackened soldier defending his trench like a guardian angel to protect the illusion of freedom; the Orthodox church, never finished, lying but a few steps away from the library and university of Pristina; all of this is only the stage setting. There, a traumatic scene unfurls each day under the flight paths of black birds which disappear into the blackened horizon.

In Tirana, the barriers and occupied zones have remained subtler, the barbed wire is still restricted to coiling around the walls of embassies and international missions. Yet the international presence and military contingents have still succeeded in profoundly modifying the lifestyles of Tirana's citizens.

In the town's centre, from the statue of Skanderberg to the mosque, a trail stretches past the constructions of the Italian occupation, past a pyramid, designed by Hoxha's son in law to fulfil the wishes of this uncle, and past humble headstones engraved with the memory of transition-time violence. This trail, paved with a history of undoubtedly Albanian memories, now borders on the territory taken over by the military and humanitarian presence. The international force, in its beneficial occupation has taken for residence the former BLOC neighbourhood, once a sort of forbidden city for the regime's highest officials. A place where ordinary civilians ventured only at their own risks and peril.

The villa of the former dictator Hoxha now houses the MAPE (the European Police), and right in the neighbourhood, the former residences of the regime's high officials are being yielded one by one to foundations, donors, NGOs, the

International Monetary Fund (IMF), the World Bank, United Nations agencies, and so on. The new structure of post-communist urban planning regulates the use of territory quite liberally, allowing real estate speculations and the unregulated resolutions of fierce urbanism to run wild. This structure was legally guaranteed immediately upon the fall of the regime, when the rights of the former property owners were restored.

Given this context, by what means can Albanian social actors possibly negotiate their goals? How can these people discuss the fate of an urban space and a governance that is theirs when before their eyes rises a temporality of emergency and transnational infiltration with its own values, its own truths and its own palette of exported institutions?

As the logic and politics of the humanitarian intervention progressively impose themselves over the logic and politics of the local population, the local government and institutions seem to acquire legitimacy only by inserting themselves into the transnational circuit, even when they succeed in this only as passive observers. Given this interaction, might not one suppose that these mobile sovereignties constitute their own form of government, which would have, as its main characterizing feat, introduced new and innovative methods of “deterritorialization”?

In Tirana and Pristina, the authority and activities of the emergency (the democratic emergency, the new market logic emergency, the emergency of bureaucratic productivity and the urgent need for institutions) have affected more than the daily lives of the citizens. The rules and regulations implanted by this international sanitation belt have influenced even the relationships of these now separated towns with those of their communities that have been able to cling to their links with the pre-existing powers. Yet the culture of urgency runs the risk of nullifying all spatial and temporal differences; in other words, urgency could transfer the same intervention strategies from one territory to another while constructing a communications network parallel to but independent from local networks.

A local “transnational” elite

Putting into practice the gospel of the market economy, democracy and the universal value of human rights has produced a stage where the whole world can witness how institution-building and the establishment of a free market economy can be generated by the application of an “exact” set of rules. Reality has of course turned

out to be different, and far more complicated. The process of transition² that took place in Albania over the last decade, and in Kosovo more recently, has been like a journey through a labyrinth. The invocation of “transition” is often a stratagem for avoiding the ambiguities and contradictions that all transitions from dictatorship towards a gradual modernisation entail. Transitions construct a constellation of often contradictory practices and meanings around the social actors involved: hence, the perception of being thrown into a labyrinth, which in the aftermath of the collapse of a political utopia characterized by total social control, may well generate anxiety. Over the last decade, the category of transition (Offe, 1996) has influenced the politics of social policies regarding eastern European countries from the Baltic to the Balkans. In the notion of transition, the two defining poles are the West and the past. Much like modernization theory, transition theory also prescribes essential steps that define the path to the desired end: 1) formation of consolidated nation-states; 2) establishment of civil liberties and freedoms protecting life and property; 3) activation of democratic political rights; 4) institutionalization of positive welfare state rights. The more these four levels converge toward the model of the modern and democratic “West”, the more these post-communist societies seek World Bank funding, abide by IMF parameters and enter in the donors’ sphere of intervention. The politics of social policies are articulated around economic liberalization, which, however, fails to take into account local forms of resistance to the standard model. The modalities of social policy-making are much broader than what is subsumed under the social policy agenda of western societies. From the point of view of a radical democratisation of society, the process of “transition” reveals some complex and interesting aspects:

1. An unavoidable urbanization process that has led to new forms of marginality;
2. The emergence of a new generation gap which has resulted in a conflict between cohorts divided by different memories and life projects;

2 Over the last decade the category of transition has influenced the politics of social policies regarding Eastern European countries from the Baltic to the Balkans. In the notion of transition, the two defining poles are the West and the past. Much like modernization theory, transition theory also prescribes essential steps that define the path to the desired end: (1) formation of consolidated nation-states; (2) establishment of civil liberties and freedoms protecting life and property; (3) activation of democratic political rights; (4) institutionalization of positive welfare state rights. The more these four levels converge toward the model of the modern and democratic “West”, the more these post-communist societies seek World Bank funding, abide by IMF parameters and enter in the donors’ sphere of intervention. The politics of social policies are articulated around economic liberalization, which, however, fails to take account of local forms of resistance to the standard model. The modalities of social policy-making are much broader than what is subsumed under the social policy agenda of Western societies.

3. The transformation of élites and the conflict between rural and urban élites, between political-bureaucratic and intellectual élites, and among the intellectual old guard. The result has been the emergence of almost xenophobic and nationalistic traits, and a class of sophisticated and polyglot intellectuals who combine familiarity with the international scene with a critical stance towards the developments of Albanian civil society and the international community. The opinions of these intellectuals have often little currency outside their international audience, at best enjoying an extremely restricted local audience. These intellectuals operate in a transnational sphere whose temporality is far more complex than the one inhabited by the majority of Albanian social and political actors. They have begun to define their identity by working on issues related to the transitional values of human rights. They have created a public image through ties with private foundations and NGOs; they have worked on creating transnational networks. This élite is deeply involved in transnational issues (such as human rights) defined in ways that are very evocative of the intellectual culture of the West. In certain cases, members of this westernized intelligentsia had progressively disconnected themselves from the values of their local community to enter the world of human rights. As the situation advances in the field of intervention, the question of governmentality³ slices across this web of actors, institutions and rhetoric, revealing a cross section of power struggles between transnational and local élites.

3 The work of Michel Foucault has broken new ground in the study of mechanisms of power. The notion of governmentality allows us to analyse mechanisms of power, domination and resistance that occur outside of a functioning State apparatus (Foucault, 1991). This notion allows us to identify the strategies which produce control through the enactment of norms, habits and production practices. Power in this case is exercised through the manner in which individuals constitute themselves as embodied subjects. Governmentality is a concept for describing the transformation from a disciplinary society to a control society. But the post-Communist scene, characterized by conflict, war and humanitarian intervention, involves more complex and different trajectories than either of these. With the fall of Communism, disciplinary institutions were destroyed; yet at the same time democratization has brought in foreign experts to construct new disciplinary institutions. In the manner of Michel Foucault, we can argue that these humanitarian interventions constitute a mobile regime of governmentality. Foucault's problematization leads us to examine the strategies which mark the articulation of this three-headed apparatus (NATO, humanitarian aid and refugees) with local State power. Arguably the by-products of failures in the enactment of state sovereignty, refugees (Malkki, 1997) are also the site of state practices that endeavour to re-articulate a state-centric imagination of life possibilities in local and global interactions (Comaroff and Comaroff, 2000). The site of refugees reconceived in humanitarian interventions could be a transformative site of modern statecraft: where bodies, boundaries, violence and power (Das, 1992) come together.

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The meaning of cultural sensitivity

Roland Littlewood*

There has lately been much talk about cultural sensitivity, as if this concept were somehow self-evident, as if no one could still wonder what exactly it is we refer to with this term. There has been a movement away from the idea of Post Traumatic Stress Disorder (PTSD); almost an unanimous exclusion of PTSD as a primarily western biomedical imposition claiming to be universal. Later, though, it almost seemed as if we had gone too far in rejecting the universalistic approach. In this theoretical conflict of the western and the local Medicine, it was suggested that local culture is not, after all, entirely “local” if it still belongs to the tradition of the western world, or that the real local healing practices were at risk of disappearing when confronted with biomedicine. The conflict paused at a discussion of cultural mediation and of justice, without seeming to resolve itself, without leading to a solution. Though it may seem that we are dealing here with many different issues, the disappearance of local culture, cultural mediation, and justice, perhaps some order might be brought to the themes if we were to consider them together as cultural notions. Justice, first, is a mutable term: whose justice do we mean? What sort of justice are we to consider, and further, what are we to consider justice?

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Likewise with cultural mediation: which two cultures do we mean? Are we not to consider a rejection of the prevailing culture a culture in itself? There is no escape to these questions and their answers, in their fluidity, must depend upon the culture, the point of view.

There is a term which bridges these propositions together, however, the idea of a “moral economy”. The expression might sound like a neologism, but it is often used in anthropology, and brings together these questions of culture. “Moral economy” is a cultural notion, a set of values governing both the local culture and that of the intervention, which also applies to the points where these cultures merge. The previously held notion of culture has been to some extent folkloric, limiting itself to questions like whether *Hoxhas*¹ were disappearing or still existed. More important at this point would be to find a reconciliation between cultures, an equivalence on notions related to concepts like Justice. We might then begin by asking how a particular culture values personal responsibility or defines a human act, how it treats reconciliation (or, to use a weightier term, reparation), and how these ideas have changed over time.

Almost 25 years ago, it was taught that war was good for mental health, that in times of war, suicide rates decreased, people became less anxious and the whole community identified with a particular, singular and moral impetus. Now of course, ideas have much changed: war, which was once beneficial to mental health, is now suddenly considered detrimental to it, and this opinion might further change according to location. It would thus be useful to ask, at this point, how the local view within a situation compares to the current global or professional opinion, whether in the particular culture, at a particular time, war is good or bad for mental health.

An answer to these questions might be found in the Albanian novel *Broken April* by Ismael Kadare². The novel is based on the famous *Kanun*³, and is obviously historical. It cannot then be relied upon as a reflection of the present or even of the recent past, but it might be allowed that some of these sentiments persist, along with part of the social structure which holds them in place. Briefly, *Broken April* is the story of a revenge murder within a cultural context, but the novel is striking in that the characters involved with the action have no feelings. They are prisoners of their culture, taking revenge because they must do so, and their personal feelings are simply not considered. In this way, the novel touches less upon psychology than sociology.

1 Traditional Albanian healers.

2 Ismael Kadare, *Broken April*, Translation: Harvill, London (1991).

3 The *Kanun of Lekë Dukagjini*: the traditional code of Albanian customary law concerning property, marriage and the correct way to carry out the blood feud.

In this context of the individuals' active avoidance of suffering, one might wonder how to place what must have been occurring contemporaneously with the story, the Turkish or Serbian massacres of Albanians. What would then have been the accepted approach? Was emotion avoided and the individuals allied to one another in blind collective violence, as a social response to the affronts? Were people at the time opposed to one another in two different reactions to the suffering? The novel itself reflects the situation of the individual within the blood feud schema, where emotion is supposedly redundant and men kill each other because they are obliged to do so, when at the same time, collective suffering continues in a greater context. One might ask whether the psychological reaction to collective suffering in this situation was equivalent to the reaction to individual suffering, or whether these two different systems run in opposition; in other words, which kind of moral economy is operant in either case.

While it may seem odd to question whether or not emotion should surface in these situations, this might also be evidence of a bias or influence. From the heights of our own western culture, whether with PTSD or by using theatre groups, we seem to assume that suffering is always there, to be given its place and to be released so it is no more. Could we not then argue that we have our own professional culture, that this concept of suffering, the cathartic model which seems so natural and inevitable, is, in fact, modern and particularly American?

In conclusion, cultural sensitivity is, at least to some extent, the knowledge of the different moral economies operant in the local society, and of those working within our professional schema. How these collide or how they might act together is definitive of the success of our ventures, and to ignore the focus of a local culture's instinct would be to ignore our own professional culture.

Myths over the field of intervention

Derek Summerfield*

There are questions to be raised, not only touching professional matters but also of an ethical nature, concerning the discourse around refugees that has emerged in the media. In the press, for instance, a collection of clippings becomes an interesting experiment in contemporary sociology, revealing often debatable ideas which are disseminated as accepted facts to a widely accepting audience. In this context of a globally supervised world, there are ten points that must be borne in mind by anyone seeking, by their intervention, to help and not harm. These points stand as reminders of what is proven and known about post-conflict situations, often in opposition to the convictions offered by the media.

Convictions of the international community

The mainstream press is rich with examples of these assumptions. In a British newspaper, for instance, one article surrounded a photograph taken during a crisis. Under a dramatic picture of a Kosovar woman in a refugee camp was the caption: “A

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traumatized woman feeds her baby at a Macedonian refugee camp yesterday.” Very little effort is made in this article or in others to explain “trauma”, however, and the word seems to bear a number of meanings. Trauma is evoked repeatedly, to suggest unusual sufferings, as an idiom of distress, or as a convenient qualifier, added to a number of emotions. It is supposedly a psychiatric condition, and yet there seems to be no single definition of trauma, given the multiple uses of the word. In the realms of journalism and in other forms of public discourse, increasingly diverse refugee experiences are collapsed into a single group of “the traumatized”, on the assumption that there is pathology. Students should be aware of this, in order for them to avoid the idea that the concept of counselling presupposes trauma, pathology or profound distress. This is also a matter of selective information, as the pictures and words present in the mainstream media are those of journalists and reporters, never of the refugees. The influence of this public discourse often overpowers any other voices, preventing us from considering how this woman, the refugee in the picture, would describe herself.

The next example is an article entitled: “Kosovo’s Wounded Women Find No Peace.” It is illustrated with a picture of three women in a clinic, captioned: “These women wait for counselling, by a clinic in Kçirë, Albania.” The second half of this same article deals with Médecins Sans Frontières (MSF), and its counselling programme in Kosovo. Above it was the picture of the three women. Did they have Post Traumatic Stress Disorder (PTSD)? Was this relevant? Were they identified thus? All of our assumptions, as readers, hinge on this single-sentence caption and the visually dramatic photograph that accompanies it.

Further down, it is written:

The aid agency Médecins Sans Frontières has set up a small camp clinic in the village to provide counselling and basic health care for what is said to be a widespread incidence of Post Traumatic Stress Disorder, but is fighting an uphill battle with ethnic Albanian doctors who prefer to prescribe drugs, rather than psychology.

Then, lower, the journalist describes: “A conservative population loath to admit to their need for the care outside agencies have brought.” Here, the population itself has become an obstacle. The implication is that these refugees need the mental health care brought by the intervention agencies because these agencies say so.

Further lies another interesting statement: “Counselling is difficult to implement because there is a lot of shame” says Fabienne Delevar, a Belgian psychologist for MSF, “Everyone here has experienced trauma, so they are not asking for help.” In other words, not asking for help, here, is just another sign of their pathology and trauma.

A third article was taken from the *British Medical Journal*. The subject here is UNICEF and its counselling programme in camps created in Macedonia. In the last section, the journalist wrote: "The aim of counselling is to restore a sense of trust." One might ask here whether "regaining a sense of trust" once one's world has been destroyed is a technical problem, and a technical problem addressable by counselling. Obviously so, according to this article. The counsellors should be aware that this discourse is continuing, with all the money and power involved, even now, and that these convictions are being disseminated by the most influential voices of the media.

The next article, from the British newspaper *The Guardian*, was written a few days after 4,300 Kosovars were admitted into Britain. The journalist quoted from the minutes of a confidential British Home Office Government Panel of Experts, during an inquiry into what kind of provisions should be made in the reception of the refugees: "The people who have arrived are in a serious state of trauma and chronic illness with a need for long-term counselling and support." Apart from the unfounded assumptions evident in this statement, there is an ethical dimension to the problem if one were to consider whose voices, in this case, are heard. Are our professional voices loud, and the refugees' voices weak? Are we, like this expert committee, characterizing these people as having all suffered irreparable damage? The implication here is that their humanity might have been destroyed, and that they must get specialist treatment by experts. UNICEF and other groups also participate in this discourse when they describe millions of children around the world as having been "brutalized". The use of this word "brutalized" rather than "treated brutally" is a judgement on their humanity. The statement claims authority over their moral and social norms, in a voice that is extraordinarily imperialistic. The workers preparing to intervene in a post-conflict situation should know that this is the kind of discourse against which they must take a position.

Another weighty conviction of the west supports the benefits of counselling as it is practiced in peacetime societies. In recent years, many well-funded programmes sought to deliver trauma counselling to war affected populations. Today, however, criticism of this counselling in its various forms is beginning to emerge. These voices remind us that there is no evidence that counselling, especially of the type usually prescribed after a traumatic event, prevents the formation of PTSD or of later mental disorders. Although people might enjoy counselling, we still have no proof of its benefits. Perhaps then, we should consider what these people, those whom we are trying to help, can gain from it. A professor at Pristina's Faculty of Medicine once stated that "the tools of a psychiatrist are inadequate to respond to this kind of distress." He was speaking of a particular kind of distress, and a

particular predicament to the intervening professional, common to these post-conflict situations. Before we attempt to intervene with our conventional methods, then, faced with these forms of war-related stress, we should indeed ask ourselves whether our beliefs hold true in these situations, whether our tools are adequate.

Case study: a moral position

This point might find illustration in the recent case of a Bosnian man from Banja Luka, whose story had much to teach about the strange nature of this war-related stress. In a sense, his case echoes the professor's point, a first question that should surely be emphasized for counsellors to consider.

The man from Banja Luka was certainly a psychiatric case. Over time, he demonstrated signs of consistent dysfunction and an inability to make anything of his life in London or to be the normal man that his wife and daughter once knew. He would sit in a corner and speak obsessively of Banja Luka and his house there, weeping if someone asked him a question. He was capable of nothing, not even of taking his daughter to school, and did not respond to his family's care and attention for three years. For three years, he was not improved by full doses of various antidepressants, nor did he respond to any encouragement to undertake a structured activity and set himself some sort of goal. "What kind of condition is he in?" one would wish to ask: here was a man whom one would label "sick", or in whom one would diagnose a disease or disorder, yet only two events have made a difference in a state which modern psychiatry has done little to cure.

The first change in his condition occurred when he was sent, on holiday, to the Isle of Wight in England. There, he saw a water mill that reminded him of one near Banja Luka. He was better for one week, then relapsed. The second change came about when he returned to Croatia with his brother and went back, at substantial risk, to Banja Luka. He walked to his home, where the Serbian man who has taken over both his house and truck came out and pelted him with insults, shouting at him to leave. The man formerly from Banja Luka looked over his old town, and saw that what he once had there was gone. However perverse this might appear, the experience improved his state for a week, before he relapsed again. What kind of a condition is this, which defies his wife and daughter, defies time, defies psychiatry, defies medication but can be lifted, albeit briefly by either a positive encounter

(seeing a familiar object like a water mill) or a surely negative encounter (going back to see that his Muslim Banja Luka is gone and that he can be abused by the man who took over his house)? The case is interesting because of what the man seems to be telling us, in a way providing, through his actions, an answer to the professor's question: What kind of condition is this?

The problem, in fact, seems in part a moral one. The man was wrestling with the moral knowledge of a world that had crumbled and the perpetrators were freed and unpunished. In a way then, within a clinic, his wife and myself, as his psychiatrist, were asking him to get better without the healing of the social world that had been destroyed. In other words, we wanted him to get better in a vacuum. His daughter, of course, also wanted him to get better, wanted him to come back to his former self, but he resisted this. What he was saying to us is that he was not haunted by the traumatic memory of PTSD, but by a sense of the absurd, an almost ethical sense of a breach in the normal order of things. If, with ten minutes notice, men could break into his life and destroy his whole world, how could he be expected to pay attention to the Yugoslav football team in the World Cup? We expected him to heal in this void, and his response, almost a moral position, was: "I will not, I cannot." The only way he could get better, as he told us with his behaviour, was by going back to the Balkans, and he was probably right.

Again, then, one might ask, "what kind of condition is this?" In a sense, this man does fulfil psychiatric case-hood, and yet only seeing a water mill has done for him what no one else could have. A morally and politically neutral psychological support has only a feeble grip on his state.

For another example, let us consider a photo, taken in a crisis situation, of people in Guatemala. In the picture, the people are shown burying the bodies they had disinterred from massacre sites. It is necessary for us to consider, as the students should, their condition at this time. In what ways might their condition be altered by having a body to bury, or by having these disappeared return to the fabric of their times? How would they describe their situation?

As a third example, one might consider a woman who, for over 50 years, had been campaigning for the recognition of her abduction as a sexual slave by the Japanese during the Second World War. She had been one of 200,000. Half a century later, in 1993, she was still campaigning for the recognition that has been denied her, and apology and reparation from the Japanese Government. Before we would even presume to approach her, psychiatrists, her situation must be understood from her point

of view. How might this have been different if there had been some kind of acknowledgement of her ordeal much earlier on, at the end of the war? Do we understand the limitations of the psychological tradition before such an experience? For a final example, one might bring up the well-used post-modernist defence that “truth is a very difficult concept.” This argument was offered by the British Government as it continued to deal with Saddam Hussein, even as it was known that he was dropping poison gas on Kurdish villages. In a sense then, what this man from Banja Luka was expressing is: “You think my psychology is separate from everything else, and that I can just get better easily, all of a sudden.” In truth, as psychologists, we do. Not all of the afflicted state this so definitively, but he serves as an example of the minority of people who continue to be seriously dysfunctional, and yet out of reach.

We then come to the second point: the fact that there is a great deal of distress, but little disorder or dysfunction present in these post-conflict situations. In other words, psychological and psychiatric frameworks as they are understood in clinics might describe a few of the people after a war, but the vast majority of them are distressed without having a disorder. It would be the duty of the counsellors to identify this small group of people in dire need, whether in Kosovar town or countryside, and to focus on the dysfunction rather than on mere distress.

Third, the counsellors should think about healing and what is meant by this word. Perhaps healing is best defined metaphorically, rather than mechanistically, as “processing”, etc. The lessons of history seem to be that recovery after such events is unspectacular, undemonstrative and unromantic, banal. Recovery is a resumption of small things. It is doing the washing, it is putting the roof back on the house, and it is not very interesting to the international community. Most healing resides in the ordinary, the continuation of what the man from Banja Luka was unable to do by not being able to return to his home. For someone in his situation, it would be better to be in Kosovo, if only because he would then have the task of rebuilding his house, the village or anything else, rather than living in an artificially safe environment. In London, fed and watered by the British Government, he could not find the means nor the will to reconstruct what was not there. He would continue to say, “this is a bizarre world”, a foreign social space, and “I wish to go back even if I am destitute in Banja Luka, that is where I can recover” even as his wife and child had taken the pragmatic view that life should continue in Britain for a time. His daughter, unlike him, had settled well in school, adapting to the new situation.

Identifying and healing distress within a changing context

There are probably three points of consensus, in this highly divided field, about how and where to identify and deal with distress:

1. **Personal History.** Those who were psychiatrically or psychologically vulnerable or who were afflicted with a mental handicap before the war are over-represented in those who break down afterwards.
2. **Ability to Function.** There is a particular image of a human being that we would all like to bear in mind: that of an active person, able to solve social or personal problems, able to make meaning out of events, Man at his most capable and well-adapted. People may be very distressed but in most cases still function adaptively.
3. **Focus.** The theoretical location or focus of the project. It appears evident that a project should work less in psychiatric areas than in social space, addressing the setting in which other forms of reconstruction and healing might take place. In the social aspect of the project, reconstruction must also take place in forms adaptable to the unpredictable, to dynamic and fluid meanings and realities. This constant motion and change will beg questions and understandings forcing us to keep the project light on its feet. A workable programme should be able to shift in mid-course, to give priority to a certain change in one or more areas, to recognize and overcome patterns imposed solely by institutional rigidities or funding restrictions. The project cannot be fixed if post-war zones are fluid, and it should be able to follow any changes if it is to prove effective.

The students should also consider memory. This word has recently become a key point of reference in war-related topics, and the counsellors should think about the dialectics between personal and collective memory and between remembering and forgetting. It is often felt that people have a need to remember, but it is not necessarily a natural state for all people to be preoccupied with history, at all times. Whilst people will never forget, it may well be that they cannot always be encouraged to remember things in their every detail if they are to rebuild. Most people make these pragmatic choices all the time in their own micro worlds and within their communities. The counsellors should also bear in mind that, insofar as the war affected person surveys the social scene around him or her, the counsellor himself will be a part of this picture. What the person brings to the counsellor will depend on their impression of the project, of its purpose or abilities, and of the counsellor. This includes the services a counsellor is able to provide, his or her personality, and the best way to attract the counsellor's attention or be compelling to him or her. In

the outlook of those we help, we, as counsellors, are objects, and their perception of our purpose, like their relationship to words like “counsellor”, will shape the discourse.

Finally, the counsellors should also examine their own perceptions: the prior assumptions they are bringing with them to work, their held views about the effects of war on people. It is believed for instance that in many cases, war might cause serious illnesses or, later, mental disorders, which may be transmitted across generations. There is no empirical evidence of this, yet in a way such claims can become a sociocultural value or aesthetic masquerading as a medical fact.

On the other hand, we would not either ignore these issues of value or diminish the enormity of a war. This is the tenth point: within each situation, and here, in Kosovo, should be considered how the people view childhood. What is the cultural and social class-based conception of person-hood? What would be a normal life and what would be abnormal? How much adversity can one person overcome? What is childhood? Do we agree that those children who have witnessed terrible things, who have seen what happened to their parents right before their eyes, will carry into adulthood some kind of mark or stain, and how will this affect the counsellor’s approach to a child who is the sole survivor of a massacre? For in this question of childhood lies our convictions, our idea of memory and the attitude we must have. These are the points we should agree upon, and the questions that, as counsellors, we will need to contemplate individually.

Rethinking the trauma of war

Patrick Bracken*

Current conceptions of trauma

The current conceptions of trauma find their clearest representation in a book edited by Carl Figley, an American psychologist who has written extensively on the subject. The main idea of the book, and of today's thought, is that the most important factor in the experience of trauma is what occurs within the individual's mind, the post-traumatic cognitive processing. In other words, when someone endures a strongly disturbing event, its outcome will depend on the experience itself, the characteristics of the individual and on a few particularities of the person's environment. What must be emphasized, however, is that in this model, the social and cultural context is understood to be something that impinges upon the mind of the person from the outside. As such, it can either accelerate or slow the processing of the event, but remains exterior to the trauma of the individual. This model is important, in its kind, and will be reconsidered within the context of a post-war situation.

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A model of reconstruction: the case of Uganda

Uganda, in East Africa, is a country that became known with the dictatorship of Idi Amin, who ruled through the 1970s and was responsible for the death and torture of a great number of his countrymen. It is seldom realized, however, that the regime of Milton Abote, which followed that of Idi Amin, was much worse: Abote was probably responsible for the deaths and disappearances of over 500,000 people during the time he was in power.

Amnesty International had been criticizing Uganda's Human Rights record through the 1970s and 1980s. When Abote's regime fell in 1985, Amnesty International funded a project to provide mental health support for those who had been tortured, or who had otherwise suffered under Abote. At the time, an organization called The Medical Foundation for Care and Victims of Torture was beginning to operate in London, where it had created a centre offering specialist psychotherapy and medical work for victims of human rights abuses and their relatives. It was decided that a sister organization would be established in Uganda, and Amnesty International recruited a team, including a gynaecologist, a local social worker and myself, to practise, on site, in the specialist centre.

Our main work site was the Luwero Triangle, an area northwest of Kampala, where most of the atrocities of the Abote regime had taken place. In 1987, most of the Luwero Triangle was destroyed, houses were completely devastated, and it was a frequent occurrence to come across piles of skulls and bones, gathered together on tables. These were the remains of people who had been killed, but not buried, while most of the corpses had been left behind in the fields when the people fled the area. The site bore resemblance to the situation in Cambodia, so much that the Luwero Triangle had become known as the "Killing Fields of Uganda". The people had only begun to gather these skulls and bones into black plastic bags behind the little medical dispensary where we worked. The Medical Assistant would show us the skulls, pointing out machete wounds and other abuses which bore witness to the way people had died.

Uganda was just entering its post-war period in 1987. People who had fled the area were beginning to return to the Luwero Triangle and to try to rebuild their lives. Though our purpose was to set up a centre offering treatment to those who had been tortured, problems soon became obvious. Early into our three years in Uganda, it became apparent that a specialist centre was inappropriate to the field.

Flaws of the specialist centres

The first shortcoming of the centre was the scale of the problem. It was not possible to ascertain before arriving in Uganda how many people would be traumatized, how frequently torture had occurred. People used the term “torture” very frequently and very widely to express what had happened to them or to their families, and the notion of establishing a specialist centre for the whole population seemed absurd.

A second problem was the inaccessibility of a Kampala-based centre. Kampala was the capital city, but given the scanty infrastructure of the country, with the poor state of roads and transport, a bus trip from the Luwero Triangle to Kampala could take an entire day. Such a centre would have to offer something very special if the people were to make the journey, and even a centre in the capital would only be within the reach of a few people.

Third was the lack of primary health care facilities: Uganda’s hospitals at the time were in very poor condition and lacked even basic medicine. The war had left the medical infrastructure completely devastated: the local health centres had been looted and destroyed, the medical assistants had fled and resources of primary care were meagre. Here again, the notion of setting up a centre to offer some sort of special treatment for a select group of people seemed out of place, and the centre system itself was not adapted to function in the shortages of a post-war situation.

Fourth, and perhaps most important, was the risk that the centre’s activities might undermine the work of the local practitioners. Any community, any society has its own means of dealing with suffering; there are local ways of helping or supporting one another, and this was certainly the case in Uganda. Also important was the question of timing. In Uganda, the intervention forces arrived right after the war, like foreign gods, into a community that had suffered terribly. Our knowledge, with our foreign expertise and our specialist centre, might send the message that we felt their local methods, traditional habits and ways of supporting one another to be somehow less scientific, less elaborate or less important than our own.

Opening the “centres” to the field

To overcome these problems, the three years of our mission were spent working in various situations, wherever people wanted a psychiatrist, a gynaecologist or a social worker to give them support. Between 1987 and 1990, about 700 people were given assistance, in alternative settings to the centre. First, people were seen in churches, because it was often through religious organizations that they searched

for help and support. Second, we worked in the Kampala, Malago and Zambia Hospitals. We also opened an office in Kampala and explained, on Uganda Radio and in the newspaper, what we were trying to do, and people would come to us there from time to time. In addition to this, throughout those three years, I worked in the clinic of a village called Massalita, in the middle of the Luwero Triangle. About twice a week, I sat with the Medical Assistant there, and worked with him. Where I had knowledge, I would contribute my opinion, but I was really learning from him, in his environment.

We created a clinic for women who had been raped during the war. It soon became apparent to us that very many women had been tortured in this way, and they were afflicted with practical problems like infections, infertility or wounds. We recognized their need for basic medical attention and, at times, for general support, both of which we worked to provide in a number of villages. We also made house calls to victims of torture, referred to them by the Human Rights Commission.

The Commission had been established by the new regime in Kampala, around 1986-1987, and collected accounts, from around the country, of those who had suffered at the hands of Amin and Abote. They gave us a list of people who had been badly tortured, those who had had their limbs cut off or who had been castrated, and assigned us to them.

Instead of practising in a fixed centre, the group moved to see the people, often by this system of referral, and became very much involved with different kinds of medical work there. The suffering that people had survived was visible, and we were told stories of more pain: loss of relatives, witnessing death, experiences of torture, rape, starvation, lack of water, forced work and destruction of their homes. Some of the victims had lived in the bush for long periods of time after being forced to flee their homes, thus being exposed to the elements, disease and imprisonment.

Systematics of healing: a contextual approach

The pain encountered in Uganda came in a multiplicity of forms, but the observations made during this period of reconstruction raised several points about the healing process, in many respects calling into question conventional models of response and trauma.

To begin with, there was no clear distinction between those who had suffered “trauma”, and other people. It was impossible to distinguish those who were victims or who had Post Traumatic Stress Disorder (PTSD) from the others. Second, it soon

became clear that the idea of trauma counselling was alien to the tortured and to the Ugandans in general. The notion of sharing one's experiences with a counsellor and somehow benefiting from merely talking was unheard of.

Third, from a questionnaire study carried out in one village, where each inhabitant was interviewed over a period of time, it became clear that although PTSD-related symptoms, like nightmares and flashbacks, were often admitted in response to a specific question, there was no correlation between these instances and the victims' ability to function socially.

On the other hand, and as a fourth point, we found that victims of torture and rape often presented us with somatic complaints. Very often, people complained of headaches or backaches, for instance, but would not simply state that they were suffering from anxiety, or any of the other post-traumatic symptoms.

Fifth, we observed that when people did seek help out and wished to see a professional, they asked for practical support: they wanted houses, schools, medical centres, seeds, bicycles and concrete assistance. They would say that the best way they could be helped was with a little money, so that they could buy a bicycle and begin earning a living again. A psychiatrist could rapidly feel like a fraud in these situations, having nothing to offer them but words.

Another thing we learned of was the dual role of traditional healers, especially in post-genocidal situations. Time spent in the Luwero Triangle brought to light their importance: learning from the healers themselves (especially one woman), it became clear that in the absence of western medicine, they had held an important role as caregivers. While these healers provided physical remedies, like herbs, they also had another role in performing rituals. For the Baganda people, these rituals involved invoking the old spirits of the tribe, the spirit of thunder, the spirit of the lake and others, through healing ceremonies. It appeared as if these healers were actually providing support for those who had suffered by making a connection with the past, and re-establishing a sense of identity that had been lost in a terrible experience.

The effects of war on mental health, cohesion and the society

In the nineteenth century, the founder of Sociology, Emile Durkheim, in his very famous book on suicide, observed that suicide rates tended to decrease in European societies during times of conflict. What is increasingly clear, as is echoed in other war-related psychiatric literature, whether books, journals or studies, is that levels of mental illness also decrease during a war. This is certainly the case if one

compares the suicide rates in Britain throughout the twentieth century: one finds a gradual rise, with two big dips, corresponding to the first and second world wars. The same has occurred in other countries. The psychiatric literature surrounding the war in Northern Ireland, for instance, would indicate that there has been no increase of mental illness during this time.

Many attempts have been made at explaining this phenomenon. Durkheim, for instance, offered as a solution the notion of social cohesion. In times of conflict, people tend to support one another, to come closer together and this increase in social cohesion would protect the individual from suffering from mental illness. There are, of course, studies and experiments to show that torture and violence, especially civil violence, often have a devastating effect on a people's mental health. It is known for example, as in South America, that torture is often used systematically by a regime to undermine social cohesion. In these cases, people and community leaders are not killed, because by killing a leader one creates a martyr. Instead, people are taken away, tortured, broken and sent back into the community as symbols of the community's vulnerability rather than as symbols of strength. In other words, war has different effects on a society, depending on the social, political and cultural contexts, which can lead either to terror and social fragmentation or, on the other hand, to cohesion and increased solidarity. The important factor here would be the social, political and cultural context.

Conclusion: an alternative model to the effects of war

One might then suggest that the sort of model in which context is seen as something exterior to what happens to individuals is inadequate and ill-adapted to the reality of war situations. To a people, in these cases, context lies at the heart of their reality. The social, political and cultural context shapes a people's personal priorities and expectations, it shapes the meaning and the impact of violence, the effects of this violence on the individual, and will determine the kind of therapeutic help and support that is available, that would be effective. Perhaps we might attempt a shift, in our understanding of the effects of war, away from a focus on individual minds, to emphasize instead the context in which events are occurring. Given this new model, we can then see what is most important: the processing that occurs in the mind of the individual. It is one thing to be an expert psychologist in New York, London or Washington University, to write books and experiment with the material at hand.

In a situation like that of Uganda, on the other hand, who can claim to be the experts in social, political and cultural practice, but the Ugandans? In the post-war situation of Kosovo, who would be truly professional, but the Kosovars?

What this change of model or shift of focus requires is a sense that our priority and necessary first step lies in working with the local people. We need to listen to their accounts of reality, both before the war and after it. We can only understand through them how things have changed, how this change affects the present and how we might, from their teachings, intervene.

What are the psychosocial domain and the role of the mental health professional in conflict and post-conflict situations?

Lynne Jones*

Introduction:
the creation of a psychosocial project

After the removal of Kosovo's autonomy in 1989, the following ten years were extremely difficult for the whole population. Large numbers of Kosovar Albanians were dismissed from their jobs, in particular within the Health Services and the University Medical School. They set up parallel structures in the form of private and charitable health facilities, and created a separate university medical school run out of private houses, with only limited access to clinical cases. The state sector also suffered from a lack of resources. Some were able to keep their jobs within the state sector, particularly in psychiatry, but no young Kosovar Albanian doctor chose to specialize in psychiatry between 1990 and 1999. There was only one psychiatrist with a particular interest in children working in the province. When the conflict escalated to full-scale war in the summer of 1998,

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psychiatric needs increased, as many atrocities were committed against the Kosovar Albanian population. The state health service in rural areas ceased to function, as it was no longer secure for Kosovar Albanian psychiatrists to travel out of the cities or for Kosovar Albanians from the rural conflict areas to reach the cities. Most of those with access to psychiatric services no longer had health insurance as they were unemployed and lacked the means to pay for it.

The Child Advocacy International (CAI) project in Kosovo began with a primary health care programme. Two mobile teams were recruited, combining local and international experience. During the assessment part of the project, it became clear that, because of the situation, mental health needs were a priority, especially in the rural areas. It thus seemed logical to add a rural mobile mental health clinic component to the programme in response to these particular circumstances.

In addition to this, I was asked to provide training for primary health care physicians within various Non Governmental Organizations (NGOs). One difficult issue at the time concerned the ambiguous boundaries between social, psychological and psychiatric work. Professionals wanting to offer assistance were uncertain which of them should take on a particular case, how they should proceed, or even if there was a case to be handled. It was thus necessary to conceptualize how social, psycho-social and psychiatric programmes could work together effectively in a conflict or post-conflict situation.

Mental health in conflict situations

Mental health needs in conflict situations can be both defined and addressed in a wide variety of ways. The term “mental health”, rather than trauma, is chosen here in order to shift the focus to survival rather than victimization, and to resilience rather than pathology. This is not to say that there is no pathology.

To state things briefly, one might describe the major effect of political violence as a destruction of people’s social and physical worlds, with a resulting sense of massive loss, both collective and individual. This experience engenders a wide range of feelings, such as fear, anger and grief. These are normal responses to abnormal circumstances. Such feelings are all compounded by the continuing stress of life as a displaced person or refugee without resources.

by a research fellowship at Cambridge University examining adolescent understandings of political violence and the means by which they cope with living in conflict regions. It involved a year of ethnographic fieldwork in Gorazde and Foca, a neighbouring town in the Serbian entity. In mid-1998, with the deterioration of the situation in Kosovo, she was asked to set up a rural, primary health care programme with a mental health component there. The points and suggestions outlined are therefore derived from extensive experience and practical knowledge of the region.

A small but significant percentage of people are so severely affected that they require specialized medical attention and additional support. However, the majority of the people, although they might benefit from what is loosely termed psychosocial support, have neither medical nor psychiatric problems. The distinction is important because it is the medicalization of many psychosocial programmes that can cause problems when making an intervention.

Some problems delivering psychosocial care in conflict regions

These are some of the problems that I have observed in the delivery of psychosocial care in conflict regions, during the last four years, in Bosnia and Kosovo:

1. Local professionals are often overly preoccupied with a medical model of stress. This model assumes that a large percentage of the population is “traumatized”, or made psychologically unwell by war, and that they therefore require “psychological treatment”.

This assumption is not supported by research evidence on children or adults. The effect of this misconception is that psychosocial aid is usually entrusted to psychologists who concentrate on screening for psychological distress and on the provision of various kinds of counselling programmes. These are often at the expense of community and social development interventions that may do more to rebuild social ties.

2. The screening questionnaires used as a starting point for psychosocial programmes have rarely been validated and are often culturally inappropriate.
3. The western model of psychological assistance, with its focus on the individual and on the ventilation of feelings through talking therapy, is culturally alien in many parts of the Balkans, and particularly in rural Muslim societies. For example one of my Bosnian patients, a deeply religious man informed me that crying would impede his dead son’s passage to paradise, and that what he wanted was help in maintaining his stoical approach. In contrast members of the orthodox religion may view vivid expressions of grief as natural and appropriate.
4. Counselling programmes can increase the individuals’ sense of victimhood by singling them out for “care”. Specialized projects may further alienate people from their communities at a time when the emphasis should be on the rebuilding of social ties between people and fragmented groups.

5. Programmes that target special groups identified in terms of age or gender can also, if not properly thought out, create a hierarchy of suffering and cause friction within communities. In Kosovo especially, the extended family provides a natural group that has been one of the main protective factors in recent time. The professional should seek ways to support and rebuild these natural networks, rather than create artificial ones.
6. The medicalization of these programmes can result in decontextualisation. The structure of the intervention is often created outside of the country in which it will take place, and imposed without any reference to the political and social context. This means that difficult questions like “Who did this?”, “Why did it happen?”, “Will there be reparation?”, all issues that have a profound impact on people’s mental health in a post-war situation, are deliberately avoided.
7. Paradoxically, psychological programmes also fail to address the real needs of the seriously mentally ill. This is partly because the screening instruments fail to identify them, but largely because counselling-type interventions are entirely inappropriate to their needs.

A psychosocial approach

In order to understand the parameters of a successful psychosocial intervention, it is worth bearing in mind the *Oxford English Dictionary’s* definition of “psychosocial”. “Pertaining to the influence of social factors on an individual’s mind and behaviour, and to the interrelation of behavioural and social factors; also more widely pertaining to the interrelation of mind and society in human development.”

Such a definition suggests that genuinely psychosocial programmes would address people’s psychological and social needs in an integrated manner, and focus on needs identified by the community themselves. They would facilitate the recreation of social networks. Social and material support, such as finding missing persons, forensic work and exhumations, legal assistance, rebuilding schools and regenerating employment, may all do much more for a people’s general mental health than purely psychological assistance, especially if these concrete interventions are constructed in a way that addresses psychological needs.

Such programmes should be built according to a community development model. This takes time, both in the initial stage, the assessment of a community’s multiple needs, and in the stage of implementation. For this reason, a community’s needs will best be addressed by an agency able to take a long-term, integrated approach to the situation.

Real psychiatric needs

Real psychiatric needs do exist in a small but greatly neglected proportion of the population. This group includes the chronically mentally ill and those with prior mental disabilities, all of whom suffer enormously in wartime, as the services that sustain them break down completely and the family resources and social networks that make life possible disappear. Those with acute illnesses induced by war also have enormous difficulty accessing the help they need. This is partly because of the stigma attached to identifying oneself as having any mental problems, partly because psychological medicine is a neglected specialty, so that few doctors have the training or confidence to deal with psychiatric illness, and partly because many of these patients can suffer quietly, without causing too much disturbance, over long periods of time.

It is important to make a clear distinction between psychosocial programmes and psychiatric programmes. Psychosocial programmes that are both non-medical in their focus and community based are likely to increase the survivor's own coping resources, by addressing the needs of the whole community rather than pathologizing a particular group. Agencies working in this area might use psychiatric programmes as a supportive source of education and training, in turn referring to them the most severely afflicted patients.

A psychosocial programme for IOM in Kosovo: trauma counselling or the community approach?

Clearly, in my view, the experiences of grief and loss, as well as the normal and abnormal reactions that may follow, are the main realms of post-conflict psychiatry and of psychosocial work. This is not to say that Post Traumatic Stress Disorder (PTSD) does not exist, but it can be overemphasized. In a case series of 95 patients from Gorazde's Psychiatric Service (January-June 1998) there were five cases of PTSD (using the ICD10 criteria for trauma¹), all affecting soldiers. The most common diagnoses, however, were not PTSD, but depression, anxiety and various forms of somatic problems. Further, many of the cases seen, both in Kosovo and Bosnia, had no psychiatric diagnosis, but were clearly responses to the war. Such

¹ International Classification of Diseases, 10th Edition.

massive loss and violence is life changing and can produce a multiplicity of effects, both social and psychological. It is for this reason that we should guard ourselves from being preoccupied with the single diagnosis of PTSD.

The idea of constructing a psychosocial intervention that is not limited to “trauma counselling” clearly runs counter to many recent projects. In 1994, for instance, there were seven so-named “psychosocial programmes” operating in Sarajevo while it was under siege. Each of these was actually little more than a “drop-in counselling centre” for traumatized individuals. None of the programmes had any other projects, and the realm of the psychosocial had thus been reduced to a psychological service. On one occasion a Bosnian social worker remarked to me that 80 percent of her people’s psychological problems would disappear immediately if my government could be persuaded to lift the siege of the city. In other words, she and her colleagues felt that political rather than psychological work would bring real relief. While I would not reject counselling *per se*, (though recent research showing negative effects of psychological debriefing should make us reconsider the nature of some of our interventions), the reduction of a psychosocial programme to just this single activity would seem an enormous waste of potential.

Given a good, broad Master’s course in psychosocial studies, as is provided by IOM, a wide range of professionals of all fields could be trained. Once sensitive to psychosocial issues, the trained professionals could return to their specific arenas, whether legal, social or pedagogical, so that each, within their professional capacity and within their own community, might deal with issues pertaining to these non-psychological effects of massive conflict with psychological sensitivity. This would be an example of genuine psychosocial work.

The most successful interventions conducted in Bosnia and Kosovo, even with the more seriously affected people, were those which involved providing employment opportunities, accommodation, legal work or assistance for family reconciliation. As Professor Ceric, a social psychiatrist from Sarajevo University stated: “The best mental health intervention [one] can make for most ex-soldiers, however traumatized...is to find them a job.” This became apparent upon returning to Gorazde, only one year after having run a mental health service there, in order to see what had happened to former patients, the soldiers with PTSD and psychosis. All had been given a similar range of psychological and pharmacological therapies, and yet those who had married or were employed were well, while those who had not married and were unemployed were still affected. In other words, for these soldiers, building a relationship and re-establishing their lives had been just as crucial to their recovery as any psychiatric intervention could have been.

Training professionals in the psychosocial approach

In order to create the most effective psychosocial intervention, IOM-trained professionals should be capable of running programmes that cover a range of activities. The programme should first offer a wide variety of social support services, or act as a referral point for such services, and act with psychological sensitivity. In other words, the professionals should remember that those who have experienced massive losses cannot always take the initiative to make use of these services, and will therefore need further assistance.

Next, the professionals should bear in mind that the word “counselling” is problematic for many people in the Balkans. It is loaded with negative connotations. The implication is that those being counselled are mentally ill. This could discourage people wanting informal psychological support from approaching the programme.

The professionals should also ensure that their programmes are visibly located within an existing community such as a school, a family, a workplace, a religious group or a small village, in order to help rebuild social ties. Setting up new structures, new networks and indeed, new professions, could undermine the existing networks and established services at a time when these most need strengthening. Finally, each professional should have the ability to identify and refer more serious mental health cases to the appropriate services, in order to guarantee the support that will make a psychosocial programme successful.

Psychiatric assistance: the example of the CAI programme

The CAI programme, which began on 1 September 1999, had two basic aims: to provide emergency psychiatric care for children, young people and their families, and to help develop a sustainable child psychiatric service run by local staff.

In the wake of the NATO air strikes, the Kosovar Albanians were beginning to return to the homes from which they had been expelled and to come to terms with the destruction and with their personal losses. The scale of the atrocities committed against them is only beginning to come to light, as survivors and witnesses gradually come forward. In addition, the civilian Kosovar Serb population now finds itself in the position of a minority under attack and is fearful for its own security. The state health service was operant, run by Kosovar Albanian doctors in cooperation with the United Nations Mission In Kosovo (UNMIK), except in

northern Kosovo, Mitrovica and health houses located within Serbian enclaves. The university and medical school had begun to establish a psychiatric training programme, with 11 psychiatric residents currently in training.

The war had created particular problems. The first was an increase in the occurrence of psychological disturbance in children. Secondly there was a shortage of trained staff able to deal with serious mental health problems. A large number of NGOs responded with psychosocial programmes aiming to support traumatized children, but though they were training staff to identify the more seriously disturbed, they lacked a service to whom they could refer these cases. Kosovo has only one psychiatrist with experience in child psychiatry, it is estimated that 52.7 percent of the population is less than 20 years of age.

Kosovo's University Psychiatry department was developing a formal psychiatric training programme but was not able to provide its residents with training in child psychiatry. CAI was thus encouraged to assist the University in the development of a child psychiatry service. The project would provide children with serious psychological problems and their families with clinical services, which would then also serve as the basis of a child-psychiatry training programme, adding to the specialized staff.

The programme is run by an expatriate child psychiatrist who recruits and trains local professionals in order to staff the service.

Clinical service

A clinical service is provided on a weekly basis in three rural areas: Kacanik, Klina and Ferizaj municipalities and an urban clinical service is run two days a week in Pristina. In addition CAI is providing referral and support services to other agencies. For example the trainees have established specialized support groups for children who have suffered losses, in collaboration with local NGO's. It is also providing specialized assessment services to United Nations agencies, or the Organization for Security and Cooperation in Europe (OSCE), for children in detention.

Of course the vast majority of people referred to us have suffered traumatic experiences. However previous problems are a significant marker for continuing morbidity, both in adults and children. Family support is a crucial protective component, as is the family's housing situation.

Training

The two psychiatric residents working with CAI receive constant on-the-job training in the assessment and management of child psychiatric cases, and the setting up of services. This training consists of mentoring, reading programmes, case supervision and regular tutorials in all aspects of child psychiatry. Video monitoring allows the residents to view their own and other's consultations.

An academic programme in child development and child and adolescent psychiatry has been established at the neuropsychiatric unit in Pristina Hospital. Residents in paediatrics and psychiatry, as well as child health care workers and undergraduate medical students attend it. At present, the programme consists of weekly lectures by the expatriate psychiatrist and a weekly journal and seminar club for the psychiatric residents. This helps them develop their own skills in teaching and supervising others.

Lectures and supervision are given on a regular basis to other NGOs as requested. For example the International Medical Corps' counsellor working with their youth programme receives supervision from the CAI expatriate psychiatrist.

Because of the significance of the extended family in Kosovar life, family work is one of the most effective therapeutic interventions, particularly for child psychiatrists. In collaboration with the American Family Therapy Academy we have established a specialized family therapy training programme alongside the other clinical teaching.

The Department of Neuropsychiatry now plans to establish a Child and Family Mental Health Service within the state sector. It would like CAI to consolidate and develop the clinical and training work done during the first year, for one further year. We plan to recruit additional non-medical staff to develop a local multidisciplinary team. Since the professional context is still western, our service appears to mesh well with the existing long-established services, but we are sensitive to cultural issues and aware that professional psychiatric services in every country have to cross-cultural divides within their own countries and learn from them.

Final observations

One serious problem so far unaddressed by all psychological services including our own, is that of learning disability. It is not attractive, it is not sexy, it is not intriguing, but it affects not just the individuals, but the family and community around them, and it is probably the largest unaddressed mental health need in Kosovo today. Moreover the learning disability problem echoes all the issues that have been discussed surrounding trauma, how it is handled and what it means to people. It serves as a reminder that the mental health needs of a people after a conflict cannot be hinged on the single psychiatric diagnosis, but are wide and complex: interweaving psychological, social, educational and human rights issues. It reminds us that the damage of a post-conflict situation cannot, therefore, be healed by the magic of counselling alone, but is repairable only by interventions that approach all aspects of the problem, in an integrated manner. This is psychosocial work.

Disconcerting
humanitarian interventions,
and the resources of
collective healing

Jean-Marie Lemaire*

Introduction

There are a few hypotheses that should be considered when a programme is prepared and methods elaborated. Before we yield to the temptation of intervening hastily, of bringing aid in whatever shape or form, there are certain questions and guidelines which need be raised, in order to avoid yet another disconcerting intervention in Kosovo. The term “disconcerting”, as it is used in this context, should be clarified because the nuances of one language often fail to translate into another: in French, as in English, to be “disconcerted” is to be disappointed, but the word has greater strength in French. It applies to a certain emotion felt in countries where violence has reached a certain magnitude, and expresses dismemberment, disconnection or shock, before a reality that is humanly difficult to accept. This has been my experience in 1993, on the Dalmatian Coast, during my first foreign mission. This was also a part of my experience in 1995, when I arrived in Sarajevo and encountered the families which had survived the furthest extremes of human violence.

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In Bosnia, however, the experience was different. Instead of feeling simply shocked or dismayed, I found myself twice affected by this feeling of disconnection. The first time, quite understandably, occurred in front of the Bosnian refugee camp. The second incidence of this profound dismay took hold of me curiously, while observing the well-meaning clinical therapists at their practice. Many of these made rounds to identify possible pathological cases, fitting victims into rigid categories according to set criteria. These victims were being labelled as “depressive”, “introverted”, “traumatized” or any other set suite, as picked out from the catalogues of mental health illnesses. In a second disconcerting scene, professionals were defining every encountered emotion in terms of pathology. Even the natural bonds of attachment between a mother and her children were objects of psychological analysis to be described in terms of psychiatric discourse. It was as if the net of psychic observation had spread from the individual to include even the maternal, emotional or familial bonds, for even they were targets for this type of observation. Professionals seeking to assist these families spoke of “fusion”, of “healing” or “medicine children”, of “pathological relationships” and “emotional dependencies”. More disconcerting still were the professionals who attempted to impose their foreign practice upon refugees. People were thus “invited” to venture individually into airless rooms for counselling, despite their obvious reluctance to do so.

Intuitively, then, as I moved from disappointment to disappointment in my first exposures to project methods, I took it upon myself to avoid creating new ordeals for the refugees and new instances of embarrassment for my profession. Recalling the first vow of the therapist: “Above all, not to harm”.

An alternative approach: rebuilding social ties

Not to harm, and whenever possible, to help heal are, of course, the first aims of the intervention. This approach becomes all important to prevent worsening, through disconcerting measures, the situation on the field.

At the time, it had become obvious to us that rape was an unconventional weapon of war (Lemaire, 1996). At this point, we can already pause to wonder what rape really attacks, what rape can destroy that is, to other weapons, unreachable. One would not underestimate the enormity of rape as a crime against the individual (and in this case, a crime of war), but according to Despret and Chauvenet, the crime

becomes much worse in its greater context. Rape, therefore does not only potentially “break” the woman, but has a final and divisive effect on the connections that support her. Rape breaks the links between individuals: the bond between husband and wife, mother and child, a woman and her community. In other words, rape combines personal destruction and mutilation, be they non-fatal, with a seemingly irreversible destruction of inter-personal connections.

Perhaps then, the first step for one seeking to help should be to search for what we called the swingback. If this traumatic attack upon the bonds uniting the individual to others is the real weapon that operates insidiously beyond and after the physical brutality (in this case, rape), we cannot neglect the importance of the bonds as therapeutic grounds in our efforts towards reconstruction.

If this idea were taken a step further from rape, one might say that this destruction of bonds, not only those between a woman and her community, but also those connecting the individual at the cultural, ethical, national, political and familial level to the supportive whole, is the aim and result of all forms of conscious violence. In order to reverse this destruction, these very bonds might be made the medium of therapy, and their reparation its goal, not merely in the case of rape, but for all situations involving violence. For this reason and despite this feeling of shock and dismay, I began to seek this medium of therapy, these bonds, in what we now refer to as residual resources.

The choice of term here is important, because the idea of a “residual resource” serves as a reminder that neither suffering nor pathology can be neglected. Further, it echoes how, by their lasting and unique nature, these final resources will stand out against the terrible backdrop of destruction and despair. In cases of near-desperation, these residual resources will be the only remaining solution, and any attempt at a beneficial intervention must then follow a method capable of drawing upon them.

Working within a network: a living example

An illustration of this method occurred in Durrës, Albania. In a shelter village, a camp set up by Handicap International and intended to host about 60 families, we had created an assistance programme. Around the village was a barbed wire, not intended to keep the refugees from leaving, but to protect them from unwanted trespassers. At the entrance of the village were the comfort stations, offices, an infirmary, a sorting centre where rations were handed out, a kitchen, a dining hall and a

school. After these common buildings, the camp was divided into rows of one-room shelters for the families to live in, on either side of a main footpath, which cut the camp through its centre.

One day, I was walking down the central pathway of the village with a group of professionals (including two Belgian psychologists and three or four local doctors). The group was visible and predictable, an important detail in what followed. As we walked, a man came to us and invited us to have tea with his family. He told us that he was originally from Gjakova, where he had worked as a policeman. He then introduced us to his wife and three children, in his own assigned cottage. We, in turn, explained our presence to him: why we were there, and what we hoped to accomplish. As we spoke about various subjects, he suddenly interrupted us. "It was good of you to come visit us here", he said, "but our cottage is on the side of the main path". He told us of a family that lived in the outer edge of the camp. They were also from Gjakova and according to this first man, needed help more than his own family. He then offered to take us to this second family and to introduce us to this second man from Gjakova.

The different levels of our encounters are relevant to our approach. On the first level, a man came towards us, a group of professionals strolling visibly down the main alleyway. On the second level, we might imagine this family man's referral of the second family, as well as his actions, as he accompanied us to the family he believed to be in greater need. Indeed, as we walked with the first family man, we were told that the father of the second family had returned to his home in the region of Gjakova, to find his two daughters abused, slaughtered and left in his own well. The elder son of the second family was staying with his father's brother in Germany. It was the first family, however, which allowed us to approach the second, connecting us to them, as with their experiences.

As we spent time with the second family, I was eventually given the chance to ask the mother if and how her second son, then living with her, offered support to her. Her answer, immediate and precise, was: "When I can no longer cope, I will sit in the corner of the hut. When my son sees me, he will run to me, and leap into my arms to cry with me". This woman's account of her son's behaviour is a clear example of a residual resource. The surviving ability of individuals of the same family to take care of one another, sometimes at the cost of a peculiar reversal of traditional roles (as in this case), wherein we might find the younger generation supporting the older one. This dynamic has been observed in many cases, including recently amongst Bosnian refugees on the Dalmatian Coast.

In an article that has not yet been published, Despret gives an accurate description of residual resources, as well as what can be accomplished with them:

Although the damage brought to the connections clearly defines the areas where we might intervene in view of reparation, any beneficial assistance cannot merely be a case of patching up or replacing, when possible, that which has been destroyed. Once these bonds were the target of destruction, they cannot merely be the sole focus of the intervention. These connections, or bonds, are in fact a fulcrum, or a leverage point. In other words, by being the targets of deliberate destruction, requiring that they be repaired, it does not therefore follow that the bonds or connections, broken or subsisting, are only the targets of the healing process. They are also the therapeutic medium, or space, the very levers of the healing process. They are not only that which needs to be repaired, but that by which what might be repaired, will be repaired. The connections or bonds constitute the means by which healing might take place, the material out of which a new strength will create itself, as well as the actualization of the healing process. They are the ends of healing, their means, and their expedient, at the same time and inseparably method, actualization and finalization of therapeutic intervention.

Based on these first principles, an alternative method was attempted in Gjakova, where a programme was created with Médecins Sans Frontières Spain. The programme was structured into two different tracks, the first intensive and the second extensive. A group of professionals was created, consisting of 20 to 25 men, half of whom were doctors, (gynaecologists, anaesthesiologists, paediatricians and general practitioners). The others were teachers, social workers, including some who had been active in the Kosovo Liberation Army (KLA), and professionals of diverse backgrounds. Together, they began searching for the articulations between destructive endeavours and residual resources. The members of this group were further experienced because they had all been directly, or had been close to someone who had been directly, involved in conflicts as targets of aggression. It was thus, by researching the articulations between tragedy and residual resources, that this group was trained as an intervention force, and by meeting once a week to discuss situations encountered in their daily practice, that they continued to add observations to their experience.

The intensive track, the most important segment of the training programme, should be completed during the first week in Pristina. It should focus first on defining what a connection or bond means, from a theoretical and clinical point of view. One definition was elaborated in the 1970s by the Hungarian author Ivan Boszormenyi-Nagy. Boszormenyi-Nagy founded the movement of family therapy against the grain of earlier methods. Unlike the first or second-generation theorists, he was largely inspired by existential philosophy and by the writings of Martin Buber, upon

which he based part of his works. Boszormenyi-Nagy proposed a contextual approach to the concept of a bond. In this definition, he set up a fundamental dimension, a starting point of relative sentiment and ethics. In other words, he described how, from the inside of a relationship, the support brought by one partner might be understood by the other, and how the other, appreciating this support, shows his acknowledgement by setting out to reward the first. The bond between both partners is thus a connection allowing for their mutual growth, for increasing trust and for increasing support to one another.

On the other hand, this is neither always, nor in every case, a positive interaction, and the contribution of either partner is not always beneficial. In each situation, a conflict of interests is often inevitable in a context where the behaviour of one individual is relative to that of the other. (The son sees his mother crying, and therefore seeks to comfort her). This concept has already been applied to methods of family therapy, and it should likewise be attempted in Kosovo, to consider the contribution of different family members to the healing process. How people show concern for one another, how members of one family become concerned for one another, how, in the last example, a mother is able to recognize the great relief this child brings her as he joins her in her mourning, and how this child, at his young age, is able to comfort her by his actions.

A conflict of interests also exists in the last example, when the son, once in a school environment, behaved in such a way that he was described as “hyperkinetic”, overly agitated. The behaviour of this child was a conflict of interests insofar as the “naughtiness” or energy was merely a compensation for the burden beyond his years which awaited him at home.

From conflict of interest to extended trust, a difference of approach

The agitated behaviour of this 11 years old child is more relevant in that it stretches beyond his school environment; his actions in school are understandable given their link to his bond with his mother. The sequence created here is similar to that which would lead a team of professionals from the first family to the second. From the evaluation of the second family, a connection can be made to what occurs in another context (in this case, the child’s scholastic environment), enabled by, or creating a link between professionals. This chain of connections would thus begin with the first family, stretch onto the second family, then onto the teachers in the school, and create a network of observations: an extensive approach. From the point where the professional makes a first effort to be visible, predictable and available,

or has allowed himself or herself to yield his or her expertise to the diagnosis of a layperson (like the father of the first family) this sequence begins. The intervening professionals are brought into the private lives of the people they are attempting to help (like the most affected family), within a context of deserved trust.

One should not see in this method a more deceptive means of diagnosis, but an entirely different approach. When the first family leads us to the second, the importance is not to point or to locate those more in need. The head of the first family becomes an overseer, supervising our contact with the second family. Family "A" indicates where, when and how to meet with family "B", meaning that the approach is much more than one of screening or diagnosis, but a process of learning. As psychiatrists, social workers or other professionals, we are led through an apprenticeship of how to work in such severe situations. These uncommon methods are known as a "concerted approach" or a "clinic of concerted approaches". "Concerted", here, is used in its original form, as derived from *certare*: "to work together or fight". Indeed, the confrontation rather than consultation of professionals is important, because it will allow for the conflict of interest, the unravelled thread to be uncovered. As Michard said, such conflicts are the "spices of life". Within visible distance of a residual resource, there is often a conflict, an opposition: or how an 11 years old child was at the same time worried about his mother and attempting to behave within a scholastic environment. The double burden upon this child must result in a conflict of interests, and this conflict, to us, hides a residual resource upon which to hang our assistance of the boy, then his family, then the community. This conflict of interests is the leaf, the unravelling thread, and the pathway, so that from one person, we might evolve naturally to work with the entire community, collectively.

Acquiring expertise on the field of intervention

Maurice Eisenbruch*

Learning the intervention:
the case of Cambodia

Cambodia, like Kosovo, has endured a recent history of turmoil. Like Kosovo, these years were not isolated, but exist within the broader setting of more than 500 years of war. The issues or points that we are now considering, genocide and auto-genocide, their context of war and migration both external and internal, are similar to those of my experience in Cambodia. Likewise, they are to be considered not only as a fragment of time but diachronically, over a long period of time.

Beyond these violent situations, both in Cambodia and in Kosovo, lie the existing local systems of belief about suffering, wellness and illness. In either culture, there is a hierarchy of resort in case of need; the people within the community networks to whom others used to turn, still turn or might turn in these difficult times. Any intervention, if it were to be successful, must therefore begin with a knowledge of this existing network, as well as of methods by which we might discover more.

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Moreover, once these local resources have been identified, the knowledge acquired from them must be applied to improve methods of training and research, as well as curriculum, policy, fundraising and collaboration with other groups.

The early intervention, and the concept of cultural bereavement

In 1980, when interventions were first attempted in Cambodia, the South-East Asian refugees had been through a period which is roughly similar to the more recent experience of the Kosovars. There had been large-scale genocide followed by war, and there had been a time since the war had ended. The people still faced civil conflict, unrest, poverty and sickness. There were no local resources: the health system had been decimated and the war had affected other social structures necessary to the normal lives of the Cambodians.

The challenge of working in resettlement countries, which is ours today as it was the challenge of the United States, Canada or Australia then, was to find ways to prepare the mental health system so as to receive these people and to deal with the kind of difficulties they might bring. It thus became apparent that in 1980, the science of psychiatry was not prepared for the problems that were to arise. At that time, Post Traumatic Stress Disorder (PTSD) had not yet been invented. We, as psychiatrists, were still working with the previous taxonomies which had come to us from Switzerland. The whole question of trauma, loss, and so forth were linked to *Heimweh* and *Nostalgie*. These were the disorders first identified in Swiss mercenary soldiers who, dispatched far from home, returned in misery, and this was perhaps the forerunner of the concept “PTSD”.

But there are alternative ways of seeing what we call PTSD. It was apparent that these displaced were searching for an identity. For this reason, most psychiatrists began by looking at acculturation, at how different the refugees were from the people of the host country in language, custom, and so on. There were acculturation scales, and many people would be “rated” as to their distance from the new culture. Beneath this was the notion of alienation: to what extent the resettled felt powerlessness, normlessness, meaninglessness, isolation and self-estrangement.

In retrospect, however, it seems that more important than acculturation was the root of this cultural alienation, the sense of bereavement which was not only individual, but also collective. In this context, 20 years ago, the notion of cultural bereavement was coined. It was the experience and reaction not only in the individual, but also

in groups of people, to the loss not only of their homeland, previous status and social structure but also of the cultural “meaning of life”, that erupted into a collective syndrome (Eisenbruch, 1987; Eisenbruch, 1989; Eisenbruch, 1991).

We attempted to understand how this idea of cultural bereavement might be applied to health services and policies (Eisenbruch, 1990). One antidote to the collective suffering was found in ritual. By rediscovering rituals lost after flight from the homeland, people were able to create and revive the attachments that had been lost in time and space. These latter attachments were not only mental or spiritual but also “supernatural”.

This last word is seldom acceptable in professional, “unsupernatural” circles, and yet it should be remembered that - regardless of the well-intended body of western expertise - the traditional healers and Buddhist monks would have been the best gatekeepers and health workers.

The traditional Cambodian healers, however, were absent at the time, because the International Committee for Migration (ICM), which then handled these migrations, was not empowered to select their workers. Host countries did not see the importance of recruiting healers and monks, so these tended to remain in the camps like the other refugees. On the other hand, when such people were found and allowed to interact with the other displaced Cambodians, incredible results followed. Rituals were carried out, reparation ceremonies were performed for those who had been left in the homeland, whose bodies had never been found and never buried or cremated. By carrying out these rituals, the Cambodians were able to focus on the future through a healing of their past.

As they learned to cope with the problems, the Cambodians began to accept their experiences. They spoke of the past in ways that worried trauma counsellors of the time, because according to the early benchmarks of the 1980s, refugees should not be encouraged to open up to their stories. It was believed better for victims to seal off their history, to move on, and the counsellors were then unprepared for this new acceptance, which later proved beneficial.

Moving upstream

There were at times five or six thousand, at times ten or 20 thousand people in one part of Australia, Canada or another refuge, and yet it seemed absurd to be spending so much time and effort working with one group when the bulk of the people were in the country from which they had fled; in the homeland that, as a “communist enclave”, was cut-off from the West. One could not even fly to Cambodia other than through Vietnam. Around 1989, the strategy of the intervention thus

shifted to a move “upstream”, towards the source of conflict. This return to Cambodia was important for its humanitarian aspect, but also for our increased understanding of the problems. A study was begun in this broken homeland, starting with a search for indigenous concepts of mental health.

During this seminar, reference has been made to psychiatry, neuropsychiatry and counselling, as adapted to the culture’s notion of mental health and suffering. Traditional healers were discussed as a medium, through which patients might be helped, and comments have been made about whether these special practitioners still exist within this moving target of culture.

Though it is accepted that culture is dynamic, not static, this return to tradition is by no means simply a yearning for “the world we have lost”. In Cambodia’s communist period, for instance, there were at first no healers to be found on the surface of society, just as in Australia or other “more developed” cities there seemed to be none. The people asked answered mockingly that these were relics of the past. They spoke the voice of the Khmer Rouge, echoed by the drumbeat of the Vietnamese regime that came after that. “Those were primitive beliefs, we do not want to go back to them”, they answered, or, “We are an agrarian socialist collective society and these superstitions have no place here anymore.” In fact, the healers did exist, but underground. They hid because, had their practice been uncovered, they ran the risk of summary execution. Cambodians would go to them in secret. Their practice was comprehensive, combining technology, systems of diagnosis, explanation, therapeutics and treatment to manage a wide range of mental health and psychosocial problems. It became one of the goals of the action research in Cambodia to learn from their methods.

Piece by piece, working with healers in this clinical-ethnographic approach, we began to understand the grammatical rules of the newly rediscovered logical map of the mind. Our approach was a humble one, in that we had to avoid superimposing western psychiatry, but to start afresh, as the experts were the healers and their patients.

We learned from this approach (and echoes appear in some of the reports from anthropologists in the Kosovo project) that there are ways in which one can divide mental suffering into causal categories: natural or supernatural, self-caused or caused by spirits, caused by recent actions or by those committed in previous lives and so on, which might be understood and accepted by a people not trained in western psychiatry. Elaborate maps of this logic can be drawn from these categories, and choices can be made accordingly (Eisenbruch, 1999; Eisenbruch, 1998; Eisenbruch, 2000). Perhaps this approach can be incorporated as a module into the curriculum of the programme in Kosovo.

Applying “supernatural” methods to the concrete

This general, local means of understanding mental health could then be applied to particular problems. For instance, we might see that the main health issues in countries like Cambodia or Laos are no longer issues of mental health. Ministry officials and Non Governmental Organizations (NGOs) will agree that the main problems reside in HIV/AIDS, in malaria or in lack of hygiene. “Psychosocial issues can wait before we solve vital problems, issues of life or death”, they remark. But the life-and-death issues of HIV/AIDS and malaria, however, are riddled with mental health problems. They are there, in questions like “Am I going to die because my husband went to work in the next village and brought me illness?”, “Is my child going to die because my husband got AIDS?”, “Am I going to die because I have to go to the forest to cut timber to feed my children or because I have to go where there are landmines?”, etc. Such are the ubiquitous problems in countries undergoing post-war reconstruction and development, and the mental health questions remain.

It thus becomes necessary to apply the new research approach to these areas, to see if in understanding these problems we could use our new knowledge in other ways. HIV/AIDS, for example, is a problem that is going to face Kosovo. It will arise in East Timor, and, just as it has plagued Cambodia, it will plague Laos. Countries recovering after difficulties will have to face these new problems, and we must ask now how we are to persuade a people that a disease of which they have no understanding could destroy them, as well as how we are to teach them what they can do to stop it.

Training therapists and community development

The experiences outlined here have not been attempted in Kosovo, nor do they draw upon particular “Balkan” expertise. Each professional must decide for themselves whether these few points might be of relevance to this new problem, and to the situations faced in Kosovo.

Returning, full circle, to the subject of Cambodia, it should be added that in the beginning, it was not known whether the healers were helpful or would ever be so. We, as western professionals, only knew what we saw on the field, in our ethnographic work. As we took this information back to Phnom Penh University, we realized that there were no psychologists there. There were paedopsychiatrists, trained in Belgrade, Moscow or other countries, and these were professionals in certain

aspects of psychology that were foreign to ours. They did not see the relevance of our approach, so our methods ended there. We also observed the methods of certain NGOs who came, but we did not work with the Ministry of Health, because it was centrally organized; working from the top of society downwards, and believing in vertical programmes of past eras.

There was another ministry however, the Ministry of Rural Development, which worked from the bottom up and believed in village development. Working in parallel with the outlook of this Ministry, we allowed ourselves to accept a goal of community health and development from which we even, at times, dropped the word “health” altogether, to stay focused in the right direction. It was eventually found that when “psychosocial” approaches, rather than “community” interventions were attempted, they led us away from the core and worked only for fundraising. We found ourselves, instead, leaving the towns to work in the villages ever further from the provincial capitals, where there were few doctors and no known notion of psychiatry. In these places, where the word for the mentally ill patient in Cambodian could raise mockery and fear rather than sympathy and understanding, we began to work within the categories and languages we learned from the village elders, traditional birth attendants and other people who controlled and shaped behaviour: the decision makers of each village. The people knew the value of their healers because they existed within their lifestyle. They did not see the value of new mental health programmes, because they had never encountered them before.

According to this method, we started to train a group of community workers, who would later train other workers in the usual cascade approach of barefoot community projects. In order to create a programme, we began with the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) manuals for refugees, but rewrote them according to the experiences particular to the field. Our new manuals were based on essential “barefoot mental health knowledge”, because it was important that the people at least recognize psychosis, suicide and dangerous behaviour in order to save lives, but this knowledge was then combined with the local information we had gathered. We worked with the healers not as people whom we would train but who would be auxiliary sources of information for the development of our programme. Though they did become part of our group of trainees, they were not taught to be mental health workers, but collaborators (Somasundaram et al., 1997).

The local approach

In conclusion, we must remember that every society has its local beliefs, this should be self-evident. After a period of war, these beliefs are threatened and even more so after the reign of a totalitarian regime which drives them underground. We cannot, of course, resurrect what no longer exists, it cannot be done, but I would think, based on my experience in one country, that it is possible to hunt and find what is important to the people now, in this February of the year 2000.

It may be folklore or dance, it may be songs or melodies, theatre or ritual. We might spend three months working with songs or protective amulets to discover how they affect the way that people deal with landmines or other risks they face. Each people will have its amulets, songs or rituals that allows them to deal with the dangers and risks of their daily lives. By proceeding step by step, learning with the people, we might discover that there are healers in Kosovo. It is no longer enough to arrive with our set questionnaires, our aerial photography and our set hypotheses. We will not help a people by pushing them into fixed theoretical categories, but only through a flexible and understanding “soft” approach that attempts to help them within the world that they had heretofore known.

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A matter of shades: trauma and psychosocial work in Kosovo

Renos Papadopoulos*

It appears that there has not been any radical dissension here: the great majority of those concerned with the intervention in Kosovo seem to agree upon the same ideas and the final options will be reduced to a matter of shades. On the other hand, it is important for each of us to compare these shades, as we come to present our different skills and experiences within our fields, before the problems we are to face in Kosovo.

Discourses and trauma

To begin with, I would like to focus on the issue of trauma. In order to illustrate the idea of trauma, let us imagine a man who was arrested for 27 minutes. For 27 minutes, he did not know what was to happen to him. He was taken from his family and his environment. Because he was subjected to 27 minutes of terrible uncertainty in the relatively normal life that he led, we would have considered that he was traumatized, and would have approached him accordingly.

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Now, if we were to stretch this example and pretend that he was not arrested for 27 minutes, but for 27 days, then we would assume that the trauma would of course be more serious, would it not? He would have spent 27 days away from his family, his work, his normal lifestyle, and we would take it that he was severely traumatized. If we were to have him be arrested for 27 months, we would feel that the severity of his trauma was undeniably high. Yet, the situation would change if we were to consider a different case.

As we know, the period that Nelson Mandela spent in prison was not 27 months but 27 years! Such a long period is inconceivable; we cannot possibly grasp the sense and experience of being behind bars for such a long time. Few people have suffered and survived such a sentence, and yet which of us would dare to offer Nelson Mandela therapeutic intervention for his trauma? Indeed, such an idea is laughable, but it is important for us then to ask why. Why would we not think of 27 years in prison as an obvious and tangible cause for trauma? One could create volumes of discourse upon this one question, but one simple reason for the absurdity of this proposition is that it mixes two discourses.

When Nelson Mandela spent 27 years in prison, he knew very well, along with a group of people around him, that these 27 lost years had some meaning, and that they fitted within a very clear political discourse. His actions that led to and his attitude towards his imprisonment followed a firm political direction, were consistent with lucid thinking, were based on a strong ideology and were part of a wider political strategy. His imprisonment fitted within his own way of perceiving himself in the world and the way others perceived him in the world. In a sense, then, his arrest and the subsequent 27 years in prison were an act of heroic patriotism and not an experience likely to create trauma. Moreover, it would have been insulting if we were to even consider applying the psychopathological label of trauma to this man. Mandela was just following the path he had set himself and in this sense no idea of trauma comes into consideration.

However, as we know, apart from the political discourse, there are many other discourses, such as military, moral, psychological, medical and a host of others. Moreover, not all of them mix well among themselves and it is precisely when such “bad” or “unclear” mixes take place that we are in danger of being inappropriate and committing epistemological and methodological errors (Papadopoulos, 1997; 1998a). For example, when a person pursuing a clear political aim changes focus and begins to attend more to his or her own personal welfare rather than maintaining the furtherance of his political aim, then it is difficult for an observer to locate the person within an appropriate discourse. Tragedies occur when such confusion takes place and different people perceive the individual from their own perspective

urging him or her to follow actions in accordance with their own discourses. For example, a member of a political movement who was imprisoned because of his political beliefs begins to worry about his own health and his is confronted by his family who urges him to renounce his beliefs and resume ordinary family life, his priest who urges him to forgive his enemies, his lawyer who emphasizes the importance of collecting legal evidence, his comrades who urge him to continue his political struggle and his medical doctor who attends to his physical health. Where does a mental health professional fit into this picture? Which discourse does he or she need to privilege? Every comment about the prisoner's person and future cannot be neutral but it will be based on one or many discourses. Attending to the psychosocial needs of individuals and groups in the context of political and military upheavals is not a straightforward matter but it is a most thorny field.

It is difficult to comment on Mandela's predicament precisely because it overlaps human suffering with a clear political discourse. Mandela is celebrated as a hero because he was able for 27 years to adhere unswervingly to his political beliefs, which he placed well above his personal, family and other needs. Things get even more complex when ordinary people, without firm political convictions and determination, fall victims of political violence. This seems to be the situation with a lot of people in Kosovo recently. During the seminar, Kosovar Albanian specialists stated that as a nation, they had been repressed for 500 years. No one offered them trauma counselling during that period; this would have been absurd not only because psychiatrists did not exist 500 years ago, but because the statement itself bears a certain political meaning. When freedom fighters are involved in their struggle, it would be demeaning and disrespectful to approach them as objects of psychopathological investigation and lose sight of the fact that they are involved in something noble that they believe in (Said, 1994). No one offers them trauma counselling when they are involved in their struggle either in active operations or when they are wounded.

Thus, it is of paramount importance first to consider the appropriateness of our very position in relation to human suffering in political contexts (Papadopoulos and Hildebrand, 1997).

Intervention within a context

Additional attention needs to be given to situations, like in Kosovo now, when there is a significant political transition. Regimes promote a certain political discourse and rhetoric which offers a strong base on which people locate themselves either as supporters or as opponents. When there is a radical change of the political structure

in a country, there is a corresponding change in its political rhetoric and its overall predominant narratives (Shotter, 1993; White, 1995; White and Epston, 1991). Under these conditions, the stability of the predominant discourse is shattered and it creates a dangerous vacuum. Often, the transition to another stable rhetoric does not happen in a smooth way and there is a big gap between the departure of the previous rhetoric and the creation of a coherent new one. It is important to appreciate that this gap generates confusion not only in the political realm but also in many other spheres, including the mental health one. The implications of such a vacuum for psychosocial help are not very obvious and hence can produce more damage.

For example, after the collapse of the apartheid regime in South Africa, a new and clear discourse was needed and it was provided by Nelson Mandela and the ANC: the message was for reconciliation and the rhetoric, concrete slogans and images fitted accordingly. The difficult act of reconciliation needed a clear rhetoric for a new beginning (rather than a return to settle old scores) and it was provided by the “new South Africa”, accompanied by the powerful image of a “rainbow nation” - an inclusive emblem of multiculturalism that comes after the deluge of the apartheid with the magic suggestion of the promised pot of gold at the end. Psychosocial help in South Africa now is firmly based within the context of this imagery and rhetoric. Unfortunately, the case of South Africa is not very common. Often, the open vacuum of a replacement discourse allows for all kinds of inappropriate ones to vie for domination, with tragic implications (Papadopoulos, 2000). For example, the end of the communist regimes in Eastern Europe and in Russia, in particular, did not usher in a coherent replacing rhetoric but, instead, created such a vacuum which was filled by crime, pornography, greed, violence and fundamentalist nationalism (Tishkov, 1996).

According to my experience, during such a vacuum of a predominant discourse in society, psychosocial caregivers face particular dangers because one of the competing discourses that is very appealing and rushes in to fill the gap is the psychopathology one. People tend to over-pathologize human suffering and, ignoring political and other dimensions, give it a medicalized hue (Papadopoulos, 1999a). Under this climate, imperceptibly, caregivers tend to follow the inappropriate over-emphasis on pathologizing because it also fits conveniently with their own approach. Under these conditions, mental health professionals are likely to commit further violence by either going along with (and even reinforcing) this tendency or by trying to impose haphazardly their own concoctions of political rhetoric.

It is evident that in Kosovo we do not have, as yet, the clarity which emerged in South Africa and the situation is that of a vacuum, without a clear new political direction and future. Thus, I would be concerned about our role as mental health professionals in Kosovo now. To begin with, it is important that we do not attempt to impose consciously or unconsciously any such direction, regardless of how tempting this may be. Although most of us would be inclined to prefer the discourse of reconciliation among all the ethnic groups in Kosovo, this may not be, as yet, the predominant direction chosen by either the people there or the international community that runs that region. Under these conditions of a dominant-discourse vacuum, we are likely to be placed under strong pressure either to attempt to impose such a discourse or to succumb to the easy option of pathologizing human suffering. This is likely to present us with a hazardous dilemma. One way out would be for us, in a conscious way, to attempt to identify and articulate such a predominant discourse on the basis of our own experience on the ground with our colleague trainees and with the people who come to their services. Ideally, our current programme should be compatible with the predominant discourse of the wider context. Therefore, it would be most advisable for us to endeavour to determine the theme of the current Kosovar discourse, whether it is “a rainbow nation”, “reconstruction” or even “the struggle carried on”. Some of these slogans may sound cheap or empty rhetoric but it is important for us to ascertain whether they are an expression of the real pulse of what is happening there or not. As we know, predominant discourses form the common ground that unites people, enables healing and gives meaning to the therapeutic interventions built upon it.

Crucial in this endeavour would be the self-reflexive attempt to gauge the impact of our own presence and position there. Our project is part of the activities of the international community which is currently running Kosovo and, as such, our role is not merely that of either observers or neutral helpers. Our colleagues and clients have a host of mixed feelings about us, our presence and our work, about our countries, power, affluence, arrogance, compassion, expertise, naïveté, curiosity, etc.; they have hopes about us, as well as expectations, fears, reservations, mistrust, idealizations, etc., which we will have to take into account very seriously. As we know, the basic institutions in Kosovo are run by the international community: the Kosovo Ministry of Health is run by the World Health Organization (WHO), while the Ministry of Education is, in fact, UNICEF. It would be important for us to open up the debate about these issues, in order to discuss how our IOM course fits within the existing structures and whether or not it is in accordance with the aspirations of the people in Kosovo.

The construction of trauma

Although the concept of trauma has already been extensively detailed and redefined during this conference, I would further argue that there is a basic confusion between trauma as a noun and trauma in its form as an adjective (i.e., “traumatic”); this confusion is similar to the lack of differentiation between trauma as an event and the experience of that event. Colloquially, the word is used in both forms. It could be argued that in so far as trauma refers to the experience of events and not to events on their own, it would be inappropriate to use the noun form of trauma under any circumstances. The confusion becomes more intelligible if we accept that when people use trauma as a noun, what they in fact mean is that the event that they are referring to had painful and disturbing effects on some individuals. In this way, the word trauma has become synonymous to words such as distressing, upsetting, stressful, harrowing, etc. To put it simply, although it is a truism that the same event can be experienced by different people in different ways, people still have the (understandable) need not to allow certain events to be given an open and neutral presentation; instead, they wish to emphasize their abhorrent nature by giving them a negative colouring right from the beginning. Although we would all agree that certain events or phenomena, for example atrocities of any kind, are condemnable outright, the question remains why we have the need to call them “traumatic” rather than just what they are -condemnable, abominable, etc. It seems that the word trauma is now used very widely by ordinary people, journalists and specialists in ways that have become too blurred. It seems that we use the word trauma whenever we wish to emphasize the enormity of human suffering involved, because we do not trust that any other description will create the same effect on people, politicians, funding organizations, etc. The word trauma has, almost, a magic quality to it in so far as it mobilizes people more than any other description that refers to human suffering and distress. Consequently, trauma has become a commodity which is traded most widely. In short, the more we fail to account for, grasp and respond to human suffering, the more we tend to use the word trauma. As we become insensitive to human tragedies, so our need to see trauma everywhere tends to increase.

Thus, I would argue that although trauma is used to refer to facts, essentially, trauma is a product of social construction (McNamee and Gergen, 1992). Trauma refers to the way one construes and experiences a fact rather than the phenomenon itself. For example, the suffering experience of a man in prison may be experienced as traumatic or heroic, depending on the context of the different discourses used, on the position of the observer and on the function of the observation.

There is another aspect of trauma, however, that might remain hidden to anyone without a strong passion for language – the meaning that is implied by its etymological roots. No one has yet written, to my knowledge, on the etymological origins of “trauma”. It was difficult to trace its roots but I am pleased to say that I have come up with some interesting connections (Papadopoulos, 1998b; in press). The first meaning of the Greek word “trauma” (τραυμα), of course, is that of a “wound”, a “lesion”, an “injury” and it comes from the verb *τιτρωσκω* (*titrosko*) which means to pierce, to penetrate. However, the important deeper root of *τιτρωσκω* is the verb *τερω* (*teiro*), which simply means “to rub”. *Teiro* has two different meanings: to “rub in” and to “rub away”, to “rub off”. If I were to rub something rough on my skin for too long, then I would create a mark or an injury, or I can equally rub something off by cleaning the surface by rubbing something away. Thus, trauma is simply the mark left by either a wound (the result of an experience being “rubbed in”) or a clean surface (the result of an experience having “rubbed [something] off” or “rubbed [it] away”). Trauma can be the result of an injury or the result of a cleansing. In this way, trauma is a neutral word implying that potentially any experience can have either an injurious or refreshing effects. Yet, the word trauma has ended up being used today exclusively in terms of its negative connotation, the pathological injury. Moreover, etymologically, trauma and *teiro* are connected to other opposite words: *τερας* (*teras*) and *αστερας* (*asteras*). *τερας* means “monster” and it comes from the belief that monsters are signs, marks of God: if a person had a monstrous disfigurement it was thought that he was marked by God, that he was differentiated by the sign of his deformity, or that through him God was giving a sign. *Αστερας*, on the other hand (which means ‘star’ – cf. stern, estrellas, etc), is another kind of mark or sign: stars are sparkling marks up in the sky to be seen by everybody; being unmoveable, stars have always been used as signifying all kinds of lofty, noble, elevated, grand or powerful meanings -from film or pop stars to national flags and military decorations. Stars are considered as most positive signs or marks. Yet, the potential duality of meaning in the word trauma suggests that there is little difference between the stars and scars. The saying that “through life we collect many stars and scars” aptly conveys this potential duality.

All this means that a “traumatic” experience (whatever this may mean) could potentially make a person either a monster, badly scarred and marked for life, or a star who could shine from being refreshed and renewed by the same experience. Moreover, there are many variations of these possibilities, some of them quite perverse. For example, we all know that some people who have been injured by certain experiences have used (abused) their scars, their label as being “traumatized” persons to gain media attention, thus becoming “stars” of a sort. In our field, we are

all too aware of the iatrogenic effects of treatment. Our own work in Kosovo, too, can create conditions, if we are not too vigilant, to fix people in the victim role with short-term dubious benefits but long-term tragic consequences. A victim, as “star”, will want to remain so. He will continue to receive aid, to be blameless, to radiate self-righteousness in such a way that he cannot be judged. This is a state to which one soon becomes addicted, and it creates a cycle of dependency, perpetuating victimhood and victimization. In this respect, trauma is a label that can place someone in this permanent “victim” role. In addition, there is another vicious trap engendered in our role as experts, in so far as suffering people transfer authority onto counsellors, and, in order to maintain contact with these special experts and continue receiving aid of various kinds, they will perpetuate a negative version (traumatic as injurious) of their experiences. Finally, it is also important to appreciate that our Kosovar Albanian counsellor colleagues and trainees will require our own approval in order to gain their own authority vis-à-vis their clients. The foreign recognition that we will offer them and the authority that they will gain from our course may indeed be used in a positive way, although it may also slip, imperceptibly, into a negative abuse of their empowerment, if they are not helped to become aware of it.

Thus, our best course of action would be to include in our training course awareness of the many variations of trauma with their positive and negative implications at all levels: from the individual client to the inter-relationship with the counsellors, and the position of the counsellors themselves. The central objective would be for us to empower people to shift positions and move to a more refreshing renewal of themselves, whilst we remain throughout genuinely respectful of the enormity of their suffering.

Post traumatic stress disorder and phases of trauma

Another aspect of trauma, which has been touched upon but should be repeated in a different context, is the question of Post Traumatic Stress disorder (PTSD) (Marsella et al., 1996; Friedman and Jaranson, 1992). The expression post traumatic stress implies that there is a “post”, an event occurred which seems to divide time into two: before and after (see figure 1). The event is this point in time, this line which divides a person’s life into two parts -the before and the after. This line (which visually is in fact a “post”, a pillar) implies that everything was wonderful before the “post”, at which point the event occurred, and that everything

which happened afterwards is problematical if not pathological. Of course, the point is not to deny the reality or painful impact of the event, but only to ask where trauma begins and where it ends.

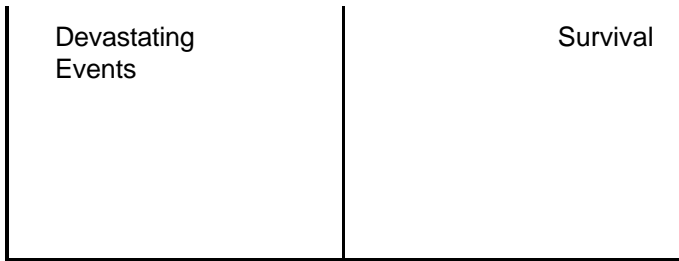
In my consulting to schools, medical general practitioners, and others with reference to refugees, I have a very vivid experience of this phenomenon. Often, the professionals would claim to be unable to help an individual or a family because they “did not know what happened to them.” They assume that there are certain tangible traumatic events (the “post”) which were solely responsible for the refugees’ current difficulties, and they seem to harbour a determination to track down these events. This is based on a belief that, unless they know “what happened to them”, they will not be able to help the refugees effectively in any other way. This illustrates the strong conviction that is widely spread that (a) a person’s present difficulties stem only from a set of “traumatic” events which occurred at one specific time, and (b) that the only help that we can offer to these “traumatized” people would be based on our full familiarity with these events.

Figure 1:



On the other hand, experience suggests that trauma does not come from one specific moment, but from several traumatic time sequences, perhaps only one of these containing devastating events. I would propose that trauma is not a result of a single time phase but of a series of such phases. It is therefore useful to differentiate these phases (Papadopoulos, in press). To begin with, I would argue that the “post” is not just one line but it is at least divided into two phases (see figure 2). Obviously, we have to accept that indeed there can be a phase during which actual devastating events occurred in a refugee’s experience. This is when, for example, enemy forces storm into a home and commit various atrocities. However, not all refugees experience such raw violence. Often, people hear of the incoming forces and they flee. In one way, as crude as this may sound, this can be disappointing to some of the younger therapists or students. In expecting to work with traumatized people, they cannot accept that perhaps the majority of refugees have not actually been traumatized by this type of “raw violence” devastating events. In other words, there is a certain romantic notion of human pain that leads some workers to exaggerate or distort the situation in a search for the concrete “source” of suffering.

Figure 2:



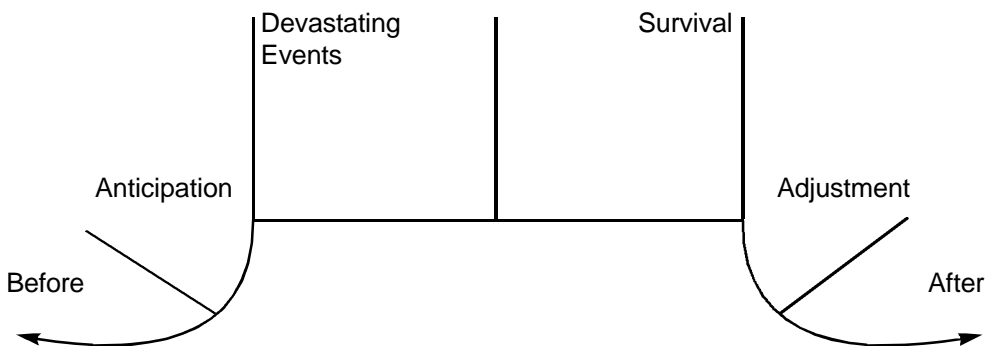
Immediately after this phase of suffering, there is another segment of time, that of Survival. In this phase, which can be terribly long, refugees find themselves in a situation where they know they are safe and will not be attacked, but still feel trapped in most painful circumstances, in refugee camps. They do not know what will happen to them, they have been torn from their usual roles in the workplace, in their family, their community and in their routine. They wait there (having survived and feeling safe from violence), feeling disempowered, helpless and disoriented. They sit around doing nothing, waiting for their fate to be decided by warlords, politicians or international organizations. They are left suspended for weeks, months, even years waiting for the wheels of power to determine their future. This period of waiting during this “survival phase” can be just as traumatic as a fixed “devastating event”, but it is less visible to others and it is often ignored by potential donors or forces of intervention. Moreover, the real tragedy is that the refugees themselves will tend to ignore the traumatic impact of this period because its “trauma” is intangible and not as striking as the content of Devastating Events. Thus, in so far as the phase of “survival” is not considered newsworthy, it does not make for impact photography, and neither does it mobilize political or financial intervention.

Another phase that is often ignored happens even before the Devastating Events, in what is considered to be the “pre-traumatic period”, when, according to common perceptions everything should have been ideal. Here we could discern the phase of Anticipation (see figure 3), when people understand that something is going to happen to them, and are immediately compelled to make life-altering decisions for themselves, for their families and for their community. “Are the children going with you or staying with me?”, “Are they going to your village or to my village?”, “Shall we take the tractor with us or not?”, ‘shall we leave home or not?’, all the while wondering which would be the best solution for the whole family. This is a most “traumatic” phase because, due to the overall chaotic circumstances and the breakdown of positive authority, law and order, there are no guidelines or predictions that apply to such a situation. These moments can be especially traumatic and have multiple consequences, many years later. There are many people who, long after the

events, still think that if they had done something differently, they might have saved their son, or that if their husband had listened to their advice, they would not have undergone such suffering, yet this period is still entirely ignored because it does not include any devastating events as such.

Finally, after the phase of Survival, there is another difficult phase, that of Adjustment or Acculturation, when people finally arrive in a new place to begin a new life. One interesting fact about this phase is that increasing evidence from recent research shows that contact with “helping professions” seems to worsen the trauma. The beginning of new life is marred not only by memories of the past, not only by the “trauma” scars but also by the real and concrete disadvantages that these people face in terms of the complete new sets of parameters in their lives. For example, the losses they have suffered, the de-skilled position they find themselves in, the new roles in the families (e.g., children assisting their parents in connecting with the new country because they learn the language faster), the overall adjustment to the new environment, the contact with the various new authorities, services and help agencies, etc. Even for people who have not left their country, as is the case with a segment of the population in Kosovo, after the phases of Devastating Events and Survival, the phase of Adjustment can still be most problematic as the whole world around them is now new.

Figure 3:



Distinguishing these four phases shows that the idea implied by a single traumatic event is erroneous. Counsellors should not attempt to track down the single event which “caused” the entire “trauma”. The whole of this sequence of phases can be most traumatic. Thus, the work of the counsellor becomes more complex and attempts to elicit the meaning of suffering people give to their experiences of all these phases. In this way, it could be said that one of the main objectives of the counsellor would be to provide the appropriate therapeutic space within which the

suffering person could explore the variety of feelings from all phases, and not to impose (unwittingly) an expectation to hunt down “the” cause of trauma. Elsewhere, I have argued that there are greater advantages in emphasizing more the “therapeutic presence” rather than “doing therapy” in these contexts.

The development of a “storied community”

Another term useful to bear in mind in connection with the project is the idea of a “storied community” (Papadopoulos, 1999b). It is well known that a community will create its own tales, but true also that the opposite occurs. Stories create communities around them and, in turn, have a powerful impact in maintaining these communities. In other words, the survival tale of people’s suffering can draw others to identify with it. Stories of resilience based on traditional values, historic experiences, religious convictions, ideological beliefs, political positions, etc., can be most helpful in providing a solid and secure new context which can counteract all feelings of being a helpless victim (Cohler, 1991; Walshe, 1996; Wolin and Wolin, 1993). In this way, such a “storied community” can counteract the disorientation and pain of the “traumatic” phases and, without negating them or ignoring them, it can provide a sense of substantial new security. Indeed, a “storied community” can recreate for adults the “secure base” that, according to John Bowlby’s theory of attachment, children find in their early relationships with their parents (Bowlby, 1988).

The idea of a “storied community” brings light to what I said above about Nelson Mandela and to why his 27 years in prison, as a part of his political discourse, did not result in trauma or anything of a pathological nature. Societies that have struggled against oppressive regimes seem to experience a surprising cohesion through shared narratives which give meaning and purpose to their struggle. Despite all the adversity, these societies also seem to produce artistic and other creative expressions of unique power and sustenance. Moreover, people who share the abhorrence of the repressive regime have highly differentiated ways of recognizing each other through certain sensitive cues, such as intonation or terminology, and this kind of recognition gives them a surprising sense of strength and support, regardless of their objective adverse predicament.

In this way, a group united as a “storied community” can heal together not only with professional help, but also by the reconstruction of the community through a sense of belonging. A simple example of this can be found in the comparison between events as they occur on the individual level, and their meaning on the collective, communal level. In other words, a man trying to rationalize the fact that his

neighbour of 25 years turned against him, killed his wife, raped his children and sent half of his family to a concentration camp would fail because it is humanly impossible to understand such evil on a personal level. On the other hand, if the man had taken in the situation from a collective point of view, realizing perhaps that he was a member of one ethnic group and his neighbour of another ethnic group, the events would begin to acquire some tolerable and comprehensible meaning for him. This is, by no means, a way of justifying the horrors of war, but to this man who has lost everything, the elevation of the personal story into a greater context can construct a new meaning which is based on the idea of a “storied community”. Acquiring his position in the context of the strife between the two ethnic communities, instead of perceiving the event as an expression of his individual connection with his neighbour, makes the hideous atrocity intelligible (yet still repugnant and condemnable).

Mandela, in his autobiography, describing how he and his comrades managed to survive the long imprisonment and brutal conditions in the infamous prison on Robben Island, clarified: “Our survival depended on understanding what the authorities were attempting to do to us, and sharing that understanding with each other. It would be very hard, if not impossible, for one man alone to resist. I do not know what I could have done if I had been alone. ... We supported each other and gained strength from each other. Whatever we knew, whatever we learned, we shared, and by sharing we multiplied whatever courage we had individually” (1994, p 463). Thus, what gave strength for Mandela was his conscious participation in a “storied community”, a community which was created around the story of defiance against the apartheid regime.

It is therefore beneficial to both community and individual when personal stories develop through their telling and exchange. *The Archives of Memory* project, for instance, is one very effective means of creating a “storied community” able to provide a solid, secure base for its members.

Guidelines for care-providers

These guidelines for care-providers were first requested by UNICEF during the war in Yugoslavia. They were meant to be distributed widely amongst UNICEF workers in order to provide basic instructions, when there was little time for de-briefing each trainee at the clinics. Although simple solutions are usually not effective in these areas, there are some key points worthy of consideration, which might still be relevant to the programme in Kosovo. From the list of guidelines I developed from UNICEF (Papadopoulos, 2000), I here extract only the basic principles.

- **Principle 1.** The people being attended have a multiplicity of needs and it is impossible for one worker or anyone, individual or agency, to address all of them.
- **Principle 2.** It must never be forgotten that this tragedy will bring about changes in such a way that many things will never be the same again. These changes are neither always positive nor are they always negative. Both should occur.
- **Principle 3.** Every worker should expect to feel inadequate at times, and should never despair. It is helpful to look around them: most likely, no one is more qualified for the task at hand. At the same time, it must be remembered that no one is indispensable, that no one person can save the entire situation alone.
- **Principle 4.** The immensity of the task is likely to bring every worker to expect heroic achievements from him or herself. This is not the struggle of the individual, but the struggle of all the workers, all the people involved, everyone. Every worker should limit their expectations and set themselves small, tangible tasks.
- **Principle 5.** No person involved should neglect themselves. It is important at all times to enjoy simple pleasures and not to forget to have fun.

Conclusion

In his book *Palace of Dreams*, Ismail Kadare speaks of an ambitious young man who climbs to the top of the social ladder and reaches great heights within an oppressive political regime. Gradually, however, some awareness begins to work inside him, and he starts to doubt his basic beliefs and his role. This does not happen suddenly but very slowly, moving from idea to idea, from one perception to another. Kadare describes this substantial transformation in a most subtle way. The reader senses the change and its enormity, and yet has no tangible proof that it is occurring. Only right at the end, Kadare offers the “proof” of this massive transformation and yet again it is only a hint: the hero, driven in his official carriage, begins to notice for the first time that “the almond trees are in bloom” and the very last sentence of the book describes how the hero “realized his eyes were full of tears”.

The changes that we are trying to implement with these programmes are likewise extremely subtle. I may dare say that the more substantial the change, the more subtle it is. Substantial healing of painful suffering does not always have tangible verification. This does not mean that we should not have clear goals both for our training course and for the counselling work our colleagues will be offering.

However, we should also never forget to show humility and respect towards the subtleties of the process of individual and collective change and transformation. We should endeavour to develop these subtleties in our approach, so that in choices that seem merely shades, we may reach the ends within our grasp.

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Mapping trauma

Jack Saul*

Introduction

There is currently a great deal of confusion about the concept of trauma, especially in the growing field of humanitarian assistance. The word “trauma” is often applied to a variety of different circumstances, and may refer to highly stressful events, to the consequences of these events, or to both. Trauma may be diagnosed in the individual by one psychiatrist, ruled out by another, or stretched to cover an entire situation, depending on the vision of the professional.

Few of these professionals, however, venture beyond an understanding of trauma at the level of the individual. A comparison was made, for instance, between the situation of one man who was captured for 27 minutes, and Nelson Mandela, imprisoned for 27 years. In this model, the man who had suddenly been abducted was later traumatized. Mandela, on the other hand, though held in prison, had expected to be arrested, and sacrificed his liberty as hero and martyr of his cause. The logical argument would suggest that he would therefore not be traumatized, nor be in need of any assistance. To go beyond this view, considering this situation at different levels,

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however, would lead to a different conclusion: we might ask how 27 years of imprisonment affected Nelson and Winnie Mandela's marital relationship or how they and their extended families were affected by the apartheid. We might then find that there was indeed disruption in their lives, with consequences both to their relationship and to the people around them. By taking into account different systems, rather than focusing solely on that of the individual or of individual pathology, we are faced with a more complex picture in which psychological trauma is only one of many factors.

Mapping trauma

One way to examine the role of trauma in human systems is to visualize a diagram, like that of Talcott Parson in his *Theory of General Systems* (Parsons, 1951) which breaks down the social system into its different components. Within this map are different systemic levels; those of the body, the individual, the collective and the cultural. At each of these levels there are many different sub-systems. Any of the systems or sub-systems of the map can be affected by significant events or stressors either directly or by disruptions occurring at any other level. Psychological trauma might follow severe abuse which has been directed toward the body. It can also result from physical attacks, torture, and other forms of human rights violations that are committed with the intention of breaking the spirit of the individual. Such violence may also be intended to and in fact undermine families, communities and cultures (see figure 1 at the end of the paper).

The word trauma has been increasingly used as a term to describe events as they occur at every level of this diagram or to qualify any disruption within the systems. Originally, however, it has been and should be restricted to the level of the individual, if used at all. The ways that severe stressors and events may cause disruption or damage other systemic levels, like communities or cultures are quite different from the effects on the psychological level of the individual and should be treated separately for conceptual clarity.

The family, for instance, is a system in itself, not just the sum of its individual members. It is an organizational unit, with particular structures and functions and sub-systems (parents, siblings), and its own logic of response to disruptive events. The normal functions of the family system can be disrupted by events like war. After a war, parents may find it difficult carrying out normal parenting functions. The marital couple may struggle with intimacy or communication. Thus the analysis at the level of the family is quite different from that of the individual, and may be vital to an effective intervention.

Beyond the family and other social systems is the cultural level. Disruptions at this level can range from the loss of collective meaning, identity and continuity to a rupture in the intricate pattern of values and customs that pattern the daily lives of communities. Experience seems to suggest that an event can have a direct impact on a culture, and that there is a threshold of what can be endured. On the cultural level, as in any other system, too much disruption or stress can reverberate through the other systemic levels. For example, the displacement of communities in war and forced migration may result in such a stressful cultural transition or the deprivation from cultural resources that the community may no longer be able to maintain coherence and thus function effectively. This disruption will also be experienced at other levels of the system by families and individuals. Too many traumatized members in one family will eventually disrupt the functioning of the family as a whole, just as too many hurt families in a community will lead to its deterioration.

Culture is unique in that it has a preserving function. It provides the patterns that help maintain the organization of social systems. And when these social systems are disrupted by traumatic events, the culture often provides the symbolic resources and practices that enable individuals to heal and communities to be reconstructed. The communities maintain a supportive structure for families, which in turn support and provide a “holding environment” for their members. The “containing” function of cultural systems toward social systems and social systems toward individuals and their bodies, is crucial to an understanding of effective interventions for recovery.

If we learn to respond to the disruptions that may occur at different systemic levels, we might better support and help rebuild the containing functions that have been damaged, allowing for recovery at each successive level of the system - from the social to the individual to the body. An example of this was brought up by Dr. Lemaire, who spoke of approaching families through a supportive network by which these families could be linked together in order to address their problems. Once this has been achieved, one can then consider other levels, and the consequences of disruption at each of these. One might discuss strengths and resources at each of the levels, and as well simultaneously support and foster resilience at the level of the individual, the family and the community.

Other levels of intervention

Recently, people working in trauma-related fields have begun to analyse cases on many planes, trying to determine at which of these an intervention would be most effective. If a person is found entirely disconnected from his or her social network,

ways can be found to facilitate social reconnection. This approach is feasible only if we consider the map of the whole, rather than focusing exclusively on individual trauma.

The IOM's *Archives of Memory* module is a promising approach, especially in a city of closed communities of refugees or migrants. In New York City, we have been developing a similar project. There, the refugee communities rarely participate in any kind of public discourse, and it is thus very difficult for an outsider to know what happens within these communities or what the people there have experienced. The project originated in an attempt to provide psychosocial services beyond the walls of the clinic, to go into these communities, and to provide opportunities for immigrants or refugees to have a voice and to engage in dialogue outside of their familiar groups. When the refugees of New York City have problems, they typically come in contact only with professionals. This is a situation that is unnatural and culturally alien to most refugee communities. There are very few opportunities for the immigrants to develop links with Americans, or with anyone living outside of their own ethnic group.

For these reasons, the voices of these communities are replaced by a collusion of silence, similar to that which occurred in relation to Nazi holocaust survivors after the Second World War. When these men and women returned to a more normal lifestyle after the war, the media did not cover their experiences, their struggle was not discussed, and they were, in this way, a very under-served and misunderstood population. This type of community development project could have broken their silence then, just as it can be beneficial to the other closed communities of a city today.

One way of implementing this kind of project would be to recruit counsellors already from the communities. In New York, at the Solace Programme for Survivors of Torture and Refugee Trauma, this has proven effective, because these professionals understand the culture of those with whom they are working, and are then able to find creative ways to address the needs of their people. These needs can be very different depending on the group. Within New York's African community, for instance, a worker operating within the Liberian group has helped create a micro-enterprise association for women who are starting their own businesses. Through it, they can meet each week to discuss the difficulties of finding work or ways of securing loans. From this essentially practical point, the association has become a forum of exchange where the women can speak about parenting or any other problems they might have, illustrating how mental health issues often emerge through other needs. It is not necessary, indeed, perhaps, not even beneficial, to address such

problems within a mental health system. Moreover, such a foreign institution might even distract the immigrants from healing, just as a friendly medium is more conducive to more significant dialogue.

Another project created in New York, and that might be effective in this context, is a Testimony Archive. Many of the refugees have been found willing, even eager to record their stories and the archive later can provide a source of information to journalists or scholars, to better understand the histories of these refugees, as well as the political situation in their countries of origin.

Theatre is also used in these projects, and creates a dignified medium for people to describe their experiences as refugees in New York. At first, the participants speak of whatever they wish to, but once they feel comfortable, they might describe some of the things they have survived. This was recently attempted with Chilean torture survivors, and it was the first time anyone outside their community had expressed an interest in having them speak about their experiences, an opportunity they were glad to have.

The results of letting these refugees express themselves through theatre illustrates the important contribution that arts can bring to the healing process. It transforms the stories within people, and moves their experiences to another level. In taking their story to the next level of representation, as they consider how their stories may be communicated aesthetically to an audience, the survivors are able to distance themselves from what they have been through. It may allow them to break free from the static recollection of their hardship - their memories change, and they begin to remember new things, away from the horrors of their experience. Gradually, they begin to focus on the resources that had helped them survive and on the moments of humanity in times of suffering. This reconnection with their positive memories is an important catalyst to the healing process.

Another effective aspect of such a programme has been the inclusion of people from different countries which have known war or humanitarian crisis, and who have already worked to set up projects dealing with these issues within their own culture. These people are, in themselves, an important potential resource. Their experience is valuable, relevant, and useful, even within a different culture, and the creation of an intercultural discourse might even, in this case, highlight the differences in what a particular people might need or hold as traditional values. For these training programmes, people who had run projects in Guatemala, Africa and Bosnia were recruited, so as to create an inter-cultural discourse with refugee groups in New York City. As a result of this, both trainees and professionals are exposed to a great deal of creativity in the variety of solutions offered for similar problems, and the expertise of one counsellor can enrich the approach of others, even as they act with-

in different contexts. There are people, for instance, developing projects in South Africa, whose methods could inspire counsellors in Pristina, as they face comparable situations.

Integrating the group, an alternative method

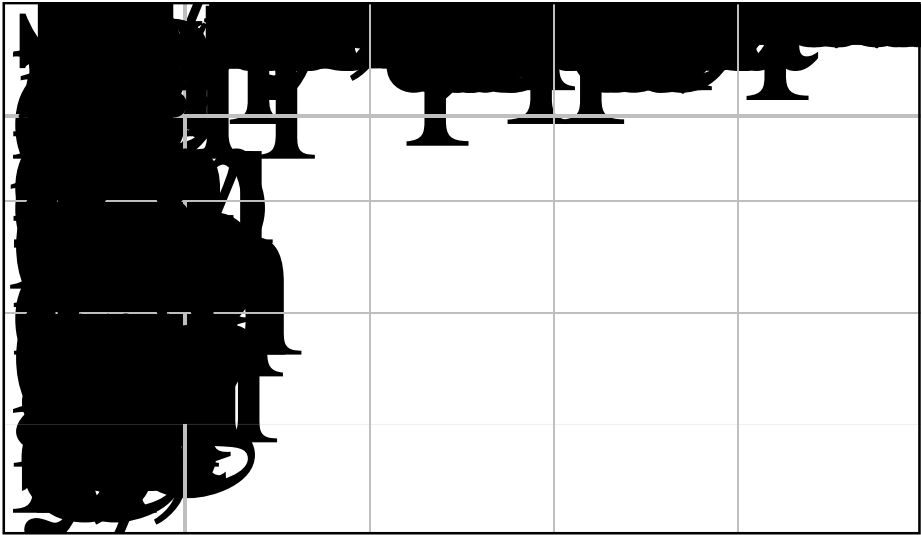
On the other hand, the role of the expert is at times also limiting, and the presence of another person as “professional” can diminish the effectiveness of the exchange. Speaking solely as a family therapist, for instance, I myself feel culturally excluded from the discussion. I cannot describe my own experience as a Jewish man married to the child of Holocaust survivors; a community that itself has a history of tragedy and of struggle in face of disaster. Given the importance of this dialogue, it would seem awkward to exclude my cultural identity from the conversation, and as the professional to be prevented from sharing human experience. An alternative method to this seemingly necessary separation was sought, and later proven during a mission to India.

In Dharmala, where many international groups were trying to document human rights abuses committed against Tibetans, it seemed as if the foreign professionals were forcing stories of hardship and torture from the victims. This occurred to such an extent that the intervention organizations were at risk of re-traumatizing the survivors, bringing them to live their stories again and again.

In order to work without requesting these terrible accounts, a nurse and colleague who practised in a monastery was asked to assemble the nuns who had been tortured, so that their needs, despite the particularly difficult context, could be discussed. We then sat down with these women to an empowering conversation about what they would tell Tibetans living in New York about what had been important to them, as they adapted to their new situation. While they spoke to us as teachers or equals sharing their experiences rather than as victims, the conversation led to a discussion about what had been helpful to them as survivors, about their problems and needs. Eventually the nuns, as survivors, formed a group. With the new bonds between them, the nurse was able to work with the nuns together, and to make progress with them as a “team”. This is only a single example, but it illustrates an important point:

That we also, might create contacts for people, and that these bonds, as new systems, will help people rediscover and rebuild their own residual resources, as members of a greater supportive framework.

Figure 1 :



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On ethnopsychiatry

Tobie Nathan*

Introduction the history of ethnopsychiatry

When a large population of immigrants settles in a western city, there also emerges the need for a new Art, combining psychiatry and anthropology, as has occurred in the United States, Canada, France, Germany, Switzerland, and, more recently, in Italy, over the course of the twentieth century. In the United States and Canada, the combination of fields came to be referred to as “transcultural psychiatry”, and took on a tint of local colour. It appeared distinctly Canadian or perfectly adapted to the United States. In France, likewise, the emerging art appeared especially French, and tended somewhat towards psychotherapy.

In either country, this new science sprung from an attempt to adapt the body of knowledge of anthropology to the practice of psychotherapy. It was in France, however, that the combination was first identified and named. It was Georges Devereux who chose the term “ethnopsychiatry”, wishing to ensure that the new field would follow the direction implied by this word; he was amongst the first to define its goals.

Dr Nathan is Professor of Psychology at the University of Paris VIII at Saint Denis, where he founded the Centre Georges Devereux, an university clinic and research lab. He has conducted research in ethnopsychiatry for over 20 years.

From its very beginnings, then, ethnopsychiatry has been the science of taking into one's care immigrants or small groups of immigrants experiencing problems, in order to help them, therapeutically, within their own worldview.

Ethnopsychiatry in practice, the importance of language

The appearance of the science in France preceded its need, when the large-scale immigration of North and Sub-Saharan Africans began to raise new questions within the field. Though most of the Africans were arriving in France from former French colonies, potential problems were already apparent, and a new situation was rapidly becoming a reality. As we asked ourselves what approach should be attempted in this unknown context, we hit upon a factor that seemed then, as now, to be crucial: that of language and its use.

As we began working with African families in Paris, whether people from Mali, Senegal, or (what was more common at the time), families from what was then Zaire (now the Democratic Republic of the Congo), we realized that there were hundreds of languages and dialects, each one specific and each one almost entirely different. We also realized that to work in the language of a particular family required an acute knowledge of their vocabulary, expressions, intonations, and of the linguistic nuances typical to their own culture. Given the multiplicity of different languages, it would obviously be very difficult, if not impossible, for a single therapist to work with several different patients. It became indispensable to include a third party into the ethnopsychiatric approach.

This third party, later referred to as the mediator, when brought into the discussion, serves as an interpreter for nuances of a language the clinician cannot know. On another level, however, this "other" is much more than a mere translator and his role is much greater than merely changing languages. Without a mediator, without a perfect understanding of the patients' language, one cannot hope to understand anything about their psychology. This is a basic principle, and one that might seem evident, yet it opposes the Kraepelinian view that language (thus meaning) acts as a distraction, barring the psychologist from deep understanding of his subject. It seems, however, that Kraepelin was wrong, if only because without language, very little can be achieved.

On the other hand, given the presence of this mediator, a conventional dialogue with the patient is no longer possible, and the "confessional" or "boudoir"-style interactions between therapist and subject disappear. Moreover, experience shows that the introduction of this third person changes the entire setting. Many have been

opposed to this new interaction, assuming that the presence of a stranger changes the clinical or counselling session from a private setting to a public place. While this may be true, such a “public” interaction is far from a “Grand Public, cast-of-thousands” psychotherapeutic arena. The additional presence of one “other” should simply open a window to the outside world, if only because the translator makes this necessary.

Another effect of introducing a translator into the group is that it moves the session beyond the “dual-relationship”, the two-person interaction of psychiatry which has always included an element of struggle. A dialogue is by nature a situation where two people oppose one another to establish which one is right. In other words, the traditional drama of a therapeutic session involves a patient and an expert: the former is an expert of his own affliction, the latter, an expert in illness. The purpose of the dialogue is to bring the subject to realize that the expert is right, and that he, as patient, understands very little of what is happening within his own mind and body. The admission of a third person into this otherwise standard battle scene changes the interaction so that the dialogue no longer serves to establish which is of the two is right, but rather to find common ground.

An example of this might be found in the case of an African immigrant, a Manjak man from Casamance, living in France. The patient, who claimed to be the ninth of 14 sons, had mourned the death of his eight older brothers, and was worried that he would be the next to die. “My eight brothers are gone,” he explained, “because my father sold all of his sons to a sorcerer in exchange for wealth and power.” A therapist, alone with the patient, would be inclined to think that this was what the patient literally believed, or that fear and anxiety were putting words in his mouth. The therapist might decide to focus on the patient’s latent aggressiveness towards his father, or delve into his past in other ways, merely as a result of dealing one on one with his patient’s words. On the other hand, the expert might choose to introduce a translator, another Manjak from the same region as his patient, to mediate between them. When asked to interpret, this third person (for this approach was indeed applied), answered that it was common in his home country, not to sell one’s sons, but to use this expression. In other words, the patient was speaking realistically, acceptably, but with the words of his own culture, which to a foreigner might sound delusional. It is irrelevant, at this point, whether the interpreter understands the patient’s past or his particular use of the expression; simply by intervening, this “mediator” enlarges the parameters of what is normal, thus introducing a dimension of the Possible where the cultures of patient and therapist overlap. His presence makes a peaceful agreement possible, when it might be said that psychotherapy is

a form of conflict. In the war of psychotherapy, both parties oppose one another in order to prove which of the two is right. Translation, on the other hand, is peace, because it seeks means of sharing a world, or a common ground of language.

The role of language in ethnopsychiatry

To continue with a Kraepelinian rejection of language, at this point, would be to ignore its value, and further, its mystery. No other element, objective or theoretical, serves the same purpose and reacts in the same, paradoxical way. Particular to language is the strange relationship between each of us and our spoken tongue: a language is no one's property, and yet we refer to "our" or "my" language. It is the most intimate of our possessions, personal to each of us, and yet in no way does it belong to any of us, or it would cease to be a language.

Secondly, a language is an entity which necessarily belongs to a community. Further, it is an entity constructed by the community that continues to be constructed every day. If someone were to ask who created the French language, he would immediately be taken for a fool. No one has ever single-handedly created the French language, and yet it is built by French speakers day by day. A language is thus an entity belonging to its architects. Its construction, as a language, is continuous, but it also shapes the very people who speak it, one by one, even as they build it. A person nurtured by French, for instance, will have a certain way of speaking, a way of feeling and a way of thinking typical of the French language, and evident to all who meet him.

The nature of this object which is created by the group, and then in turn moulds the individual, becomes almost tangible once the translator is admitted into the exchange. One might then liken it to the African concept of a Voodoo. The word Voodoo has gained a certain reputation, but its real significance is understood by few, and seldom used outside of the Republics of Benin and Togo. In its correct usage, the word Voodoo designates an object created by a group. Each of those present is then invited to touch this object and to eat of it, until all individuals have been united through the Voodoo as members of one community. This is only a weak reflection of the powers of language, and yet it illustrates an important point; that without an intermediate, one who has tasted or touched the same Voodoo as the patient, we can hope to understand but little of the individual member of the group who has migrated.

The organized collective

Using these methods, we started working with patients in the Avicenne Hospital in Bobigny, an area of France with a large population of immigrants, then at the Georges Devereux Centre of the University of Paris VIII. With over 20 years of experience, we have arrived at a certain number of conclusions:

1. A large number of patients were referred to us because they were afflicted with what was then known as “Traumatic Neurosis”. The term has many advantages over PTSD, mostly because it suggests the conception of a neurosis structured around trauma. The expression PTSD, on the other hand, simply evokes a disorder, in other words, a mere syndrome. The term implies the absence of logical organization, while “Traumatic Neurosis” suggests a fundamentally logical process.

For evidence of this, one might consider a “typical” instance of Traumatic Neurosis, in the form contracted by many immigrants. Most of these cases of PTSD appeared suddenly, curiously, in people who had already spent ten to 20 years in France, and who seemed to have adjusted to the change. Often however, an accident on the road or in the workplace served as a somatic precipitant or, perhaps, as a warning signal regarding their psychological condition. As these patients were taken into care and given physical treatment, it soon became apparent that intervention on this level would be useless. Evidence of this lay in the patients’ pain, which resisted to any treatment. Even as medicine was given them, the patients’ pain persisted, often made worse by new forms of trauma resulting from the treatments themselves. It was at this point that the patient’s suffering was diagnosed as other than somatic in origin, and the patient was then referred to psychiatrists.

We gradually came to realize that the patients were victims of a kind of double mistake, in which they were trapped. On one hand, they themselves believed that they had not changed since their immigration, and that the alien environment of France was the cause of their distress. On the other hand, the doctors treating them were convinced that they had adjusted, or been “naturalized”, and that their Traumatic Neurosis could occur only if the patients were somehow different. They took their patients to be new people since their immigration, omitting their past. In other words, the doctors believed that these people (most of them from Maghreb) had changed during their move, while for these men, who were still North Africans in a foreign land, everything had suddenly fallen into disorder. This is why neuroses could catch up with them, even ten or 20 years after their arrival.

In many cases, the patients were originally Algerian, but once immigrants, had learned to live and thrive in France. They had worked in France, they had watched their children grow up as French children, they had participated to a limited extent in France's administration. At one point, the men had therefore been required to complete government forms, social security questionnaires or perhaps, tax forms. Unable to communicate sufficiently in the French language, the immigrants might have asked their French son or daughter, a child typically only seven or eight years old, to help them. With the realization that they, though head of the family, were dependent on their own young children, the immigrants experienced a reversal of the natural order of things and of their entire world. In this new foreign, upside-down world with its incomprehensible language and in which their children were made adults, the immigrants would then return to work, and fall off the scaffolding at the construction site.

The patients therefore felt that they had not changed in their move to France, when in fact, the fundamental structure of their lives had been altered. At the same time, the doctors and therapists were behaving as if their patients had changed, simply by taking these men into their care and expecting them to heal by way of Western (thus "foreign") medical treatment, when in fact these patients had not changed at this level. It is at this point of conflict that the patients contracted the traumatic neuroses. As this became apparent, we began working with the patients in their own language. We followed their own interpretations of events, conjured objects or concepts specific to their world, and suddenly, something seemed to return, to begin to work again within them. Given this opportunity to interact in their own language, the patients suddenly changed, became other people. They reverted from their state of powerless immigrant to one of individuals that could heal.

2. Another important element in ethnopsychiatry is the relevance of objects. Returning to the example of the man who fell from the scaffolding: he had suffered three days of extreme pain, after which his rheumatologist told him that he was cured, that he could no longer claim to be hurt and could return to work. Despite the diagnosis, the pain persisted and 15 years later, he still suffered. As we began to work with this man, in his own language, he claimed that he had fallen not because of unstable scaffolding, but because his sister in law had "taken the towel his wife and he used after making love". According to this man, his wife's sister had done this in order to cast a spell on him, and this was why he fell off the scaffolding at work.

If we were to work within an ethnopsychiatric approach, we would have to bear in mind that the fall was the fall not of just any man, but of a North African man, a man from that particular world. In order for this North African man to get back onto his feet, we would then have to treat the object; the towel, and not the pathology. This was indeed the only thing the patient was asking for, the only thing he required. Following this new theory, it was realized that such objects (here, the towel), despite their trivial aspect, carry great significance within the context of the patient's community. The suggestion, in a discussion with psychiatrists, that the patient fell because of the towel his sister in law used to put a curse on him, would quickly be labelled as a superstition. On the other hand, this psychiatric circle is not the patient's community. If one were to enter a mosque and suggest the same, one would be greeted with solemn acknowledgement, from every man, that there are evil people in this world.

The object therefore identifies the community, and is of fundamental importance to the process of socialization. To claim that the man fell because he has a psychological problem amounts to identifying oneself as belonging to another, foreign community, thereby excluding the patient's own environment. Torn from his own community and expected by a foreign psychiatrist to stand in alien surroundings, the patient is fated to fall again and again.

Conclusion: suffering and its healing

One way to understand the traumatized is to consider them as individually fighting a war which concerns an entire people. One way to explain this man's fall would be to blame his accident on the fact that France does not want to accept blame. This might seem strange, and yet it makes sense if we remember that France colonized Algeria. At the time, Jules Ferry¹ led his country into colonialism because he did not want to educate only the French, but the entire world. His colonization of Algeria was partly motivated by his wish to spread literacy in Africa. Despite these ostensibly altruistic intentions, Algeria revolted and became independent, though poor. Many impoverished Algerians moved to France to work and provide for their families, and at one point or another, in any sense, one of these might have fallen. It is when these hurt Algerians seek professional help that a conflict occurs because, in effect, the professional response they are likely to get carries on the work of Jules

1 (1832-1893) France's Minister of Education, then Prime Minister who established the modern, secular French school system and instituted schooling for every French child. He was an exponent of imperialism and directed his country's colonial expansion into several countries, among them Algeria.

Ferry, proponent of education and colonialism. In effect, the physician or psychiatrist who expects an Algerian to heal by way of state of the art western interventions is asking the patient to read and write, to submit to French supremacy, to sustain, as an isolated expatriate, the same kind of aggression he survived in Algeria: to sustain at an individual level, an attack directed at anentire people.

Once this becomes clear, it follows that a traumatized person might be healed by reversing this last process, by directing the assault away from the individual and back to the people. This was attempted in Armenia, where we went with Médecins Sans Frontières France to work with the traumatized after the earthquake of 1988. Before intervening people within conventional “Western” methods, we asked the local professionals how Armenians treated anxiety before Soviet occupation. Since few remembered, our team was referred to Armenian ethnologists, and these, when found, were included in a round-table discussion. As the conversation turned to ancestral healing practices, some of the professionals remembered that for fears and anxiety, doctors would prescribe the urine of a virgin woman, applied as ointment. When we accepted this idea, agreeing that it was much less expensive than Prozac, we found that the very act of unearthing these elements within a professional discussion, amongst professional therapists suddenly changed the perspective, the situation. Another kind of discourse suddenly emerged from hiding, and it is this open exchange that we should strive to undertake in Pristina, amongst local families.

This ethnopsychiatric approach can only be learned or understood through practice. It requires a training programme that begins within the families while, in these families’ own language, we seek resource people to tell us how Kosovars traditionally dealt with fear and anxiety. This third party of professionals-by-origin might remember approaches used before the arrival of psychiatrists who are, in truth, of little important to that world of rich traditions. We, as professionals, might thus be led into another dimension, where terrifying beings “captured” the traumatized. We might find ourselves having recourse to amulets or older rituals, and yet these are the elements that we must fuse with our approach, or at least discuss. As we work this way with family after family, and bring together all manner of experts, from psychiatrists, to anthropologists, to all “resource people” with knowledge about pre-psychiatric healing in Kosovo, we might then presume to assist, even as we learn. Beyond our conventional pre-absorbed Western methods and foreign approaches, we must strive, at each interaction, to unite all these different professionals around each single family.

The Exiled Body

Altrimenti*

The *Exiled Body* theatre project was originally created as a distinct unit of *The Archives of Memory*, within the larger Psychosocial and Trauma Response in Kosovo project. Its purpose was to apply theatre techniques to investigate the memory of the body.

The work of *The Exiled Body* resulted in several projects, which were completed at the end of the course:

1. A photography exhibition documenting the activities which took place inside the theatre workshops;
2. A filmed documentary with a structure similar to that of the exhibition;
3. Video and written records of the theatrical exercises performed during the first three weeks of the project;
4. A theatrical performance based on the collaboration between the Altrimenti group and the counsellors.

The theatre project itself consisted of three levels. On the first, participants explored

* *Altrimenti*, which means otherwise, another way, is the name of the cultural association that implemented the theatrical part of the project. The three participants for *Altrimenti* were Anna Fascendini, Alessandra Ghiglione and Michele Losi. This paper was written by Michele Losi.

personal experiences using body language as a non-verbal means of communication. On the second, they were trained to acquire the skills and methods necessary to perform “theatrical interventions” in an environment of post-war trauma. Finally, the course provided them with tools that they could use in the workshops.

Beginning with Tobie Nathan’s definition of trauma as “suffering individually a war which was directed to a group”, the theatre work becomes important in that it provides a possible means of deflecting this conflict and its dynamic of trauma. Just as art functions with symbols and signs, theatre specifically emphasizes space and the relationship between actors and audience. Ritual is vital to theatre work and verbal communication is no longer predominant in the reaction. By making use of the mechanisms specific to theatre, we are given the opportunity to reverse the thrust of trauma, raising a suffering that might be imprisoned in the heart or body of the individual to the dimension of the collective.

Our work, at first, consisted mainly in observing the responses and messages communicated by the body through gesture and action. During *Altrimenti*’s first workshop in Kosovo, these theatrical exercises and improvisations helped both counsellors and tutors to free latent energies, driving them to change the focus and weight of trauma from the individual to the group, according to Nathan’s definition.

A plain example of this shift occurred on the last day of activity. After an improvisation staging a wedding that had become a funeral, and during the time allotted to feedback, some of the counsellors claimed that for the first time since the end of the conflict, they were able to sing. After a ritual of collective mourning, one of the counsellors found that for the first time, he was able to speak of the 170 dead bodies he had been forced to identify during the war, others then chose this story to represent their experiences of the conflict.

Through this theatrical work, which seems to reverse the course of trauma away from the individual, it seemed possible to accelerate and magnify the benefits of therapeutic work. What should be emphasized, however, is that the theatre work is not a scientific or therapeutic approach but an artistic one, based on the complexity of signs and movements, on actions, as well as words.

Why theatre?

Most victims of traumatic experiences are unable to speak comfortably of their situation. Furthermore, most people who find themselves uprooted from a once relatively stable social, psychological and material environment are inhibited by emotional doubts and uncertainties. Since theatre acts on a different plane of communication and without the restraint of verbal mediation, the process of acting

reverberates throughout the body, reaching the individuals at the deepest levels of their hidden persona. Moreover, since acting requires a certain stagecraft, or *mise-en-scène*, people are helped, through theatre play, to find and display the roots of their suffering, joy and pain.

The process

1. Preliminary meeting

As a “contractual exchange” between trainees and counsellors, the first period of the project was very important. During that time, the expectations and motivations of both parties were outlined and the goals and limitations of the project defined.

2. The methods

As the focus of the workshop is the memory of the body, both movement and gesture are emphasized over the words generally employed for conventional recollection and conversation. During the first phase of the theatre project, the 40 trainees were thus provided with guidelines for working with and understanding body language.

The training workshop was divided into three parts. The first focused on the acquisition of bodily self-consciousness, in order to control the body as it responds to internal and external commands. The next segment of the training attempted to impart the ability for enhanced listening and for interpreting or creating expressive physical actions. Lastly, the third phase consisted in the search, through sequences of movements, for personal elements, which might then be related to a specific historical and social context, present in each individual’s actions.

At the beginning of the workshop, the actors of Altrimenti performed two plays, *Ali* (Wings) and *Per Amore* (For Love), where they explained the purpose of their work and presented their theatrical (and personal) backgrounds. What should be made clear, however, is that the aim of the workshop is the creation of a play, not a segment of psychiatric drama. This play, performed at the end of the activities, will then become the foundation stone of the next trainee workshop.

One essential element of this theatre workshop has been the documentation, through video and photography, of the workshop’s internal activities and of everyday life outside the university: some trainees were asked to leave the site with the cameraman, in order to “discover” the city’s landmarks and histories.

This first part of the work belongs to a wider project that has led to the creation of a play. The play, along with the technical skills acquired by the 40 trainees, will become a valuable tool for contribution in schools, for instance. Moreover, like the photographic and video documents, the play may later be presented throughout Kosovo and across the international community. The physical theatrical exercises used within The Exiled Body workshop might also be used as means of recounting some of the experiences and ideas brought forth during the other parts of the programme to a wider public. In this last aspect, the theatre is particularly effective, as a medium allowing for direct contact with an audience.

Topics explored

The themes explored during the workshop include “Memory”, as defined by space and body; the “Theatre”, as an opportunity to win back for the community what was thought to be lost, and to destroy loneliness at its roots; Gaining recognition for the conflict and its images; “Borderline”, theatre of uneasiness and work on the Missing; “Body”, the role of rhythm, ritual and collective consciousness, the changing of the body, as a first witness to violence; and “Not to forget”, the role of fear in our own history, and the family, as foundation of the social structure.

Direction

The main goals of *The Exiled Body* were:

1. Providing the opportunity of a new and effective means of connecting the individual experience with the collective discourse on war, exile and return;
2. Training the 40 counsellors of The Psychosocial and Trauma Response in Kosovo project to use and understand the potential of this valuable tool;
3. Disseminating the results of the work done within the training groups by making the research and training of 40 participants accessible to anyone in Kosovo;
4. Producing one or more plays, to be staged in Kosovo and in other countries;
5. Documenting observations, results and achievements in order to contribute to the discourse of war and suffering, particularly with the video documentaries and photography exhibition;
6. Establishing in the field a method for future work with theatre tools, exercises and records, as well as their functions and roles in such a particular environment.

Videos and photography

The video and photographic documentation is an integral part of the theatre workshops and was originally included to fulfil several aims:

- To document what has been done in order to create an archive of our experiences;
- To make the workings of each workshop available to the group for suggestions, commentary, ideas;
- To work with different playwrights, focusing on fragments of videos to polish different stories with different editing;
- To objectify the work done and thus create an inner distance with it, as it is important to the programme that each actor also learn to be a spectator;
- To document each counsellor's reality and vision of the conflict, in order to link their experience to what took place within the workshop.

Videos will be used in the preparation of some of the materials of the final performance as well as to shoot documentaries to illustrate what has been accomplished, so that as a result of our work with the theatre, we might carry our learning towards its future need.

The Archives of Memory, from the
experience of
the individual to the
conscience of the collective

Silvia Salvatici*

The Archives
in their context

Ever since its creation, *The Archives of Memory* has been closely affiliated with IOM's larger *Psychosocial and Trauma Response in Kosovo* project. The aim of this larger project was to create a structure of response for the emerging psychosocial needs of the population, following their experiences of war, exile and return. In this setting, *The Archives of Memory* were conceived as places devoted to both the preservation and dissemination of the different kinds of "documents" (a term that should be given the widest possible meaning) remaining from the Kosovo conflict.

At the base of this project, the production, collection and circulation of the documented memory, was the idea that the material could serve as a necessary preparation and precipitant for further sharing of painful stories, which had generally been restricted to the experience and memory of their individual actors. The project was therefore intended to ensure that the stories of suffering and distress created by war, displacement and return could be expressed and preserved within their

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sociocultural context. However, the Archives were also conceived to be open, lively and dynamic places, and to relate to their social context in a mutual exchange, reflecting and interacting with the changing environment.

Their potential social impact was attributed mainly to the importance of conserving and transmitting memory, at a time when identities individual and collective are being constructed. This was understood to become even more important as the collective identity began to crystallize, forming itself into a supportive structure to strengthen the mental health of its individuals.

Created from these assumptions, the Archives were intended to preserve only the materials produced during the training course. Most of these “documents” were to be taken from the first phase of the project, from interviews, group talks, focus-group interactions, videos, discussions and other activities aspired to bring forth war experiences from individuals and groups.

According to the original plan, the collection of documents preserved in *The Archives of Memory* stretched beyond the events in Kosovo. Experiences from all war-torn areas and stories from every aspect of the conflict were collected, then added to more interviews and materials (like videos and pictures) gathered throughout the region. Beyond the villages, cities and rural communities, the research reached even across the borders of Kosovo, following particularly upon the paths of wartime and post-war migration flows, and into the host countries. Interviews were collected in Italy and the Federal Republic of Yugoslavia, gathered intentionally from refugees of different ethnic groups (Albanian and Roma in Italy, Serbian in Serbia).

Each of these different subjects were found to bear different memories, and these many voices and narratives added to power of a common, complex memory, when they would otherwise have been left divided. By reconstructing these voices, thus hindering the imposition of a monolithic, “public” memory, we sought to avoid traumatizing those who would be excluded from the “official” recollection. The aim also was to avoid the risk of a monochromatic memory that reflects only upon itself and its actors, perenniating a form of isolation at individual or collective levels. By mingling memories from different sides of the conflict, we also gave the subjects a chance to know themselves through the perception of others, strengthening both the individual and the collective in their awareness of their own identity.

Another purpose of the Archives was the collection and preservation of documents already produced during the war, not only those issued by local and international organizations or institutions, but the accounts of ordinary people. This included interviews, pictures and videos, as well as letters, diaries and memoirs. As it had occurred in other regions affected by war, these materials were plentiful, as during

the conflict, people had become eager to share their experiences. Many wanted to offer their own painful memories to future readers, others were unable to contain the strength of their emotions without committing them to written words, and even at the beginning of the course, three diaries were yielded from its participants.

Expanding the project: beyond the war

Throughout its creation, the *Archives of Memory* was influenced by the training course: they were constructed along with the beginning of the training, and results from the students' work on memory guided us, step by step, as we translated our initial plan into concrete activities. Their research, both amongst themselves and on the field, served as feedback for the Archives' development. As the students gathered interviews and documented experiences of war, exile and return, they collected also new and significant ideas on methods, contents and future uses for the Archives.

Another result of their work was the empirical confirmation of the importance of memory. While notions of psychopathology and post-war trauma are understood only in narrow clinical definitions and theories, memory, lived experiences and re-collected pasts serve to redefine these theories into concrete terms of "healing" and "illness". Thus brought into the discussion in individual stories, these human reactions could be universally understood, even as events were experienced and "processed" within the specific sociocultural context of the interviewees.

It was also realized that in order for the Archives to be successful, the parameters of our research had to be extended beyond the context of war, exile and return. We had to search further, both chronologically (extending the time span to the period before the conflict, searching into the present and anticipating the future), and by further investigating the pathways of memory.

The students' research further contributed to our understanding of past events and their importance. In the testimonies collected by the students amongst themselves and on the field, the past and its recollection were both characterized by affliction, pain and anguish. This was clearly shown in a conversation with Valon, a 12 years old boy who survived a firing squad but was seriously wounded:

- _ "What is bothering you?", he was asked,
- _ "Everything", he replied.
- _ "For example? Can you be more precise?"
- _ "I always wander around in my memory."
- _ "What do you think about?"
- _ "About that day only."

The narration of these memories infused with pain became a way to express anguish, to see and face its consequences in the present. In this particular case, the links between past and present were important, yet sometimes conflictual, when the present held with it images of peace and freedom. As these first interviews suggest, live emotions still remain and there is still a strong necessity to alleviate their sting.

Still another insight gained from the students' research concerned the source of this all-important past: during the plenary discussion held following their fieldwork, students suggested that our research be extended to the period of "confrontation without weapons", ten years before the conflict. While every individual "memory path" seemed to lead inexorably to the war, with all the dramatic outcomes and side effects that brought the Kosovo issue to the forefront of international attention, the sources of suffering were often found far before the conflict came to mediatic attention. It would therefore be important for us, as interviewees, to overcome this fixation with the war, in order to analyse long-term distress in the individual or the community.

A project created: the Archives at present

The *Archives of the Memory* are thus a place where past experiences might be experienced again, as a new way to understand the present, and yet this library of retrospection also holds hopes for the future. We have been impressed by the enthusiastic welcome of both students and interviewees to the idea of this archive, and perceived it as the possibility to externalize their experience of sorrow, in order, somehow, to eternalize it. The knowledge that such an experience will not be forgotten, and therefore has not been insignificant, is a worthy tool for survivors who face the anguish of the present. Given time to explore this, their perception of their past, and to make use of the other archived memories, these people might also teach us about the value of memory. As they understand which aspect of their past they choose to transmit into the future and which part of their memory will enrich and support their present. The Archives provide a justification of their suffering that makes this pain more tolerable and becomes a supportive force, as they begin to build their identity. The re-creation of their selves is also something one should learn from, so that we might apply our understanding to the changes brought about by the war; from the transformation of social roles and power relations, to the weighty presence of the so-called international community.

As we moved from the understanding we acquired in the first phase of the course, a framework for the Archives' interviews was designed. This framework is purposefully not centered solely on the war but extends its interests toward many other aspects of the memories, like the individual and family contexts; the local

interrelation of the communities; the gap between the normalizing public discourse and the intensity of the popular experience of war, displacement, return; the coping strategies and the emergence of suffering in the individual; the familiar, generational, gender-related, and community-oriented dimensions of life; the narrative and discourse of suffering and healing, within this particular sociocultural and historical environment; the interrelation of strategies, past and current, with discourses of identity; the people's own accounts of the Kosovars' current situation, as it compares to both their perceptions and expectations and to accounts of past and present experiences of coexistence between ethnic groups; and, finally, the perspectives, their dreams, their desires, and their projects for a future Kosovar society. In the cases when "documents" are collected abroad, amongst Kosovar refugees of different ethnic groups, this framework includes still more questions, such as the relationship between the refugees and their host countries.

Following the experience of the first module, the interview framework was not conceived as a rigid questionnaire, but as a set of topics that might be covered during conversation. Some additional points, however, taken from the students' observations and practice on the field, were included as guidelines, to be considered while memories are collected:

1. That the word "interview" should be replaced by "conversation", thereby granting all participants in the interaction equal status;
2. That no dialogue should be forced into a specific shape: during conversation, it is always restraining to follow strictly a pre-arranged questioning scheme. The conversation can and should be altered according to the contributions of the interviewee, who is then rightly allowed the important role of leading the interaction.

Other suggestions concerned the set-up of the interview/conversations, and particularly the importance of the cultural context. Relationships with family members, the choice of location or the layout of a space will all have an immediate effect upon the interaction. Before their conversation with 12 years old survivor Valon, for instance, the group of interviewers spoke first with his old grandfather, traditionally acknowledged as the head of the family. In other cases, they always chose their positions according to traditional gender or family relations: when members of the group conversed with someone of their own sex, they would sit close to their interviewee. In the opposite case, they would remain at a certain distance. In an interview with a rural family living in a distant village near Suva Reka, the patriarch sat in the middle of the room while other family members and the interviewers sat in a circle around him, with their backs to the walls of the room, according to traditional space and seating arrangements.

Conclusion: the future of the Archives

While the initial phase of the Archives was successful in yielding a first collection of materials, the work also indicated some of their possible applications. A plenary session held so that the video-recordings of the interviews could be shared between groups, for example, allowed the students to understand the differences and commonalities of the experiences, to evaluate subjective reactions to similar approaches, and to learn the different methods or solutions which were effective in a given case. As our methods are thus improved by our experience, we might believe that the archived documents can likewise become tools in the hands of the counsellors, once they begin to practice, or that they can be used as fundamental documents in psychosocial training activities.

Finally, there might be one added dimension to *The Archives of Memory*: the active importance they will have as Kosovar people rebuild their identity. In this context, though the impact of these materials would be less direct, and their function less perceptible, they remain closely and profoundly integrated with the response to the psychosocial needs of a people, a response that the project in Kosovo will strive to share with the society entire.

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Annex

The activities implemented through the project can be divided into three main categories: didactics, direct assistance and research.

Didactics

- The teaching activities included:

- 37 students trained in 5 different periods;
- 532 hours of lectures;
- 750 hours of fieldwork.

- The lectures and the fieldwork were supervised by 25 experts coming from eight different institutions and as many different countries.

- Ten local professionals were involved as tutors and provided with updated teaching methods.

- The material produced for future didactic activities (also in other countries) comprises:

- Twelve videos;
- Two booklets;
- One manual.

Direct assistance

- Under the supervision of local and international professionals, the students supported 350 families.

- The individuals thus assisted included, among others, people having experienced multiple losses, raped women, disabled children, and former combatants.

- The area covered by their services included six different municipalities (115 villages).

Research

- Through the project, the following materials were produced:

- Essays on each stage on individual basis or in group;
- Reports on each case;
- Videos on most of the cases;

- Videos and pictures produced during the theatrical stage.
 - Materials collected for *The Archives of the Memory* included:
 - 160 testimonies were collected inside and outside Kosovo, among the different ethnic groups, focusing on the experience of forced migration, suffering and post-war trauma;
 - Diaries, memories, letters, drawings and pictures (all together 140 pieces) produced by ordinary people during the war.
- All the materials are in the original language, translated into English and catalogued.
- Two international seminars were organized.

Psychosocial and Trauma Response in War-Torn Societies

The Case of Kosovo

This notebook is a compilation of papers presented at the *First International Seminar on Psychosocial and Trauma Response in Kosovo*, which was held at IOM Geneva, Switzerland, from 8 to 10 March 2000.

Participants to this seminar included international experts and professors from universities and institutions worldwide. The present publication comprises the presentations of the following participants:

- Natale Losi
- Harry Minas
- Mariella Pandolfi
- Roland Littlewood
- Derek Summerfield
- Patrick Bracken
- Lynne Jones
- Jean Marie Lemaire
- Maurice Eisenbruch
- Renos Papadopoulos
- Tobie Nathan
- The Association *Altrimenti*
- Silvia Salvatici