

Charles David Tauber  
M.D. Head of Mission  
Coalition for Work With Psychotrauma and Peace, Vukovar, Croatia

## **Work in Eastern Croatia, Northern Bosnia and Vojvodina: Results and Perspectives for a Community-Based Model of Complex Rehabilitation**

### **Background**

The Coalition for Work With Psychotrauma and Peace has worked in roughly 25 locations in eastern Croatia, northern Bosnia and Vojvodina since 1995. The impetus for starting the Coalition was a meeting of the so called Balkan Group of the International Physicians for the Prevention of Nuclear War (currently the Medical Network for Social Reconstruction in the Former Yugoslavia) in the spring of 1994 near Budapest, Hungary at which an appeal was made for foreign organizations to look closely at possible programs which would be adapted to local conditions, which would include psychological and medical aspects, non-violent conflict resolution aspects, and community building aspects of the situation, and which would seek to empower local groups. In 1995 t an assessment mission was carried out.

The CWWPP has been working in Eastern Croatia since 1996, in Brcko since 1997, and has had a small presence in Vojvodina and in the Posavina region of Bosnia Herzegovina.

The mandate of the CWWPP is the empowerment of people to take control of their own lives, particularly at local level.

The issues with which the CWWPP is involved include:

1. health, in particular the widespread psychotraumatization of the population and in its effects on the rebuilding of society and the prevention of future conflict;
2. techniques of non violent conflict resolution and conflict prevention;
3. community building and social reconstruction, including
4. the encouragement of the people to take initiatives for themselves;
5. return;
6. human rights, particularly in conjunction with the complex rehabilitation of torture victims and other victims of violations of human rights; and
7. reconciliation.

**Aims:** The initial aim of this work was to train professionals and non-professionals at village level in techniques of psychotrauma and non-violent conflict resolution. However, this changed considerably in the course of the work (see "Conclusions" below).

**Method:** Both "village" or "client" groups and (semi-) professional groups were held. Group sessions lasted from 2-4 hours. Groups were conducted weekly. The majority of groups were of single ethnicity. The groups included persons of Serb, Croat and "Bosniak" ("Moslem") ethnicity as well as persons who were the result of mixed marriages and/or who were currently in mixed marriages. It is estimated that roughly 80% of the participants had at least one relative of third degree or less of another ethnicity. In general, groups included long-term residents as well as refugees and internally displaced persons. No criteria for participation

were set with regard to ethnicity or residential status. An effort was made to include individuals who had been mistreated.. The median lifetime of both types of groups was about two years, but ranged from 6 months to 3 years. Groups were organized in the first instance through interaction with a local intermediary, that is, a local doctor, social worker, teacher, leader of a refugee group, or other person. Such referrals were given by international or local organizations or locally known contacts. All groups were conducted in local language.

### *Village or Client Groups*

A total of 26 such groups were conducted, 14 in the region of Osijek-Eastern Slavonia-Baranja, 8 in the Brcko region of Bosnia, 2 in other areas of northern Bosnia, and two in the Vojvodina Province of the Federal Republic of Yugoslavia. Conditions under which the groups were conducted varied very considerably. Some were held in municipal facilities, others were held in the offices of other groups, others in private homes (the majority) and few under unconventional circumstances such as in cafes. Roughly 60% of the participants were female, though several of the groups were exclusively male. The age range within the groups was also extremely broad, from 18-80 with a median of about 40. Again, there were exceptions, and in at least two cases the median was below 30. The educational level also varied considerably within and between groups. Some persons taking part were illiterate while others had at least several years of post-secondary education and a few were (semi-) professionals. The size of the groups ranged from 3-25 with a median of 12.

During the first session of a group, the intention of the sessions was explained fully. At first, this intention was to deal exclusively with psychotrauma. This intention changed within the first 3 months of working to dealing with the problems seen by the participants themselves. The goal, however, was always to move in the directions of work with psychotrauma, in particular where human rights were concerned, non-violent conflict resolution, and reconciliation, even when "back doors" needed to be used at first. Still another goal was to try to understand the problems of the local population and to adapt the program to those sometimes rapidly changing needs, still keeping in mind the long-term perspectives.

An introduction procedure was also used during the first session of the groups. Persons were invited to tell as much or as little about themselves as they desired. Also, during this procedure, participants were assured of the confidentiality of what they said and were encouraged to express their emotions.

During the first and all subsequent sessions, participants were invited to discuss events in their own lives which were of concern to them.

The further topic of the group discussion was usually defined by this introductory period. Otherwise, the group as a whole decided on the topic, sometimes with suggestions from the leadership.

Leadership, at first, was held by the author of this paper who is a physician who has had experience in psychological and physical assistance to refugees and asylum seekers since 1988. Later, once leadership skills were learned, leadership was devolved to group members. In a few cases, leadership was carried out jointly with another professional.

Because of the problem of confidence building, in some of the more sensitive areas in which the groups were conducted, statistical data was collected only on a sporadic basis.

### *(Semi-) Professional Groups*

A total of 12 such groups were carried out in the period covered by this paper. Of these, 6 were in the region Osijek-Eastern Slavonia-Baranja, 2 were in the Brcko region of northern Bosnia, 1 was in another area of northern Bosnia (Modrica), and 1 was in the Vojvodina Province of the Federal Republic of Yugoslavia. The participants included pedagogues, teachers, psychologists, "defectologists" (professionals dealing with the physical and mental handicaps of children), social workers, sociologists, psychiatrists and other health professionals. Two groups of theology students, also participated in these groups. The age range was 20-60, with a median of about 45. Roughly 70% of participants were female. Group size ranged from 5-20 with a median of 10.

In general, the groups were held as open seminars. During the first session, participants were invited to introduce themselves. During subsequent sessions, the program consisted of work on introductory "golden rules" (these are postulates which the author of this paper finds necessary for work with clients and client groups, which are sometimes mildly provocative and which provide the basis for an introductory discussion, also allowing the participants to get to know one another professionally and personally), individual and group communication, and the theory and practice of work with psychotrauma, non-violent conflict resolution/transformation, and community development.

As with client groups, at the beginning of each session, participants were invited to discuss issues relevant to their work or their own lives. This frequently determined the course of the remainder of the session and sometimes subsequent sessions.

A great deal of room was given for feedback and discussion of the issues relevant to the theory and practice of the topics noted two paragraphs earlier and for input by the participants.

### *Individual Clients*

A total of 19 individual clients were dealt with during the period covered by this paper. Of these, 10 were in the region of Osijek-Eastern Slavonia-Baranja, 5 were in the Brcko region of northern Bosnia, and 1 was in the Vojvodina Province of the Federal Republic of Yugoslavia. The age range was from 25-70, with a median of about 35. Virtually all were either refugees or internally displaced persons, as defined under client groups. The educational level ranged from two years of secondary school to a professional psychologist.

The majority of clients were referred by members of groups, other clients, or groups or by individuals in contact with the CWWPP in other ways.

Cognitive counseling techniques were used in all cases. In general, the counseling was carried out in the home of the client, although in 4 cases of clients living in the Vukovar region it was carried out in the offices of the CWWPP. Duration of the counseling was from 6 months to 2 years with a median of 16 months.

## **Results**

Issues dealt with in the groups included loss, mistreatment, denial, blocked mourning, inability or inexperience in expressing feelings, effects of previous traumatization, identity, coping mechanisms, addiction, family violence, physical health, skills of communication,

skills of democratization, individual responsibility, initiative, reconciliation, return, non-violent conflict resolution and economics. The (semi-) professional groups dealt with the adaptation of the concepts of traumatization to conflict and post-conflict situations.

#### *Village or Client Groups*

Few quantitative data are available for these groups. A total of roughly 300 persons were dealt with, however.

The length of time required to establish a coherent group also varied very considerably. It ranged from one week to 18 months. The median time was about four months. This issue will be dealt with in more detail in the Discussion section.

Important qualitative issues arising from the groups were as follows:

1. **Loss.** Virtually all participants in the groups had encountered a loss of some type—in many cases, a close relative. This was extreme in some cases, one woman having noted that 25 "close" relatives had been lost. There were also losses of close friends and colleagues.

A second category of loss was that of material goods, including their homes and belonging and highly personal items, particularly but not exclusively among refugees and internally displaced persons.

A third category of loss was that of economic stability. This was universal.

2. In virtually all cases, losses were multiple and of multiple types.

3. **Mistreatment.** A number of the groups included persons who were severely mistreated. In these cases, an attempt was made to carry out group counseling. This was more commonly present in the Brcko area than in Croatia and was more common among men than women, but it was a significant issue in virtually all groups. A small number of groups consisted exclusively of such persons.

4. **Denial.** A large proportion of the population we dealt with seemed to be in a state of denial with regard to their losses and their feelings during the initial phases of the groups. Frequently, such denial was displaced onto economic issues and/or issues of return of the persons to their previous homes. Thus statements like, "If I only get a job everything will be fine" and "If I get back home there won't be anything to worry about" were common. In many cases, such statements indicated a lack of recognition and acceptance of the reality of the situation. In the majority of cases, as confidence was gained in both the leadership and the other participants, this began change and feelings began to be expressed.

5. **Blocked mourning.** This is related to the previous issue. Many of the group participants had not mourned for their losses, and the mourning seemed to be blocked. Again, in the course of time, in a large number of cases, it was possible to break through these blockages.

6. **Inability/inexperience in expressing feelings.** We did see evident cultural differences in this problem, although this is an issue which needs to be looked at more closely in future work.

7. Residual effects of previous traumatization. Such effects were seen in the majority of older persons who had lived through the Second World War. There were also clear effects caused by the transmission to subsequent generations. Again, this is a point which needs further investigation, particularly with regard to cumulative traumatization, that is, effect of the addition of the new trauma to the transmitted one.
8. Problems of identity. Identity was virtually a universal topic within these groups, and many sessions were spent on it. There was a clear relationship to loss. Furthermore, self-image was, in the majority of cases, very narrowly defined in terms of ethnicity and economic status. One function which the groups served was to assist the clients in redefining their identities.
9. Coping Mechanisms. Mechanisms used both during the War and under the current post-conflict conditions were discussed. Many of these indicated a passive mode of reaction. Further work is clearly needed on this issue.
10. Problems of addiction. Cigarettes and alcohol are the prime culprits here. No precise data are available, but, from our experience, we estimate that the levels of alcoholism in the locations in which we worked was higher than 50%. The use of tobacco was virtually universal. Most participants admitted that this was used as a tranquilizer. Furthermore, many participants admitted to addiction to drugs which had either been prescribed or which had been bought at a pharmacy. The predominant type of drug in this context was tranquilizers, particularly benzodiazepines. In many cases, clients were taking as many as nine different kinds of drugs together with alcohol.
11. Family Violence. During the groups, particularly those with women, participants noted that family violence was a very substantial problem. The victims were frequently, but not exclusively women, children and the elderly. Remarkably, in many cases, the men committing the acts were willing and in some cases asking to undergo treatment.
12. Problems of physical health. Again, this was a universal topic within groups. Stress-related diseases seemed to be highly prevalent. There were many cases of endocrinological problems, circulatory problems, and even cancer in our groups. More work is needed to confirm this impression.
13. Communications skills. In most groups, at first, group communication skills were deficient. With assistance from the leadership, these improved with time, in some cases dramatically. This problem was one which caused a reassessment at the beginning of the work and sometimes led to an initial concentration on this issue.
14. Skills of democratization. During the course of virtually all groups, we were asked at one point or another to approach local, national, or international authorities on issues of human or civil rights, return, and a wide variety of personal and societal issues. It was clear that the skills to approach such authorities in a meaningful way were not present. Education in such skills became a significant part of group activity in a number of cases. Also evident in this context was a general fear of authority as well as the assumption that an authority would carry out all functions required for society. Thus, it became crucial to this aspect of the group to introduce and encourage critical thinking and self-initiative.

15. Individual Responsibility. This issue came up frequently in the context of the previous point and that of reconciliation. There are clearly cultural differences and differences of education with regard to this point.

16. Reconciliation. The expressed levels of disappointment with neighbors and friends as well as with authorities from all sides (their own, the "other" side and internationals) were extremely high. These can be categorized as hatred of "the other" in many cases. Furthermore, this did not come out at first in all groups, as people at some points were telling us what they thought we wanted to hear, though, with the building of confidence, people almost always later felt prepared to express their real feelings. The effect of the group work, at least in a number of instances, was to reduce the level of these feelings of hatred. They were clearly not made extinct, and much more work would be required to reach even the level of coexistence. In several instances, however, members of the group asked for meetings with members of other ethnic groups.

17. Return. Issues of return to the participant's own homes figured clearly in the discussions (see also the issue of democratization above). While it is beyond the scope of this paper to discuss these issues in detail (the CWWPP has produced a position paper on the Obstacles to Return), elements of the barriers included security, the availability of essential services including health care and schooling, economics and demining. The issue of return will also be discussed later in this paper in our approach to Complex Rehabilitation.

18. Non-Violent Conflict Resolution. This issue came up directly in about half the groups worked with. In most others, a start was made with it through the return and reconciliation issues. In several instances, analogies of minority situations were made to the Civil Rights Movement in the USA, and the work of Martin Luther King and Gandhi was discussed.

19. Lack of Confidence in Local, National and International Authorities and the Feeling that They and Their Problems are not Understood by Them. While highly unfortunate, this is a virtually universal feeling among the participants in the groups.

20. Economics. This point again was virtually universal. One of the characteristics of the populations represented in the groups is poverty. Furthermore, the pre-War standard of living, as expressed by the participants, was high. In this context, and in the context of the previous point, the participants blame the groups mentioned in the previous point for inaction or late action. Self-initiative became a key issue in this context (see also the point of democratization above). Great encouragement had to be given to get people to find new methods of supporting themselves through cooperatives, making business plans, or acquiring the skills and knowledge necessary to obtain new work. As would be expected, this point was particularly acute among the elderly.

#### *(Semi-) Professional Groups*

1. In the course of this work, 120 people gained further insight into the issues of psychotrauma in post-conflict regions. We must add here that a large part of the insight involved the discussion and ordering of knowledge which they had already gained through their own experience.

2. Furthermore, in many cases, the group gave the participants the possibility to come together for supervision and intervision. In one particular instance, it served additionally as a

burn-out control group. Also, in the majority of cases, a number of sessions were spent in self-help therapy, dealing with the personal issues of the participants.

3. It must also be noted that these groups were particularly educational for us as well as for the participants, and that, though these groups, we learned a great deal more about the nature of psychotrauma in (post-) conflict regions.

Issues discussed included:

- a. The general course of psychotraumatic experiences and their phases.
- b. The problem of definition of what is a "normal" consequence of such experiences and what is pathological, particularly in the regions in which the groups took place. These discussions included various levels, that is, those of the individual, the family, the group, the community and the society.
- c. The problems of intensive, multi-causal, multiple psychotrauma.
- d. The specific problems of children and youth traumatized by war.
- e. The relationship of psychological trauma and physical illness in (post-) conflict situations.
- f. The problems of professionals dealing with trauma including supervision and intervention.
- g. The relationship of psychotrauma to non-violent conflict resolution and peacemaking under the circumstances prevalent at the time of the group.
- h. The relationship of psychotrauma to economic (re-) development.
- i. The relationship of the direct experiences of the participants to the material which they had learned through their educational processes or through literature, and the need for revision of concepts. This discussion applied to conflict resolution (which some had studied) as well as to psychological aspects of the situation.
- j. Support for their work from local, national, and international authorities, both on a professional level and in terms of funding. Most participants did not feel that they were getting the required support in either manner.
- k. The need for more research – which the participants of these groups would be willing and able to carry out – on all of the above issues.

### *Clients*

A large proportion of the client population had been severely mistreated both physically and psychologically. Others had been under high stress through processes of the War – loss as given above – becoming refugees, migration to other countries and refusal of refugee status there, etc. About half had had important life events in their pre-War situations which, in our view, substantially contributed to their symptomatology.

Many clients either had no health insurance or could not obtain proper (mental) health care from other sources. The majority did not wish psychopharmacological treatment, although it had been prescribed in a number of cases. In many instances, we were the only alternative left to them, which made our position sometimes uncomfortable in dealing with clients who, in our judgement, either needed inpatient treatment or who required far more intensive care than we were able to provide. Although, in such cases, we attempted to persuade clients to obtain such treatment, all subsequently returned to us claiming that they had nowhere else to turn. We also found ourselves refusing a number of potential clients because of lack of capacity.

Presenting symptomatology included depression (in two cases with the threat of suicide), anxiety, aggression, physical symptoms which had been diagnosed by a physician as psychologically based, sleeplessness, preoccupation with the previous events, and, in one client, mild visual and auditory hallucinations.

Issues dealt with during counseling included items 1-10, 13, 15 and 18 as given under "Client Groups" above. In cases where important life events were present in the pre-War lives of the clients, these proved to be significant factors contributing to their distress. Relational problems were present in virtually all cases. PTSD and the similar syndromes as defined in the DSM-IV and the ICD 10 were also present in virtually all clients, but so were many additional psychological and physical syndromes.

Significant improvement in functioning was seen in all clients, in some cases after only a few sessions but, in the majority, after at least two months of weekly counseling. It should be noted here that the issues dealt with concerned not only the trauma but also the entire life history of the client and the context of the trauma within that history.

## **Discussion**

A number of issues arose in the course of the work which bear further elucidation:

1. Vision of the work; the relationship of issues to one another. It quickly became clear to us (within the first three months of fieldwork) that it was not possible to deal with one issue in isolation to others. Thus, psychotrauma, non-violent conflict resolution, human rights, communications, economics, democratization and community development and several other issues are inter-related and must be dealt with as a whole. This requires skills and knowledge from a variety of fields and thus requires cooperation between local, national and international agencies.
2. Situational difficulties. It is not always easy to find appropriate locations to carry out group work or individual counseling. While work in private homes has its advantages, it is also subject to interruptions and to the problems of privacy. In some cases, the problems led to our even carrying out work in cafes and other public locations, particularly but not exclusively during the first stages of group or client contact. This had the obvious disadvantage of problems with privacy but had the advantage of making known the type of work we were doing. Thus, difficult compromises must frequently be made if clients and groups are to be reached at all.
3. Problems of confidence building. Establishment of a relationship with a group was frequently a time-consuming process, taking up to 18 months of intermediate visitation in one instance. This is a function of the location of the group and its history, of the internal (to the community) organizer of the group and of changing political factors within the region. The point to be made here is that, if meaningful work is to be done at grassroots level, the researcher/field worker as well as the organization involved must have persistence and patience in pursuing their goals.
4. Time and intensity constraints on group and individual work. One of the problems which was found was that workload with a specific group or individual was not constant. Once the group began to operate, this workload increased exponentially. The same was true of

individuals. Many of the clients coming to us required far more intensive counseling than we were able to provide because of our workload.

5. Problem of Capacity. Closely related to the previous point is the problem of capacity. The gap between the need for the kind of work described in this paper and the capacity of persons to carry it out is enormous. This is not a problem of availability of trained or trainable persons. As has been indicated in the section on the results of the work with (semi-) professional groups, skills and knowledge are present within the region. Other persons could be trained within a relatively short period of time. Thus, the problem of capacity relates to the degree to which such programs can be funded.

A similar problem is present in the care system of the regions involved. The professionals who are employed are overworked and thus there is a gap between need and what could be termed adequate care. There is thus sometimes the tendency, for example, to prescribe medication rather than to carry out counseling or psychotherapy simply because of time factors. There is also a need within the region for further education of professionals and semi-professionals and for the establishment of systems of supervision and intervision.

Furthermore, as was indicated under the results section for clients, many persons are currently uninsured and thus have no access to care or to medication.

One solutions which we see to this critical problem of capacity is peer group counseling, that is, the training of some members of the affected group to counsel others. This has the advantage that there is virtually immediate trust between the counselor or group leader and those being counseled. It also has the advantage of scale, that is, that it is possible to train such people within a relatively short period of time. Of course, it is obligatory that there be adequate training and supervision of such peer counselors. We feel that this type of solution may be appropriate to a wide variety of types of groups.

6. Professional issues are summarized below. A number of these have been dealt with in the results section.

- a. A lack of epidemiological data on either mental or physical health. Such data simply does not exist, or exist such as to be of only partial assistance in practical and research program planning. There are many specific groups which warrant particular study,
- b. Problems with extreme levels of loss, as described above.
- c. Problems with high levels of mistreatment. We estimate, from evidence given to us by local ngos and refugee groups as well as from our beneficiaries that, depending on location, some 5-15% of the population has undergone severe physical mistreatment. This obviously requires special measures in terms of treatment. Furthermore, there are regions in which massive human rights violations have taken place, again requiring highly specific measures. .
- d. Problems with denial and displacement. This problem has been described in the results section for client groups.
- e. Problems with mourning. Mourning is essential if people are to deal with their losses. Again, detail has been given in the results section for client groups above. We feel that there is a need to carry out further research into mourning after trauma and into the cultural correlates of such mourning.
- f. Problems with pre-morbid personality and problems. There seems to be a high level of pre-morbid problems which influence the reaction to the trauma.

- g. Inadequate ability to express feelings. This seems to be a common phenomenon. The mechanism here seems to be to bottle up feelings and not even admit them to the self. Thus, the risk of explosion or implosion is extremely high. We feel that this may, in fact, be an important factor in the violence which has taken place in this region. Obviously, much more work on this issue is required.
- h. Inadequate processing of previous traumas and transmission of previous traumas. This issue brings up the problem of cumulative traumatization, that is, how a transmitted trauma adds to the problems caused by traumatization experienced by the person him/herself and how the reaction to a number of such trauma accumulates. Again, this is an area for further work.
- i. Inadequate coping mechanisms. It has already been mentioned that people in the areas in which we work tend to bottle up their feelings. We feel that it is essential to make a study of the coping mechanisms which have been used during both the conflict and post-conflict periods (and, if possible to determine those mechanisms used during the pre-conflict period) to find out which are those most effective and which are ineffective, and to teach the former. We think that these may have been an important contributing factor to the conflict and to the adaptation to the post-conflict period.
- j. Problems with identity. This key issue has been dealt with above to some extent. Virtually every person whom we have worked with has a problem with identity. It would seem that identity (personal, group, and community) was not always well defined or well understood before the conflicts took place. The strong nationalist propaganda had a destructive effect on personal identity as well as national identity, as a very large number of people here come from mixed families or are in mixed marriages themselves. Furthermore, a great deal of pre-conflict identity seems to have been bound up in material items. We must also not underestimate the scale of the trauma and the losses which have taken place here. These have had the effect that personal, family, group, community, and societal identities have been badly damaged. In our view, this is an extremely important area for further work.
- k. High addiction levels. There are indications from our work that, in some places, alcoholism levels are much higher than 50%. Certainly, nicotine addiction in this region is very high. Furthermore, through the reports of our beneficiaries, we have reason to suspect that there is a high level of addiction to prescription drugs, frequently in combination. This is certainly a point for further investigation and action.
- l. High levels of family violence. As indicated above, this seems to be a serious problem throughout the region. While it does not always come forward spontaneously, when mentioned it is responded to strongly. Victims are, in general, women, children, and the elderly, though this is not always the case. Male perpetrators frequently are willing, or even ask for treatment and indicate that they would participate if it were to be offered. It is now significant that, in a region where such problems are handled within a small social circle, the police and social workers are being notified about them to an increasing degree.
- m. The problems of males. In our experience, the problems of males have been ignored. There are very high traumatization levels among males, particularly among the population of (ex-) soldiers and (ex-) policemen. We have strong indications, from talking to our beneficiaries, to local field workers, to physicians and local health care professionals and others in the caring professions that there are very high levels of suicide and suicide attempts among this group, as well as high levels of other psychological and physical health problems. Again, more research work in this area is required, and treatment programs need to be designed and implemented.

- n. Lack of communications skills. This is, again, a crucial factor in the production of conflict. This lack applies both to inter-personal and group communications skills.
- o. Lack of knowledge of non-violent techniques of conflict resolution. This factor has also, in our view, contributed to the production of conflict in this region.
- p. Lack of skills of democratization (see also point 12 of the results section for client groups). Such skills are urgently required if the societies involved are to evolve democratically.
- q. Lack of self-initiative, lack of critical thinking, and lack of individual responsibility. These are partly problems resulting of inexperience through history, but also are partly problems caused by psychotraumatization.
- r. Reconciliation. It is beyond the scope of this paper to deal with the full range of issues involved in reconciliation. However, it is clear from our experience that, with time, patience and intensive work on issues including but certainly not limited to traumatization, non-violent resolution and human rights, progress at very least toward coexistence is possible. It is clear, however, that superficial programs, many of which have been carried out in the past, do not contribute significantly to this goal and, in fact, might even interfere with it. It is clear, however, that more research on these issues is badly needed.
- s. Return. The same comments given with regard to reconciliation also apply to return. A number of our beneficiaries were returnees. Others were refugees and displaced persons, many of whom were planning to return. It is clear that the return process is an additional trauma for those who undergo it as well as for those present in the community to which those persons are returning. In the following sections on conclusions and perspectives for the future, we shall in more detail with the types of programs which might be considered appropriate for such persons. Certainly, however, more careful planning and more research on this issue is needed.

7. Difficulties of Recognition of the Problem and of Funding, Particularly for Research. One of the chief difficulties which we and other groups and workers in the field have encountered in this work has been that of recognition by governmental and inter-governmental agencies and particularly by funders that the problems described in this paper exist at all or that they of a high priority. As an organization, we have been continually struggling for existence, and we are not alone in this. There seems to be little understanding of what seems to us to be a very simple point, namely that before a program can be implemented efficiently and effectively, sufficient data needs to be present to be able to plan for that program. A further point here is that both successes and mistakes need to be transmitted to other programs, again to make them more efficient. Thus, the entire issue of research has been derogated whereas, in our view, it is crucial.

### **Further Conclusions**

- 1. A number of seriously affected groups have been ignored. The three groups which come to mind most readily are:
  - a. Men, including ex-soldiers and policemen who have frequently seen and sometimes carried out things which no human beings should see or do and who, according to reliable reports (see discussion section above) are currently having extremely serious psychological and physical problems.

- b. Youth, who are likely to be ignored and who have the potential for the future for either great good or great problems. Such persons are also likely to transmit their traumas to future generations if not treated.
- c. The elderly, who frequently cannot care for themselves, are impoverished, are isolated, and have large psychological and medical needs.

2. A far more intensive and integrated approach must be taken than in the past, if true recovery is to be accomplished and if future violence is to be prevented. The strategy/model of complex rehabilitation, as described in the perspectives section below, is an example of the type of work which should be undertaken.

3. A similar approach must be taken to the return issue, that is, that return must not be considered merely as a matter of transport but rather as a serious endeavor to bring together previously torn communities and to work with people who have undergone highly stressful experiences. Thus, programs such as the one outlined above must be designed which take these elements into account. One approach is described below.

### **Perspectives for the Future**

#### *The Strategy of Complex Rehabilitation*

Together with Prof. Dr. Arpad Barath of the Universities of Zagreb (Croatia) and Pecs (Hungary), in the period since 1998, we have developed what we consider to be one possible solution to some of these problems. This is known as the strategy of Complex Rehabilitation. Its basic goal is to empower the people of a region, starting from the ground up, to take control of their own lives after a major disaster. A second goal of the strategy is to provide data such that other regions can learn from the experience of that containing the project. In the strategy, research and practice are integrated such that they enhance one another. It should be emphasized that the total implementation of the model is a long-term process, requiring a minimum of 4 years.

It should also be emphasized that the model/strategy should work at the levels of the individual, the family, the group, the community and the society. This should be kept in mind during the following discussions, particularly in the planning and implementation phases.

The first step in the strategy is a thorough needs assessment. This should include:

1. An epidemiological study of both physical and mental health which is as complete as possible. While it goes beyond the scope of this paper to go into great detail, a number of particulars will be given.
  - a. Sampling techniques should be randomized but should include all relevant groups with snowball techniques if required.
  - b. Variables to be studied should include:
    - i. vital statistics and basic health indicators;
    - ii. iphysical health data, including medical history, physical examination, instrumental examination (blood, urine, ecg, chest x-ray, Pap smear, dental examination), analysis of sexually transmitted diseases and nutritional analysis;

- iii. mental health indicators, including customary measures of mental health functioning, specific measures for post-war mental disorders and family losses due to war
  - c. Techniques to be used include standard instruments, physical and instrumental examination and a narrative in-depth semi-structured interview with key family members and individual family members according to circumstances.
- 2. Indicators of economic means and conditions of living.
- 3. Specific variables for the targeted groups (as required).
- 4. Community measures, such as power structure within the community, leadership, the value climate, intra-community relationships, accessibility to resources for support, and hard measures such as the number of crimes and open conflicts, the number of families living in poverty, measures of economic loss to the community resulting from the disaster, the pre- and post-disaster rates of unemployment, and the use of time.
- 5. The level of exposure to traumatic events.
- 6. The relative rates of social mobility of all groups.
- 7. The systems changes, including the destruction of infrastructure.
- 8. The relative degree of political and social change.
- 9. The aspirations, desires, and needs as seen by community members.

With regard to points 2-9, both "hard" data and interviews with community leaders and participant-observer interviews would be used. In such interviews, techniques are employed to involve all groups within the community. Further interviews are also carried out with any organizations – non-governmental, governmental and inter-governmental – which may influence the community.

The needs assessment also has the additional functions of activating the community and involving it in thinking about its own future.

It should be repeated at regular intervals to determine changes in the community.

The second stage of the strategy is thus the preparation of a community plan with all groups and organizations indicated above. The object here is to first obtain at least some consensus on the "diagnosis" and then to develop a plan of action. This plan should, at a minimum, include giving knowledge and skills of psychotrauma, other aspects of health, non-violent conflict resolution, human rights, democratization, reconciliation, social infrastructure, economics, self-initiative and critical thinking to the general populace.

Another essential part of the community plan is reporting. This will involve local individuals or organizations as well as external ones, including academic institutions. Such involvement insures that the experience gained is not lost.

Still another element of community plan is coalition formation. We believe that this is essential, as few if any organizations have the ability to carry out all aspects of the plan alone. Furthermore, competition for funding creates duplications and gaps and leads to reduced efficiency and effectiveness.

The following stage is that of implementation. This will be specific to the location concerned. The participating organizations and groups might be in the position to carry out the plan themselves but, most likely, will engage external organizations to assist them. We would also suggest that one important element in the implementation strategy be the creation of

polyvalent multi-ethnic Community Building Teams. These teams would be educated by the participating organizations at an elementary level in as many of the disciplines as possible and keep close contact with the populace. Specialists (or specialist teams) would back them up for difficult problems. Such Community Building Teams also undergo supervision and further education on a regular basis, usually weekly.

Also important in the implementation phase is the encouragement of self-initiative and the formation of interest groups and/or new non-governmental organizations to deal with specific problems (psychotrauma, reconciliation, school curriculum, health provision, and family violence are examples). Furthermore, economic initiatives may also arise from these efforts. In addition, the formation of groups required to deal with a specific element of the community (alcoholics, ex-soldiers, women) may be formed.

A further element of the strategy is research. As has been mentioned elsewhere, research, and the involvement of academic institutions in such work has advantages for both sides. For the community it allows optimization of programs and additional education for local persons. For the academic institution, it provides a location for students and researchers to carry out their work as well as providing empirical information not otherwise obtainable.

Another important aspect of the strategy is network formation, that is, networks of groups in various municipalities with similar problems and carrying out similar programs. The object of such networks is to exchange knowledge and experience between such groups.

Finally, the strategy includes an element of transmission of skills and knowledge. This would ideally be carried out through the Community Building Teams and other community members transmitting the strategy, as well as their knowledge and skills, to other communities.

**The Adaptation of the Strategy/Model of Complex Rehabilitation to Return.**

The strategy can, and in our view should, be applied to situations involving the return of refugees and internally displaced persons to their homes. In such cases, several additional stages should be added. The first is that of preparation for return. This includes:

1. Psychological and legal preparation of both the returnee community and the community to which they are returning.
2. Visits of the returnees to the community to be returned to. During such visits, preliminary meetings are held with potential neighbors, local officials and other community members. Follow-up work by the group carrying out the preparation would be held after each such visit.

Further, the actual return process should be led by the Community Building Teams.

The strategy in such cases then follows the general strategy, with a somewhat greater emphasis on reconciliation aspects, depending on need.

### **Further Perspectives and Epilogue**

It is our feeling that a field institute for conflict and post-conflict studies needs to be established within this region to study and implement solutions to such problems. Local and international educational institutions as well as local and international non-governmental institutions and governmental and inter-governmental bodies need to be involved in this type

of effort. The Coalition for Work With Psychotrauma and Peace has begun to talk to a number of institutions with the hope of starting this important work.

The problems of traumatization of war-torn communities, particularly in regard to persons with human rights violations and with regard to those seeking to obtain their human rights, are extremely complex. It is only through an integrated, concerted and intensive approach that such problems will be solved.