

# **THERAPEUTIC APPROACHES TO THE TREATMENT OF REFUGEES**

## **– A HISTORICAL PERSPECTIVE**

**Directions during the last 20 years in the work with refugees affected by persecution and war,  
and expectations about possible future directions of psychosocial work**

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This morning I will be looking at two main models or approaches for understanding the psychological pain of refugees and other persecuted people. Please, notice that I am not using the term “traumatised” refugees, because by using that expression, I would already have placed myself within one of the models, approaches or discourses that we will try to look at today from a historical, political and cultural perspective. I see each model, approach or discourse as one way of talking about or understanding the pain of the human soul when it experiences deliberate evil at the hands of another human being. I am building on the assumption that both models are ways of understanding human feelings and behaviour, and that one model is therefore not more correct than the other but that both should be seen in the social-political-cultural context in which they are being applied.

I will start with an outline explaining the two approaches: first I will examine the Rights Approach with examples from my fieldwork in Chile and the former Yugoslavia, and then at the Trauma Approach. Thereafter I will add some historical perspectives to the discussion. The next issue I will take up is the political significance of using the trauma approach based on examples from the former Yugoslavia. I will end with an indication of how I see the possible future direction of psychosocial work.

I. The two approaches

The intense discussions that are currently going on within the international psychosocial community about the “correct” approach could be seen as discussions between followers of what I have called the “Trauma Approach”, and followers of the “Rights Approach”. While the more “political” or “socially” oriented Rights Approach is associated with interventions that emphasise the human rights of suffering refugees – including the rights of local culture and traditions to deal with psychological suffering, the more treatment oriented Trauma Approach is associated with the application of “medical”, psychotherapeutic western intervention models – mostly building on the post-traumatic stress disorder – PTSD - diagnosis.

### 1. The Rights Approach

So what do we mean by a Rights Approach?

Witnessing and advocacy are important aspects of a Rights-based Approach. A Rights Approach builds on basic human rights and has thereby guidelines for optimal standards of protection and assistance. This approach attempts to move beyond a model of service provision and the stigma of being “treated”.

I was first in contact with a Rights Approach in the 1970s in the consciousness-raising groups in the Women’s Movement where we tried to understand how “the private is political”. Later on, I met this approach in the 1980s, when we worked with the Testimony Method in psychotherapeutic assistance to political refugees who were survivors of torture. Chilean mental health professionals had developed the method during the dictatorship where it served the dual purpose of collecting evidence against the dictatorship and providing the survivors with a means of catharsis as well as integration of the stressful experiences.

In the Testimony Method, the survivor’s story is recorded and written out. It is approved by the survivor and given to him or her to use as they wish. The Testimony Method has several important symbolic aspects: the evil is transferred to the “clean” white paper; the story is now in the

power of the survivor; the Testimony channels aggression in a pro-social and useful way by becoming evidence that could possibly help other survivors.

However, it can be a rather complicated job to advocate human rights in civil wars and complex emergencies, as we discovered in the former Yugoslavia ten years later. Careful discussions are required when universal human rights standards can be used as weapons of war by warring factions who accuse each other (often rightly) of human rights violations. There is no truth about right or wrong here, but only personal beliefs and ethics.

During my fieldwork in Chile just before arriving in the former Yugoslavia, I had felt how fear creeps into a person who lives in a terrorist state, and how this fear can lead to denial and mistrust. These feelings were not different from my experience of life in the former Yugoslavia during the war: betrayal was at the core of the social wound in this tormented region. The human rights model attempts to raise awareness among people about these psychosocial dynamics, so that they can protect their sanity and dignity: they are experiencing a political problem, not a personal mental health problem.

Under the type of state terrorism that we often see in ethno-political wars, the social strategies of splitting and victimisation are directed at all societal levels: at the individual, the family, the group and the whole society. In the former Yugoslavia, this type of strategy threatened the many mixed marriages (Agger, 1996). A Rights Approach would involve consciousness-raising about the political implications of this policy. But the ideology of ethnic nationalism that was reigning in the former Yugoslavia was a powerful strategy for splitting and victimisation. During the war, psychosocial project participants and national mental health professionals mostly rejected raising awareness about the destructive consequences of this ideology, and a national human rights movement was not on the agenda.

The over-all purpose of a human rights movement, as I experienced it during fieldwork in Chile, is to counteract silence and destruction by denouncing and healing. A human rights movement is built on social relations between people, and in Chile it was the collective consciousness and moral community of this movement that was the primary denouncing and healing agent. It was the collective feeling and this movement that were the primary denouncing and healing agents. It was this collective feeling and this moral commitment that was able to create a force to counteract the repressive strategies. However, in the former Yugoslavia there was no cross-national human rights movement. The various ethnic groups (the Croats, the Serbs, the Muslims) had their own human rights organisations that mostly denounced violations committed by the other ethnic groups, not by perpetrators from their own group. In this way, a human rights approach could actually help feed the war propaganda. *Within* ethnic groups human rights work was done, testimonies collected, and violations were denounced. But in the context of ethno-political warfare, it was as if the Rights Approach would only aggravate the conflict, creating more hatred when testifying against “the evil other”.

In a Rights Approach, the personal suffering can be integrated by allowing it to become part of the survivor’s history through the giving of testimony. On the family and group levels, I saw how the suffering in Chile was integrated through the work of the Associations of Family Members, and the various other survivor groups that flourished, and that cooperated closely with the psychosocial NGOs. On the societal level, national rituals of remembrance were performed, as well as the symbolic healing attempted through the Truth and Reconciliation Commission. Self-empowerment was nurtured by membership of a collective movement; a human rights movement that validated the injustice a person had suffered, projecting the guilt and shame towards the abusers. A human rights movement works on all levels: the private, the professional, and the political levels of society. The work is focused on the individual, the family, and the survivor group and on all of society.

Between therapists working in the Chilean human rights movement there were theoretical differences as to which intervention method was the “right” one: a psychoanalytic, a systemic, or existentialist approach, but these differences were minor in relation to the overall attitude that recognised that the private, professional and political levels could not be separated.

A question that arose again and again was: the problem of silence and speech. In a dictatorship silence is supported. After the dictatorship has ended, many members of the new government want to forget. The survivors of abuse feel that speech is painful. Researchers and therapists who ask questions about the suffering may become new violators. *When should there be silence, and when should there be speech?* Or maybe the question should be posed in another way: under which circumstances should the unspeakable be spoken?

When I arrived in the former Yugoslavia, I tried to find out if elements of the Latin American Rights Approach could be useful under conditions of ethno-political warfare. When discussing with local mental health professionals, they often mentioned the lack of a Truth and Reconciliation process after the Second World War as a reason for the violent hatred demonstrated in inter-ethnic atrocities committed during the present Balkans wars. This I saw as an expression of a need for public justice to take place.

But was there now a human rights movement that could initiate a Truth and Reconciliation Process? If so, how could international organisations help strengthen this movement? Was there denunciation, a public outcry, blaming those responsible, on all sides of the frontlines, for the violations of human rights? Were human rights violations investigated and denounced? Were testimonies taken that verified the reality that was officially denied? In the psychosocial treatment of people who had been abused, did the professionals relate the private suffering to the political reality of human rights violations? Did people know about their human rights through educational and consciousness-raising programs? Were there survivor groups and networks at the grassroots

level? Were there professional solidarity organisations or institutions supporting survivors? Were there any “protective shields” under which human rights work could be done? To most of these questions, the answer was “no”. The main problem was to develop a human rights movement that worked across ethnic and national frontlines – and above the logic of war, a problem that was not easy to solve. So why not use another approach then, why not use the clinical, Trauma Approach?

## 2. The Trauma Approach

So what is meant by the “Trauma Approach”? I am not going to explain it in detail, because this is the approach that western psychotherapists are familiar with, this is our usual approach to the psychological suffering of refugees. It is an approach that builds on the assumption that the suffering that some refugees have gone through has resulted in psychological trauma, or post-traumatic stress disorder - PTSD, and that we can help them by psychotherapeutic interventions that alleviate, integrate or heal that trauma.

There has been a widespread critique of the application of the PTSD diagnosis to war-affected people (e.g. Ager, 1997). The applicability of the PTSD diagnosis in complex political emergencies is now being questioned from many different angles (e.g. Wessels & Monteiro, 2001): Is it useful? Is it trans-culturally valid? Does it really encompass the suffering of prolonged armed conflicts?

The discourse of PTSD in psychosocial interventions for war-affected people risks “doing harm” (Anderson, 1996), because of its medical “illness” focus. Although PTSD is viewed as a normal reaction to an abnormal event, it is still a diagnosis of a mental disorder. In addition, it is a western, “scientific” diagnosis that people might therefore feel more frightened of. The non-intended effect of this approach might result in the war-affected person feeling more “ill” and even more victimised, an impact that would be highly counterproductive in relation to the general humanitarian aid policy aim of strengthening local resources.

The reactions or symptoms described by the PTSD concept fail to take account of contextual factors, particularly the social, cultural and political dimensions of the stressful experiences, and how individuals experience these. Concretely, the loss of a home, being rendered destitute, becoming a refugee, and many other stressful experiences, all contribute to the *meaning* of suffering for the individual person or family, and cannot be expressed in generalised terms of post-traumatic symptoms. In addition, grief, sorrow and mourning for loved ones almost always accompany such experiences but are not captured in the PTSD format (Agger et al., 1999).

As critics say, local, traditional healing rituals may have a better therapeutic chance in the treatment of war trauma in non-western societies, than PTSD therapy, building on the practices that people have used to survive and heal through history. And when facing the challenge of how to alleviate human suffering in complex political emergencies it might be more useful to move to the other end of the spectrum and look at the coping, the resilience and the protective factors at work among the people we want to assist.

## II. Historical perspectives

The discussions between proponents of these two approaches, the Rights Approach and the Trauma Approach, are not new but represent tentative answers to challenges that in different variations have manifested themselves since a professional interest in the mental health of refugees and displaced began to develop in the western world in the 1950s.

When the healing of war trauma became an object of scientific study and professional interventions after the First and the Second World Wars, it was mostly prompted by the military's need for assisting traumatised soldiers. However, it was also inspired by the need for addressing the psychosocial problems of the many refugees that the Second World War had created (Malkki, 1995). This development was further impelled by the need to help the Holocaust survivors.

During and after the Vietnam War in the 1960s and 1970s, theory and methods for dealing with war trauma were further developed and engendered a whole new professional knowledge with a diagnosis (Post-Traumatic Stress Disorder (PTSD)) and an intervention method (Post-Traumatic Therapy) (Wilson & Raphael, 1993). During the 1970s and 1980s, when rape was an object of extensive scientific inquiry inspired by the Women's Movement and the political discourse of feminism (Brownmiller, 1975), other types of knowledge relevant for many refugees and war affected who had been sexually tortured began being produced. Most of this knowledge was connected with a Trauma Approach with a strong clinical and individualised discourse focusing on the psychological problems of refugees or torture victims and their treatment needs.

However, parallel to this development another approach was also gradually unfolding in Europe at the end of the 1970s and in the 1980s based on a human rights discourse with focus on the *political* aspects of being a refugee. It was mainly Latin American psychologists and psychiatrists in exile from the military dictatorships in Chile and Argentina who inspired this approach. Their interest was to understand how political repression and human rights violations had affected the mental health of refugees, exemplified by concepts such as "Mental Health and Human Rights", and descriptions of patients as "suffering from the dictatorship" not from mental illness or PTSD (Agger & Jensen, 1996). The treatment approach was community oriented with emphasis on the resources of the refugee community and "reconstruction of the social network and preparation of collective projects" (Barudy, 1988, p. 151). There was already at that time in the professional psychosocial community in Europe a heated debate between proponents of a more medical oriented Trauma Approach and a socially oriented Rights Approach. I remember these discussions from the middle of the eighties when I started working with torture survivors mostly from Latin America. The discussions also reflected earlier discussions within psychiatry about "anti-psychiatry", and the political role of psychiatric diagnosing.

## 1. Psychosocial interventions in developing countries

During the eighties and nineties, humanitarian organisations also started including psychosocial interventions in their work in the developing countries. Many of the themes from the debate just mentioned were replicated in the discussions about the psychosocial approaches to war-affected in developing countries that unfolded in the 1990s. It was only during the 1980s and 1990s that psychosocial interventions on a larger scale began being provided in the developing world. Until then, the study and practice of psychosocial assistance to refugees and other survivors of armed conflict had primarily been confined to the western world. During her fieldwork in 1981-82 among refugees in Sudan, the anthropologist Harrell-Bond observed that “humanitarian aid programmes did not take account of the need for psychological services for African refugees (Harrell-Bond, 1986, p. 185).

It was mainly in organisations such as Save the Children, which assisted war-affected *children* in the developing countries, that psychosocial interventions up through the 1980s became an integral part of the aid package. This effort was supported by the UN Convention on the Rights of the Child that was adopted in 1989.

This approach was further enforced when the UN refugee agency, UNHCR, in 1994 incorporated the standards and principles of the Convention into its protection and assistance framework by issuing its “Guidance on the Care and Protection of Refugee Children” (UNHCR, 1994). This initiative was followed up the same year by the UN appointment of Graca Machel, former Minister for Education in Mozambique, and wife of the former Mozambican President and FRELIMO leader, to conduct an investigation on the impact of armed conflict on children. Her report was submitted to the UN in 1996, and it had a considerable impact on the intervention strategies of UNHCR and UNICEF as well as other organisations protecting children in the developing world (Machel, 1996).

## 2. Psychosocial interventions in a European war

When war started in Europe in 1991 in the former Yugoslavia the picture changed again. The systematic inclusion of psychosocial assistance into the humanitarian aid package for war-affected *adults* started mainly in connection with the Balkans wars and with the increasing expansion of humanitarian aid into the area of rehabilitation. In 1991, UNHCR had issued “Guidelines on the Protection of Refugee Women” (UNHCR, 1991) in which it was recognised that “counselling services should be provided for refugee victims of trauma, especially for refugee women... (p. 20). However, it was also recognised that “...mental health services are lacking in most refugee camps” (p. 53), and that UNHCR should “institute counselling and mental health services for refugee women, particularly for victims of torture, rape and other physical and sexual abuse” (p. 54). However, no organised UNHCR psychosocial programme was started on the Balkans until the beginning of 1993. Around this time, many other international organisations had also started psychosocial programmes, and in 1994 we counted a total of 185 smaller or larger psychosocial programmes in Bosnia and Croatia (Agger, Vuk & Mimica, 1995).

As part of *the new humanitarian discourse* that developed during the Balkans wars after the end of the Cold War and the disintegration of the Soviet Union, many studies were done to document the suffering of victims during complex emergencies, studies that later formed the basis for the psychosocial projects which the victims became beneficiaries of. It is maybe surprising that much less research was done on how people managed to survive and cope with this type of extreme adversity, and which factors make some people more resilient to misfortune than others (Boyden & Mann, 2000). In fact, this is not surprising. The new humanitarian discourse is mainly focused on victim-hood, and in an effort to receive funds from donors the objects of our assistance are often described as helpless and passive. We make new victim identities by grouping people into categories such as “trauma victims” or “rape victims”. In addition, the terms “trauma” and

“traumatised” are being used to describe all sorts of unpleasant feelings and have also entered everyday speech with a variety of interpretations and meanings.

Most of the psychosocial programmes in the former Yugoslavia were in theory based on a Trauma Approach, while they in practice were providing community-oriented social services at basic levels. It proved difficult to apply a Rights Approach during an armed ethno-political conflict that took place in a European context: To summarise, we could explain these problems in the following way:

- The national professionals who were educated in a strong medical tradition did not support a Rights Approach;
- The discourse of PTSD and rape were very prominent both among international and local professionals who at that time saw these issues as the most important threats to psychological well-being;
- The complex emergency of the Balkans was so “complex” that it prevented a clear understanding of whose rights to protect: who were the victims and who were the perpetrators? A focus on a technical or medical Trauma Approach was therefore seen as the best way to avoid taking sides in the ethno-political conflict (Mimica, 2001).
- One of the important methods of the Rights Approach, the testimony Method, proved to be a problematic intervention in an ethno-political conflict.

### III. The political significance of a suffering-based approach in an ethno-political conflict

The Croatian psychologist, Jadranka Mimica (2001), who coordinated NGO psychosocial work in Bosnia and Croatia during the war together with me, says that many of the local mental health professionals from the former Yugoslavia did have awareness about the political aspects of mental health interventions, but it was not so clearly formulated. When the war started there was great confusion about how to position oneself as a psychotherapist who wanted to help. All political

standpoints were seriously challenged, and the mental health professionals needed time to adjust their political attitudes. In addition, they were all quite affected by the war, by fear, by sudden poverty. They chose to defend themselves by narrowing the overall picture and offer what they knew, which was some type of therapeutic approach. A therapeutic approach was experienced as a technique that was above the daily politics, which consisted of interethnic tensions, nationalism and war. This also meant that they – as holders of the technique and skill – could offer services to all people regardless of their ethnicity, and thereby place themselves above the logic of the current warfare. They almost felt an envy of surgeons who could just “do their cutting” (Mimica, 2001, p. 133) without challenging their beliefs or values.

This was a political standpoint, but it also became the coping pattern of many local mental health professionals in the former Yugoslavia at that time. In a sense, according to Mimica, it was also part of their initial processing of the war, since they were not able to articulate political dimensions (in the form they can now, after the war has ended), before they had been able to process it in themselves.

A Rights Approach, or placing therapeutic work into a political context, was simply too painful at that time, because it might involve entrapment in a nationalistic pattern, and “taking sides”. Aggressive nationalist mothers were stressing the ancient victim hood of the Croatian people that had constantly been exposed to Serbian dominance and violence, while the Croats had developed a culture of work and peace (this was the main stream political approach of those who stressed the rights of the Croats to their own state). To avoid that, the mental health professionals developed a “suffering based approach”, to protect them from this type of propaganda. This was the political base, or context, in which their approach was developed. The source of this medicalisation or “professionalism”, as they called it, was clearly political. It was the choice of decent people – and

that was a very progressive choice at that time – to deny the political dimensions of their work, to avoid these aspects, and to base the work on suffering.

They were not able to focus on universal human rights. The main stream Rights Discourse at that time in Croatia was focused on the rights of Croats to have their own state, cleansed of Serbs, while anti-nationalistic professionals focused on universal suffering, which does not imply or lead to hatred and nationalism. When they started working during the war, the overall goal was to offer people a space to ventilate their ethnic tensions and afterwards go home and live as before. Anti-nationalistic professionals were accused of not being aware of the political implications of their work, while they in fact were very much conscious of the political challenges involved in their work. The choice of the Trauma Approach was their most progressive political choice, and the only one they could articulate in the midst of all the suffering accompanying the dissolution of the former Yugoslavia.

#### 1. The Kosovo case

As another example of the problems and political implications of using the Trauma Approach I will mention the development that took place later in Kosovo in the aftermath of the NATO bombings and the large invasion of international organisations in 1999. Many of these organisations had come to offer psychosocial assistance to what they had termed “the traumatised population”. This was an assistance that had mostly not been requested by the Kosovars themselves, but had been deemed necessary by Western agencies that also wanted to show their flag in a hot and much featured spot such as Kosovo. Although the Kosovars were suffering, many felt that they had more urgent needs than psychosocial assistance.

The *intervention approach* of many of these psychosocial projects was questionable and also often contradictory. On the one hand, in the concrete practice of the projects, most of the projects were working on very basic levels of psychosocial support, after models that are well known in

western social services systems. This could be in the form of various types of handicraft workshops for specific groups, e.g. knitting groups for village women.

On the other hand, when explaining about their projects in reports or during training courses for national staff or professionals, the international staff members were using a dramatic terminology taken from clinical – even psychiatric – language, labelling large percentages of the Kosovar populations as trauma victims. What that meant for the interventions was unclear. Were the handicraft workshops meant to be trauma therapy?

Very little was actually known about the culture of the Kosovars, and their traditional patterns for dealing with suffering and misfortune, and the impact of this “*trauma discourse*” was at best dubious. Basically, the suffering in Kosovo is not a medical, but a political problem. So, one must ask the question: whose interests does this medicalisation serve?

A number of international surveys illustrate how a political problem was medicalised in Kosovo: two American surveys published in August 2000 (Cardozo et al., 2000; Salama et al., 2000) found high rates of psychiatric symptoms among the Albanians and Serbs (Westermeyer, 2000). Other American surveys carried out in September 1999 and May 2000 among Kosovar Albanians claimed that one person out of four showed one or several symptoms of Post Traumatic Stress Disorder (IOM, July 2000). These investigations were, for example, referenced in a major Danish newspaper under the heading: “A large number of people suffer from mental illness in Kosova” (Politiken, 2000).

In group interviews I carried out with Kosovar Albanian village women that participated in psychosocial projects, the women repeatedly underlined how traumatised they were. Some of these women were illiterate and they used the word “trauma” which is easily recognisable although I do not understand Albanian. National social workers and teachers employed by the project also told me that they were traumatised.

Kosovar Albanian students participating in an international training course on trauma pointed out that the word “trauma” was rarely used by Kosovars prior to the arrival of international trauma experts (IOM, 2000, p. 14). “Instead they use words such as ‘pain’...’despair’, ‘suffering’...a ‘deep spiritual disorder’”. The students also said that the ‘scientific methods’ they learned in the course were not sufficient for Kosovars to overcome trauma, that “the rationality does not reach the centre of the case” (IOM, 2000, p. 13), and that Kosovars have other methods which they have always used during the many preceding wars and hardships that they have gone through in history.

The western trauma discourse is supposed to represent modernity, rationality and scientific approach, and the Kosovars have learned the language, readily taking on the identity of trauma victims. However, not much is in reality known by the international experts about the Kosovar culture and traditional ways of handling misfortune.

The clinical language of the trauma discourse was unfortunate for several reasons:

- It distracted the attention from the social and political root problems, including the problems created by the NATO intervention;
- It was based on an incomplete knowledge of Kosovar culture;
- It was counterproductive to healing because it encouraged the development of a passive victim identity.

In her UNHCR working paper, Vanessa Pupavac from the University of Nottingham expresses the same criticism of the Trauma Approach with Kosovo as an example. According to Pupavac, psychosocial intervention is not only a form of cultural imperialism, that is, the imposition of a Western therapeutic model on other societies, which have their own coping strategies”...it also echoes Western colonial and racist psychology...the consequence of the idea that whole populations

becoming dysfunctional as a result of trauma is a belief that extensive international administration is necessary (Pupavac, 2002, p. 1-2).

#### IV. Possible future directions of psychosocial work

People in war-affected countries mostly find their own ways of creating spaces in which they can heal the psychosocial wounds of war. They do not wait for humanitarian interventions when experiencing misfortune. However, the task of rebuilding social networks can be problematic indeed.

Complex political emergencies naturally have an impact on the identity of the people living in the midst of the wars and conflicts. From studies of the Balkans and the Caucasus emergencies, we found that these ethno-political conflicts resulted in general trends in the social identity of the war affected, which were commonly expressed by the people we interviewed as:

- A loss of trust in a common future with neighbours and earlier friends;
- A loss of the sense of solidarity and development of feelings of being betrayed;
- A crisis of values and beliefs;
- A development of enemy images on an ethnic basis.

The development of this type of social identity is another challenge to the mental health professionals who must work on many other levels than the individual clinical level. However, in most psychosocial projects, there have been little focus on issues such as human rights and advocacy, peace-building and reconciliation, the resources and the coping abilities of the participants, community development and training of national staff in democratic participation and critical thinking about their own theory and method (Agger et al., 1999).

##### 1. The political significance of a Community-Based Approach

In a symposium sponsored by the American Red Cross that brought together representatives of the leading humanitarian aid organisations to discuss approaches to psychosocial interventions, it was

noted in the introduction that “one fundamental point of discussion concerns the challenges of bridging the dichotomy between individual and community-based interventions...It is clear that a great deal of work needs to be done to organize practitioners and formulate acceptable theoretical frameworks...” (American Red Cross, 1999, p. 1).

The symposium identified a number of successful, culturally grounded program approaches to psychosocial interventions (based on American Red Cross, 1999, p. 5-8):

- *Culturally grounded assessment techniques*: Shift from a Trauma Approach to a Community-Based Approach (e.g. focus on healing through already existing cultural and spiritual belief systems);
- *Program design and implementation*: Promote natural support networks and coping strategies (e.g. prevent dependency on the aid organisation and the victimisation cycle by validating and encouraging traditional healing methods);
- *Sustainability of project*: Identify, incorporate and promote local capacities (e.g. recognise that competent mental health professionals may already exist in the region, and do not enlighten them on what they already know!);
- *Treatment of vulnerable groups (e.g. child soldiers, the disabled and women who have experienced gender-based violence)*: Understand community standards for socialisation (e.g. identify culture specific healing methods in the community for vulnerable groups, including the community’s capacity to reintegrate them);
- *Community support, conflict prevention and evaluation*: Focus on social support and community integration rather than clinical diagnosis. Involve evaluation and research specialists in assessment and program design to create measurable indicators of success.

The American psychologist Mike Wessels (1999, p. 268) emphasises how “work on healing is part of comprehensive programs of post-conflict reconstruction and conflict prevention”, but that it

is imperative to place “culture at the centre” in any type of psychosocial assistance so as to avoid de-empowering further those local voices and traditions which could be an important source of strength in the midst of social disintegration, following a civil war. In contexts of extreme poverty and social disruption, “psychological wounds cannot be separated from collective wounds – they are psychosocial with an emphasis on the social” (p. 269). Wessels also points out, how from an ethical viewpoint, “it is questionable to address traumas in contexts of political oppression without working to support human rights and constructive political change” (p. 270-271).

We must try to build on local cultural resources such as traditions, and human resources such as traditional healers, elders, women groups, teachers, and key people within religious communities. Also community processes – both the traditional and the official structures – should be drawn into the work. But “sadly, it is often local people who view their own approaches as inferior, believing that the modern, western, methods are better. This deeply ingrained sense of inferiority is one of the worst residues of colonialism and is itself a major form of psychological damage” (Wessels, 1999, p. 276).

Here, it could be part of the intervention to support recognition of traditional practices and collaborate with community structures among refugees in planning the projects, seeking to integrate western and traditional modes of healing.

There are no clear answers to the overriding challenge for psychosocial work in the aftermath of war and political violence. This is a blurred context where mental health discourse and interventions may become weapons of propaganda and war. But I do hope that I have been able to highlight some of the important discussion points that we must take departure from in our further research and practice of intervention. I do also hope that I have been able to convey the message about the dangers of an uncritical and universal application of the Trauma Approach. The same is true for the Rights Approach, as I have tried to demonstrate through the Balkans case.

When working with people's terrorised souls, it becomes very important to try to avoid doing more harm than good. But interventions fail, and the problem of suffering continues. However, it is in the meeting between people that healing starts: in the meeting between people representing organisations that want to "help", and people representing the suffering refugee population. When we catch a glimpse of each other's humanness, something that is healing might start to happen – in spite of it all, although it is sometimes hard to believe.

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