

*...the most important thing  
is to learn how to live with  
what we went through,  
not to forget...*

# Psycho-social

assistance to

# Victims *of* War

in Bosnia-Herzegovina  
and Croatia

A N E V A L U A T I O N

INGER AGGER AND  
JADRANKA MIMICA

CEE: VIII / 57



European Community  
Humanitarian Office



**ECHO PSYCHO-SOCIAL ASSISTANCE  
TO VICTIMS OF WAR  
IN BOSNIA-HERZEGOVINA AND CROATIA**

---



*“...the most important thing  
is to learn how to live  
with what we went through,  
not to forget”*

**Inger Agger and Jadranka Mimica**

**ECHO PSYCHO-SOCIAL ASSISTANCE  
TO VICTIMS OF WAR  
IN BOSNIA-HERZEGOVINA AND CROATIA**

*AN EVALUATION*

*EUROPEAN COMMUNITY HUMANITARIAN OFFICE (ECHO)*

*&*

*EUROPEAN COMMUNITY TASK FORCE (ECTF)*

*PSYCHO-SOCIAL UNIT*

**1996**

# CONTENTS

---

<b>ACKNOWLEDGEMENTS</b> - - - - -	7
<b>SUMMARY</b> - - - - -	9
<b>I. INTRODUCTION</b> - - - - -	12
<b>II. PSYCHO-SOCIAL UNIT</b> - - - - -	24
<b>III. THE BENEFICIARY STUDY</b> - - - - -	34
A. GENERAL FINDINGS: A STUDY OF THE TOTAL SAMPLE - - - - -	38
B. REGIONAL FINDINGS - - - - -	47
1. "The besieged city" - Sarajevo - - - - -	47
2. "The divided city" - Mostar - - - - -	51
3. "The tortured city" - Tuzla - - - - -	56
4. "The divided enclave" - Bihac - - - - -	60
5. "Sunshine and desolation" - The Adriatic Coast - - - - -	65
6. "The forgotten land" - Slavonia - - - - -	69
C. CONCLUSION - - - - -	72
<b>IV. THE STAFF STUDY</b> - - - - -	76
A. Sarajevo - - - - -	79
B. The Adriatic Coast - - - - -	84
C. Conclusion - - - - -	88
<b>CONCLUSIONS AND RECOMMENDATIONS</b> - - - - -	94
A. Conclusions - - - - -	95
B. Recommendations - - - - -	97
1. Adjustments of further psycho-social field action both in former Yugoslavia and in other contexts - - - - -	97
2. Recommendations for standard evaluation procedures for psycho-social actions. - - - - -	98
<b>REFERENCES</b> - - - - -	101
<b>APPENDICES</b> - - - - -	107
1. ECHO/ECTF Beneficiary Questionnaire - - - - -	107
2. ECHO/ECTF Staff Questionnaire - - - - -	115
3. INGER AGGER: Activities 1993-1996 - - - - -	121

## ACKNOWLEDGEMENTS

---

As we finish this evaluation we wonder how it is possible that months and months of hard work be represented in just a few pages. We would therefore like to stress that this report was born out of curiosity, enthusiasm, and a desire to make the world a better place to live in, ideals which we share with many of our colleagues, and without whose help and support this report could never have been written.

We would, first and foremost, like to thank ECHO for providing essential resources for both the NGOs and the ECTF Psycho-Social Unit, and for encouraging us to carry out this evaluation. The Danish Ministry of Foreign Affairs also deserves our grateful thanks for providing means for the work of the Psycho-Social Unit from July 1993 to December 1994. Our special gratitude goes to Francisco Martínez-Esparza, Head of ECTF, for his support and understanding of our work.

We want to thank our beneficiaries for their openness in completing the questionnaires and for their honest and touching comments which enabled us to learn a lot about how to improve our work. We thank our NGO staff for sharing our enthusiasm, and for their efficiency and promptness in administration of the questionnaires, as well as our colleagues Pauline Taylor McKeown and Antje Streit from Marie Stopes International, and Catherine Mazy of UNHCR, who shared with us their reflections on the history of the implementation of psycho-social projects in this region. Batja Mesquita from UNICEF, Solveig Dahl from Norwegian People's Aid and John P. Wilson from Cleveland State University are much appreciated for inspiring us to enter into this adventure.

A special debt of gratitude is due to the WHO field staff who helped us recover the questionnaires from war areas where postal services were little more than a dream; to Søren Buus Jensen, WHO Special Representative, for his spirit of creativity which he constantly offered us when things were difficult, and to his collaborators Mladen Radosević and Deborah Mrakovčić who provided emergency aid in the printing phase of the report. And finally we want to express our appreciation to all the staff of ECTF, especially to Suzana Dujmović and Enisa Smailagić for their commitment and work as well as their valuable comments and suggestions which helped us put life into the material; to Alex Saelaert for his help, humour and friendly attitude, and to all the other colleagues from ECTF who helped us reach a point where we could say: mission accomplished.

*Inger Agger Ph D  
Psycho-Social Coordinator*

*Jadranka Mimica, Clinical Psychologist  
Psycho-Social Assistant*

*European Community Task Force  
Zagreb, 29 March 1996*





## SUMMARY

---

Conflicts involving ethnic tensions are fuelled by emotions such as anger, hatred, distrust and betrayal. These emotions do not create the conflict, but they contribute to its perpetuation and are serious obstacles to peace and reconciliation. During the acute stages of conflict, psycho-social programmes provide a framework for emotional and social survival. However, by working with emotions and social relationships, psycho-social programmes also become important elements in efforts to stop the conflict and facilitate peace and reconciliation.

The importance of including psycho-social assistance in humanitarian aid became increasingly clear during the war in former Yugoslavia. When the war started in 1991, national mental health professionals immediately began providing assistance to the refugees and displaced people. The international community joined these efforts, and in 1993 the European Community Humanitarian Office (ECHO) began funding European psycho-social non-governmental organizations (NGOs), providing assistance to traumatized women and children. With the creation of the European Community Task Force (ECTF) Psycho-Social Unit, professional support was offered to the NGOs, and to national mental health professionals.

After more than two years of experience with psycho-social programmes under war conditions, the Psycho-Social Unit undertook a large-scale evaluation of the projects, collecting data on 2,291 beneficiaries of ECHO psycho-social projects. Data on 167 staff members were also compiled. The findings show that the projects reached the target group and that trauma symptoms of the women were reduced considerably. A space which offered contact, care and understanding seemed to be the primary need of beneficiaries; organized activities were secondary to this. The study also showed that the staff had had the same type of traumatic experiences as beneficiaries, but had coped differently. There was a need for more support for national and international staff members.





**INTRODUCTION**  
**EARLY DEVELOPMENTS**

---



## I. EARLY DEVELOPMENTS

---

In this introductory chapter our main focus will be the early development of psycho-social assistance to victims of war in former Yugoslavia. To us, as Europeans, and to international humanitarian organizations, this was a unique war: it was the first war in Europe since the Second World War, and it was also the first war in which an organized effort was made to provide the traumatized population with psycho-social assistance while the war was still going on. Therefore, we find it of interest for future emergency operations under war conditions to examine how the practice of offering psycho-social assistance to the victims developed: how did it all begin?

Contrary to widespread belief in the international community, psycho-social assistance to the war traumatized was not initiated by international organizations but by national mental health professionals in Croatia and Serbia-Montenegro a month after the war had started – long before any international psycho-social programme was even planned.

In the following pages, we first attempt to describe how this effort started on a national level. We then outline the gradual involvement of the international community in the effort to provide psycho-social/mental health assistance to war victims. In this context, we also review the issue of rape, as it came to public attention at the end of 1992.<sup>1</sup>

### ***National psycho-social assistance begins***

During the summer of 1991, soon after the war in Croatia had started, the social and health infrastructures of former Yugoslavia were faced with thousands of refugees fleeing the battlefields. In August the number was estimated at 90,000. At the end of October 1991, this figure had increased to over 400,000 (ICRC and UNHCR, 1992).

Although social welfare and health services were well developed at that time, they could not respond to the needs of so many desperate and distressed people who required all types of services: food, shelter, medical aid – and psycho-social assistance.

The refugees consisted mainly of women, children and elderly people, while the majority of the men stayed at the front lines as soldiers. The refugees were mostly accommodated with host families, but many in Croatia were also sheltered in tourist facilities along the Adriatic Coast.

In the beginning, neither the refugees nor their hosts believed that the crisis would last more than a couple of weeks. However, not only did the refugees not return to their homes, but day after day an increasing number of people fled from their homes. Finally, the situation had to be acknowledged for what it was: a disaster. The flight from the battlefields rarely happened in an organized way. Rather than being evacuated in collective transports, people escaped the bullets and shells as best they could. They walked through the woods for days, or drove

1 - The information brought together in this introduction builds on a multitude of reports, papers and other documents collected during the last three years. For the purpose of readability not all sources are mentioned.

in their own vehicles, often reaching safety with the car full of bullet-holes, deadly scared and worried about the fate of other family members, i.e. their husbands, sons and fathers who stayed behind. Most of all, the refugees seemed to be in a state of utter helplessness, feeling deeply betrayed by neighbours, friends – the whole social context in which they had lived until then.

The rest of the population showed a great deal of solidarity by receiving the refugees in their homes. However, the host families were also under stress – both economically and psychologically – from the emergency situation created by the war. It was obvious to national mental health professionals that the refugees needed more support than the humanitarian aid and shelter they could receive from host families, centres for social welfare and international aid organizations. Therefore, from as early as July 1991 in Croatia, the Mental Health Department of the Headquarters of the Medical Corps formulated a programme for psycho-social assistance to refugees and began setting up a network of regional departments of mental health across Croatia (Moro & Vidović, 1992).

A considerable number of national mental health professionals, psychologists, psychiatrists, social workers and others started addressing the psycho-social needs of the refugees, attempting to help them in any way they could think of. However, they had to both establish new structures for the provision of such assistance, and gain new knowledge about how to help traumatized people in the most appropriate way.

Traditionally in former Yugoslavia, psychological and social services were provided through institutions, and despite the presence of a relatively high number of mental health professionals, there were only a few who had experience in the treatment of trauma survivors. Those few were mostly working in specialized institutions with limited experience of mobile or large-scale emergency work.

Moreover, there was only a rudimentary culture of providing community services through non-governmental organizations (NGOs) or similar grassroots initiatives. However, an exception was the Antiwar Campaign Croatia which started working as a network of environmental, women's and human rights initiatives in July 1991. Working conditions for such initiatives were difficult, as the following quotation shows:

*“Signers of the basic document ‘Charter of Antiwar Campaign’ came not only from Croatia but also from other states on the territory of former Yugoslavia and from all over Europe. In August, telephone and mail communications with Serbia, Montenegro and Macedonia were cut. Due to that, any chance for building up a network of groups from former Yugoslavia, outside Croatia, was lost. Even today communication has to rely on occasional visits.” (Antiwar Campaign Croatia, 1992, p.1)*

In the Rijeka region in Croatia, psychotherapists and volunteers provided group counselling for the refugees from August 1991 in order to help them adapt to the new situation and organize their lives (Francišković, Moro & Palle-Rotar, 1993). Ljiljana Moro, a Croatian psychiatrist and psychotherapist, related how she was confronted with terrible stories about torture when she interviewed refugees from Vukovar in December 1991. Among other types of abuse, she also learned about

rapes. However, at that time, coping with the overwhelming reality of torture and war in general did not allow the professionals to devote special attention to the issue of rape. Moreover, dealing with sexual abuse and rape was a rather unknown professional field in former Yugoslavia (Moro, 1996).

On the other side of the front line, in Serbia-Montenegro, national initiatives were also taken at an early stage to assist refugees arriving from Croatia. In July 1991, the Institute of Mental Health formed mobile teams of mental health professionals who visited refugee camps, and started organizing one-day training seminars on "prevention and management of psycho-social consequences of war and crisis in children, adolescents and parents" (Išpanović -Radojković, Bojanin, Rudić, Rakić & Lazić, 1993, p.2). From the very beginning of the war mental health professionals were aware of the danger threatening the population (Kalicanin, Bukelić, Ispanović-Radojković & Lecić-Toševski, 1993).

Generally, a great deal of the first national psycho-social emergency work was done on a voluntary basis, but gradually NGO structures began developing, and as international psycho-social aid started coming in, working in NGOs became a regular job for many national mental health professionals.

### ***International response during the first months***

During the first months of the war, not many international organizations had resources to address the issue of mental health and psycho-social assistance.

The International Committee of the Red Cross (ICRC) had had representatives in former Yugoslavia since 1990. Its activities had mostly focused on visiting security prisoners. However, with the outbreak of war in June 1991, it strengthened its presence there considerably and delivered a wide array of humanitarian aid to the victims of war.

The European mission started on 13 July 1991 with the creation of the European Community Monitoring Mission (ECMM) after an agreement with the republics of former Yugoslavia. In the beginning, the majority of the ECMM's tasks concerned hostilities in Slovenia, where it arrived on 17 July, but on 1 September its mission was formally expanded to include Croatia. At the end of September, the ECMM started implementing its mission of observation in Croatia. Its tasks were originally to help stabilize the cease-fire but they soon came to include various humanitarian activities. On 13 October the ECMM's mandate was prolonged indefinitely.

In September, Médecins sans Frontières (MSF) also began working in former Yugoslavia distributing food and medicine.

On 5 October, the first funding decision was taken by the European Union to supply humanitarian aid to former Yugoslavia (followed by three others: on 15 October, 7 November and 29 November). The aid was to be distributed primarily through the United Nations High Commissioner for Refugees (UNHCR), the ICRC and NGOs.

On 25 October, the UN Secretary-General announced that he had requested the UNHCR to assist refugees and displaced people in former Yugoslavia, and in November, UNHCR/United Nations Children's Fund (UNICEF) sent a mission to

former Yugoslavia which resulted in an appeal to raise US\$ 25 million to fund a joint programme involving the UNHCR, UNICEF and the World Health Organization (WHO).

Within this joint appeal, the WHO proposed, among other initiatives, immediate measures and interventions for mental health problems. UNICEF proposed to back up community level initiatives and strengthen local social welfare services – specifically with regards to health and education needs of refugee women and children. This appeal in November 1991 was the first international initiative taken concerning the mental health of war victims.

From November 1991, UNICEF distributed large quantities of humanitarian aid to children, families and elderly, and by December, offices had been set up in Belgrade and Zagreb.

On 6 November, a decision was made by the European Commission to create the European Community Humanitarian Office (ECHO) and on 26 November this was ratified by the Council of Ministers. The purpose was “to ensure swifter and more effective intervention”, by setting up a single department in charge of every aspect of its humanitarian aid effort. (ECHO, 1992, p.7)

On 28 November, UNHCR relief efforts started when the first Special Envoy arrived with a staff of one. The first office was opened in Belgrade. In mid December, offices were also opened in Sarajevo and Zagreb. At the end of 1991, the UNHCR was named the lead agency for humanitarian relief operations in former Yugoslavia.

Towards the end of 1991, there were already many international NGOs operational in former Yugoslavia, especially in Croatia, many of which were funded by the European Union (e.g. Médecins sans Frontières, Médecins du Monde, Pharmaciens sans Frontières, Hopitaux sans Frontières, Handicap International). However, hardly any of these NGOs had at that time become involved in psycho-social assistance in the field.

### ***International psycho-social assistance begins***

#### ***1. WHO***

As a follow-up to the joint appeal in November, the WHO sent a mental health mission to former Yugoslavia in December 1991 and January 1992.

At that time, there were more than half a million refugees or displaced people in the region. The majority of these were elderly people, women and children fleeing from the war in Croatia. In addition, hundreds of thousands were living in combat zones and subject to great stress. Some 20,000 were reported to have died (WHO, 1992a).

The purpose of the WHO mission was to identify the need for mental health interventions related to the war and to the great number of refugees and displaced people. The mission recognized the following main types of factors causing psycho-social stress:

- physical injury and disability of the individual or of members of the family



- bereavement in the family
- psychological and/or physical torture of the individual or of members of the family
- break-up and displacement of the family
- material losses: house and other possessions, salary and pensions, insurance schemes, etc.
- overcrowding, boredom and apathy, poverty and ill-health
- the threat of more general social breakdown and demoralization due to the political and economic disintegration (ibid., p.6).

The WHO mission also noted that “interestingly (and fortunately) the team were not informed of cases of rape or similar types of abuse and torture during this mission” (ibid., p.6). Both during the visit to Serbia and the subsequent visit to Croatia in January 1992, the team consistently inquired about rapes, knowing that this type of abuse usually happens during wars – but no information about rapes was given or was available at this early stage (Orley, 1996).

Among other observations by the team were “the general sense of loss and insecurity, and especially...the development of negative ethnic stereotypes” (WHO, 1992a, p.6) among the refugees and displaced. This affected young people and people living in mixed marriages in particular. The team mentioned the widespread feelings of powerlessness, passivity, dependency, helplessness, alcohol problems and hopelessness and they noted that “virtually all suffered post-traumatic stress symptoms (recurrent nightmares, etc.)” and that “these were not recognized by the health professionals looking after them” (ibid., p.7).

It was, therefore, especially underlined by the mission that there was a need to train health and social service staff in how to deal with these problems, although it was also stated that about 10 educational seminars on psycho-social distress due to the war had already been held in Serbia, attended by 500–600 psychiatrists.

In general it was concluded that:

*“there is a lack of awareness among health workers and others involved in the aid programme, regarding the mental health needs of displaced and otherwise traumatized people and a lack of knowledge about what to do for them.” (ibid., p.15)*

The mission recommended that the WHO should initiate a number of mental health activities in former Yugoslavia (WHO, 1992b).

A WHO office was established in Zagreb in July 1992, and two short-term mental health consultants visited the region (August–September 1992 and January 1993). However, due to lack of funding, no systematic WHO mental health/psycho-social assistance to former Yugoslavia started until 1 February 1994, i.e. more than two years after the mission made its recommendations.

## **2. UNICEF**

In February 1992, UNICEF started a pilot programme for responding to the psycho-social needs of war-affected children in Croatia (Stuvland, 1996). In June 1992, a framework was established for psycho-social rehabilitation of war-traumatized children, including the preparation of six television programmes and the establishment of a number of support groups for displaced and emotionally distressed people (UNHCR, 1992b). A large-scale programme for psycho-social rehabilitation of children in Bosnia started in October 1992.

## **3. UNHCR**

In July 1992, after a month-long mission to former Yugoslavia, the UNHCR Senior Social Services Officer prepared a proposal for initiation of a social/community services programme. In August, a budget was drawn up for the programme, and a Social Services Officer appointed for four months, based in Zagreb. However, during the following months, the budget intended for social services was deleted for various reasons.

Consequently, UNHCR did not provide any systematic programme of social services until the end of 1992 after a new mission had been undertaken by the Senior Social Services Officer in November–December 1992. During this mission, she had the budget for social services reestablished, and she also appointed a number of female social services officers (the sex of the staff being of special importance due to the growing concern over the issue of war rapes). In connection with the mission, a new set of practical guidelines for implementation of a community-based approach was also drawn up (UNHCR, 1993).

### ***The issue of war rapes***

As mentioned above, some Croatian mental health professionals had been notified about war rapes as early as December 1991 in connection with the fall of Vukovar.

News of rapes in the Bosnian war reached national mental health professionals as early as April 1992, about a month after the war in Bosnia-Herzegovina broke out (Sarajlić, 1996). These professionals assisted Bosnian refugees in camps in Croatia, and they learned about the rapes along with all the other gruesome details of torture related by the refugees. According to various observers, the practice of rape reached its peak during the months May–July 1992 in connection with the intensive ethnic cleansing going on at that time.

International staff of the French NGO Partage offering psycho-social assistance to refugees in camps in Croatia learned about the rapes during the early summer of 1992. French journalists were also writing about the rapes at that time (Mazy, 1996).

In July 1992, the UNHCR suggested the appointment of a commission to investigate stories of atrocities, including sexual atrocities against women. In this context it was strongly recommended that a female Social Services Officer be employed to investigate the alleged rapes. However, the male Social Services Officer, who was appointed in August 1992, did not seem to collect any information about the rapes during his tour of duty in Zagreb.

Consequently, until late November 1992, the UNHCR did not address the rape problem. This was probably also due to the general lack of a social services programme and an organizational ambivalence in the field regarding dealing with social issues (UNHCR, 1993).

In UNHCR headquarters, however, the need for providing such support to refugees had already been demonstrated in 1991 with the publication "Guidelines on the Protection of Refugee Women" (UNHCR, 1991) in which it was recognized that:

*"counselling services should be provided for refugee victims of trauma, especially for refugee women who are particularly vulnerable to physical attacks, rape, abduction, threats, sexual harassment, obligation to grant sexual favours in return for documentation and/or assistance, forced prostitution, forced sale of children."* (p.20)

However, it was also recognized in the report that:

*"rape counselling programmes, or their cultural equivalents, are few in number although many refugee women have been raped. Other mental health services are also lacking in most refugee camps. Nor are counselling programmes available for women who have undergone the trauma of dislocation."* (p.53)

Among possible programme interventions suggested were to:

*"institute counselling and mental health services for refugee women, particularly for victims of torture, rape and other physical and sexual abuse."* (p.54)

This document is quoted at length because it expresses a general trend: it was already recognized at the beginning of the 1990s in the international aid community that psychological trauma should also be a focus of humanitarian assistance.

However, no large-scale international action was taken over the rapes until November–December 1992, when the rape issue suddenly hit the media headlines all over the world. The question of why this happened when it did is open to speculation. Probably, it was primarily due to initiatives from the national women's movements, in collaboration with European and American feminist organizations, that the information on rapes was finally brought to the attention of a wider public and thereby also became a concern of international politicians.

This development resulted in at least four investigative missions being sent to the war zone during December 1992 and January 1993, accompanied by a wave of journalists: the International Ecumenical Women's Team; the EU Warburton Mission (which will be described in more detail below); the UN Commission of Experts, and a UNHCR Mission on the situation of women and children in Bosnia-Herzegovina and Croatia.

This was a turning-point as far as psycho-social assistance is concerned. From then on, i.e. from the beginning of 1993, international funding for mental health and psycho-social assistance began flowing into the region. A large number of international NGOs also came in to assist rape victims, and at one time it even seemed there were more NGOs trying to assist rape victims than there were actual victims.

Many of the national and international agencies started implementing psycho-social projects with enthusiasm, but sometimes without a clear strategy of how to achieve their goals and solve the problems they were facing. This was understandable since the objective which the NGOs were so eager to attain was in fact a pioneering one: the attempt to provide psycho-social assistance under war conditions at a grassroots level.

### ***ECHO begins to support psycho-social assistance***

The European Community Humanitarian Office (ECHO) established an office in Zagreb in April 1992 to monitor EU funding. Until the end of 1992, EU funds were spent on food, blankets, mattresses, hygiene articles, family parcels (containing essential household items and foodstuffs), lorries, medical teams and drugs, building refugee camps and rebuilding bomb-damaged houses.

In addition, assistance in counteracting nationalist propaganda was supported with the setting up of an independent radio station as well as aid to independent newspapers in Croatia, Bosnia-Herzegovina and Serbia.

However, at the December 1992 meeting of the EU Council of Ministers in Edinburgh, it was decided to send a fact-finding mission to the region to investigate the alleged rapes. The mission, which was headed by Lady Anne Warburton, visited Bosnia-Herzegovina and Croatia twice: at the end of December 1992 and at the end of January 1993. In the mission report which was issued in February 1993, the Warburton Report, the media reports of rape and maltreatment of women were verified, and a number of recommendations were made for emergency assistance to the traumatized women.

Following the recommendations in the Warburton Report, the European Commission and member states decided in February 1993 to contribute financially to psycho-social assistance for traumatized women by allocating 2 million ECUs for European NGOs implementing such programmes. At the same time, an appeal was sent out to EU member states to supply technical support in the field for the NGOs. This support was to be provided within the framework of the newly established European Community Task Force (ECTF).

In March 1993, the Danish government announced its willingness to second psycho-social expertise to the ECTF based in Zagreb, and the ECTF Psycho-Social Unit started its activities in July 1993. The Unit was dissolved at the end of March 1996 along with the closure of the ECTF.

The British NGO Marie Stopes International was among the first NGOs allocated funding in the spring of 1993. This was for a project entitled "An Emergency Programme of Assistance for Displaced Women in Bosnia Through Self-Help Groups and Field Service Teams". The project was specifically aimed at implementing the recommendations of the Warburton Report, targeting Muslim

women in Bosnia. Since then, the ECHO has funded more than 25 EU psycho-social NGOs, gradually increasing its financial support. In the period from May 1995 till April 1996, 8.24 million ECUs were allocated for psycho-social programmes, reaching about 50,000 beneficiaries.

### ***Conclusion***

This brief attempt at a historical overview of a period largely dominated by chaos and powerlessness among those trying to assist the victims in the midst of the atrocious reality of war should not be perceived as a criticism. Rather, this story should be seen as an illustration of the long and arduous journey required to reach a goal which ought to be close at hand: an understanding by organizations and politicians of the necessity of providing humanitarian assistance to both the body and the soul of war victims.

The initiatives of national mental health professionals were gradually strengthened and developed through the programmes of international organizations. The UNHCR and UNICEF developed their social services programmes in Bosnia-Herzegovina, Croatia and Serbia-Montenegro from 1992 to 1996 in close cooperation with a network of national NGOs and governmental structures.

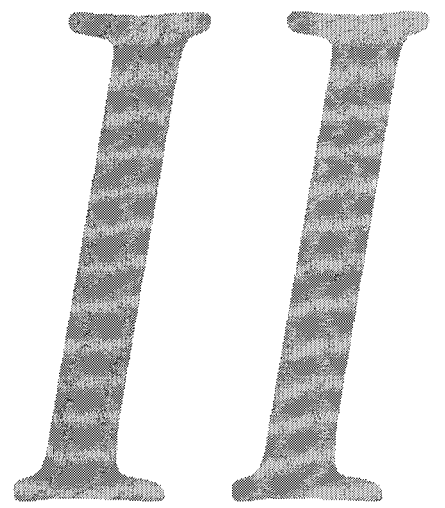
The WHO initiated regional models for mental health from 1994 to 1996, including national mental health professionals in a network of professional expertise which crossed front lines and borders.

The International Federation of Red Cross and Red Crescent Societies (IFRC) worked in close cooperation with the national Red Cross movements in the region in 1992-96 and created an impressive social services programme for the most vulnerable refugees.

NGOs were involved in other activities which space does not allow us to pursue (for further information, see Agger, Vuk & Mimica, 1995). ECHO funding allowed European psycho-social NGOs to enter the scene in 1993 and contribute to the development of a community-based, grassroots approach.

The news of the tragic war rapes seemed to have served as a major catalyst for changes in the attitude of many donors and politicians, so that they became aware of the importance of also providing funding for psycho-social assistance. This awareness was given the stamp of authority when a WHO/MSF workshop in Geneva in 1995, assembling key players in the humanitarian aid mission to former Yugoslavia, unanimously adopted a recommendation that "psycho-social programmes should be an integrated part of humanitarian aid".





**THE PSYCHO-SOCIAL UNIT  
NEW PERSPECTIVES**

---





## **II. THE PSYCHO-SOCIAL UNIT NEW PERSPECTIVES: FOSTERING SELF-HELP**

---

When the ECTF Psycho-Social Unit entered the field in July 1993, there were – as described in the preceding chapter – already a multitude of other players present, each with their own projects and agendas. After two years of war, the humanitarian operation seemed to be running smoothly (considering the circumstances), and at coordination meetings the various organizations attempted to convey to each other what we were doing in order to “avoid duplication and overlaps”.

Many of the national mental health professionals were at that time employed in international psycho-social programmes, a development which was inevitable and positive in most respects, but which also had the negative effect of draining the national governmental systems of their most qualified professionals.

However, behind the smooth, humanitarian surface, things looked rather different: struggles were being fought between organizations and individuals for power, funding and visibility; there was growing resentment among the local population towards the international presence; and in the international community itself, feelings of frustration and hopelessness were pervasive concerning the effect of the aid which was being provided.

Media interest in the sensational rape issue had died down, and most of the international psycho-social NGOs that had come to assist rape victims managed to reframe their projects into more generalized assistance projects for traumatized women, children and families. This was a very positive development. Rape was certainly not the only type of abuse which this war had inflicted on the population, and there was an acute need for psycho-social assistance to victims of human rights violations of various types.

During the course of the war, refugees and displaced people in Bosnia and Croatia lived under continuously stressful and traumatizing conditions. Therefore, in spite of all the programmes carried out by national as well as international organizations, needs for assistance were increasing, and only 3-5% of the requirements for emergency mental health assistance were actually covered (WHO, 1995).

Under these circumstances, it was important to address the enormous needs from a new perspective. With the lack of sufficient numbers of professionals, a self-help approach had to be developed which could spread and foster new self-help initiatives in a kind of ripple effect. Moreover, apart from solving a practical problem of staffing, this could also support the development of national grassroots movements, strengthening the capacity of “victims” to become survivors, to oppose the war, and – perhaps – also to begin a peace process.

The funds allocated by ECHO for psycho-social assistance to traumatized women supported a number of such NGO initiatives, several of which developed into impressive networks of centres in Bosnia and Croatia where thousands of women and children met and regained the strength to continue life.

### ***Creating an overview***

On arrival, one of the first challenges was to establish an overview of the many different – and rather confusing – actions happening on the psycho-social scene: what services were already being provided, to whom, by whom, what and where, and what other services were most needed.

The collection of this information was a difficult task, since the various existing sources had not listed psycho-social programmes as a special category, nor had they described the interventions in a systematic way.

The first overview of psycho-social projects (27 pages) was compiled as early as August 1993 with the intention of contributing to coordination and exchange of experiences between agencies. The overview also contained a short introductory paper, “Definitions, levels of intervention and strategies of psycho-social projects for victims of war in former Yugoslavia: A proposal”. Levels of intervention were visualized by means of a pyramidal model in an effort to clarify fruitless discussions about “right” or “wrong” interventions.

Psycho-social emergency assistance was defined as actions which:

*“promote mental health and human rights by strategies that enhance the already existing protective social and psychological factors and diminish the stressor factors at different levels of intervention.”*

In order to develop the conceptual framework further, a Psycho-Social Working Group was established in Zagreb in September 1993 with representatives from the UNHCR, WHO, UNICEF, American Refugee Committee (ARC) and ECTF. The participants elaborated the above-mentioned paper into a new and expanded version: “Under war conditions: What is a psycho-social project?”

The paper was published in September together with a new, enlarged edition of the overview of psycho-social projects. In fact, from the response to the first overview, it had become evident that there was a great need for an overview of the many initiatives taken in the field of psycho-social programmes.

A collaboration was started in October 1993 with the University of Zagreb to develop a database of psycho-social projects, and this resulted in the publication of the third overview of psycho-social projects in January 1994. The Psycho-Social Unit collaborated closely with the UNHCR both on the further development of a theoretical introduction to this overview, and on the data collection.

The database was continuously updated and widely used by national and international agencies, especially for needs assessments. In addition to the knowledge we gained from numerous needs assessments and monitoring missions in the field, the database provided us with a basic framework, which we could use when consulted by NGOs on how and where to provide services. Thus, we were often in an advisory function both in relation to ECHO and to the many organizations that visited us, and the database served as an important tool for coordination of field action as well as for proposals for new actions.

1 - Written in collaboration with Søren Buus Jensen.

### ***The pyramidal model***

In the third edition of the overview, the pyramidal model was further developed as a framework for identifying psycho-social projects. In addition to political psycho-social and physical survival interventions, it is possible to intervene on five psycho-social levels:

- emotional/social survival interventions
- task-oriented interventions
- psychologically oriented group interventions
- counselling
- intensive psycho-therapy.

It is important to have a clear theoretical concept of our work, given the complex nature of the phenomenon we were targeting. “War trauma”, “mental health” and “psycho-social” can be defined in various ways depending on the discourse. The interventions we choose in order to reach our goals will to a great degree depend (explicitly or implicitly) on our theory.

Moreover, there are always a variety of possible interventions, and – especially under war conditions – it is difficult to know in advance what type of intervention is the most appropriate or will lead to the goal as effectively as possible.

Using the pyramidal model can facilitate the understanding of what we are actually doing and the choice of new methods. The concept “levels of intervention” can be used as an analytical tool for clarification of our practice. However, it is also paramount to experiment with different types of intervention and subsequently evaluate their impact. In this interplay between theory, practice and evaluation, a model is developed which is shared with others so that it can be improved or changed.

An important element in the philosophy behind project-oriented action and NGO movements is to experiment with different methods which can bring new ideas to existing governmental structures. The flexibility of NGOs also gives them an advantage in service provision under precarious conditions. However, their activity should be followed by conceptualization and reflection in a number of implementation–reflection sequences (Mimica & Stubbs, 1995).

In psycho-social work with war victims, whether it is counselling, group therapy, provision of social services or community work, we are entering new territory. Usually, we must rely on ourselves as the best tool available, with whatever maturity and strength we possess. The only other guideline we have for selecting appropriate actions is our model – our theory of the world which enables us to understand the daily problems we are facing. Our model helps us find a way to solve problems or cope with them. When we lose the main focus of what we are doing, when we become overwhelmed by events, when we cannot see the wood for the trees – then reflection within a theoretical model is the only way to get back on track.

The pyramidal model is one such model which can help us analyse the content of projects: is there consistency between their objectives, methods, quantitative and qualitative staff resources, and budget? By analysing the various levels of intervention of a large number of psycho-social "trees", a "wood" emerged showing specific characteristics which helped us find our way.

In January 1995, a fourth edition of the overview was published which further elaborated the theoretical framework for psycho-social assistance (Agger, Vuk & Mimica, 1995).

### ***Monitoring of projects***

Not much theory exists about monitoring of psycho-social projects. In fact, this would be an important area to develop from a conceptual point of view.

NGOs implement projects at various levels of intervention and they attempt to achieve multiple and difficult goals. In monitoring, one of the objectives is to clarify the interaction between beneficiaries and staff: does the staff need more support, training, supervision; is the staff working on a level of intervention which corresponds with the needs of the beneficiaries; do the levels of intervention correspond to the goals? The monitor also examines procedures between staff and headquarters: is the field staff receiving adequate support from the organization; how does the relationship between field staff and headquarters affect their work with beneficiaries; does headquarters have the same objectives for the projects as the field staff have? Furthermore, the monitor also follows the process between NGO and donor: does the work of the NGO reflect the policy of the donor; does this policy also reflect the needs in the field; does the policy of the donor need adjusting; what are the chances that the NGO will receive continued funding from the donor?

It is very important for the monitoring process that the NGO has itself established a quality control mechanism for its project. Already during the planning phase of a project, the NGO should decide what categories it will employ as a measure of effectiveness: is it quantity of beneficiaries reached; quantity of daily/weekly/monthly groups; ethnic diversity of beneficiaries; certain levels of intervention; reduction of certain psychological symptoms; certain changes in social status of beneficiaries; or is it skills developed by beneficiaries?

Although we are dealing with processes and not fixed categories or values in psycho-social assistance, it is still possible to establish some parameters which indicate an approximate position in the process. Such categories are helpful not only for the monitor, but primarily for the NGO itself which thereby obtains a frame of reference for its actions. Regrettably, not many (if any) psycho-social NGOs had such evaluation mechanisms built into their projects. Consequently, this is one of the important lessons learned for future psycho-social assistance quality control, and it is recommended that the donor require that a quality control mechanism be part of the project. It is suggested that NGOs receive assistance and supervision in the project formulation, so that standard evaluation variables are used (e.g. the proposed variables in Chapter V).

In the exchange process which develops between monitor and NGO, it is of utmost importance to respect the NGO's wish for independence. The basis for self-organization and democratic participation is freedom – an ideal which is also

the essence of NGO philosophy. However, the donor does also have the right to control whether funds are being used appropriately. Thus, in monitoring, a delicate balance must be established between collaboration and control – with emphasis on collaboration in an open and trusting atmosphere.

For NGOs, it is extremely important that the monitor trusts them and understands their efforts, that she/he provides support and encouragement – especially when the staff works in stressful, or even dangerous, circumstances in a war. If the monitor comes as an “inspector”, she/he will add to the stress which NGOs are already exposed to. The monitoring process should, likewise, be free of simple value judgements such as a “good” or “bad” project. Instead, NGOs should be offered an open and honest second opinion which can open new perspectives in situations where implementation is confronted with difficulties.

In our monitoring work, we attempted to establish a positive exchange process with the NGOs by emphasizing professional issues and creating a collegial dialogue with NGO staff. This facilitated our field work, but we feel that it also helped NGOs conceptualize their experience and develop their skills.

### ***Why technical support?***

Although former Yugoslavia had a well-trained core group of mental health professionals, there were not many who had experience in working with refugees. Knowledge had to be imported from countries with experience in provision of services to refugees, asylum seekers, and victims of human rights violations.

Consequently, the Psycho-Social Unit developed a collaboration with the WHO over the training of national mental health professionals. As part of the WHO Regional Models for Mental Health (Jensen & Wilson, 1966), the Psycho-Social Unit taught at seminars and workshops in topics such as: post-traumatic therapy, secondary traumatization and burn-out in service providers, countertransference reactions, the testimony method as a therapeutic tool, testimony and social memory, mental health and human rights, and the psychological aspects of mixed marriages under war conditions.<sup>1</sup>

### ***Psycho-social projects and humanitarian aid***

During the first years of our work in the Psycho-Social Unit, we saw a great deal of interest from donors and implementing agencies in providing psycho-social assistance to victims of war, but in recent months, we have witnessed this interest declining. This is a problem which is related to the nature of psycho-social work.

If we want to assist traumatized people, we must first create a relatively safe atmosphere. Thereafter contact must be established with the beneficiaries, a healing process must be facilitated through various interventions, and finally we must direct beneficiaries towards independence and self-organization by encouraging them and teaching them new skills. Each step requires increasing amounts of funding, especially if we want to develop the services to cover a wide spectrum of traumatized groups.

However, most field experience is of the opposite: NGOs receive most funding at the beginning of a project. This is the phase during which they are profiling their project, finding their way and gaining experience. Later, when they have

1 - See Appendix 3 for an overview of the activities of the Psycho-Social Unit, 1993-96.

matured and are capable of providing more sophisticated services for a greater number of people, funding often stops.

Even in the project planning phase, the question of sustainability should be addressed: how is the international NGO going to withdraw; how will the international NGO ensure that the work it has done remains viable in one form or another? Such plans should be a requirement for all projects receiving financial support. The donor, on the other hand, should maintain its support until sustainability has been secured.

It has now formally been recognized that psycho-social projects must be part of emergency humanitarian assistance and that our actions in that phase will have an important influence on the following reconstruction phase (MSF/WHO, 1995). However, in practice it is still common to encounter mistrust, lack of knowledge and under-valuing of this type of crisis intervention. As psychologists we are used to meeting these attitudes to our work, which seems provocative to quite a number of people. However, we do feel that it is our moral duty to keep up advocacy for the beneficiaries, so that no-one is denied the right to be informed about what happened in this war – both to the bodies and to the souls of people. If not us, who? If not now, when?

In the evaluation presented in Chapters III and IV, we have shown that it is possible to quantify psycho-social work: socio-demographic data on beneficiaries and staff, traumatic experiences, coping mechanisms, psycho-social interventions, changes in symptoms, benefit of interventions, training needs of staff. This evaluation has brought us closer to an understanding of the beneficiaries, of their needs and their hopes.

For the peace process to develop, changes must happen – not only on the leadership level – but also among people. Trauma and suffering breed withdrawn people who are not able to integrate or assimilate their traumatic experiences – that would be too painful. Psycho-social programmes counteract this withdrawal by providing care and facilitating solidarity, helping people survive emotionally. It is to be hoped that the power of such positive experiences can become so strong that trauma victims may at last be able to absorb their painful stories. There will then be resources to meet others with equally painful stories, even if they belong to the “other side”.

### ***Conclusion***

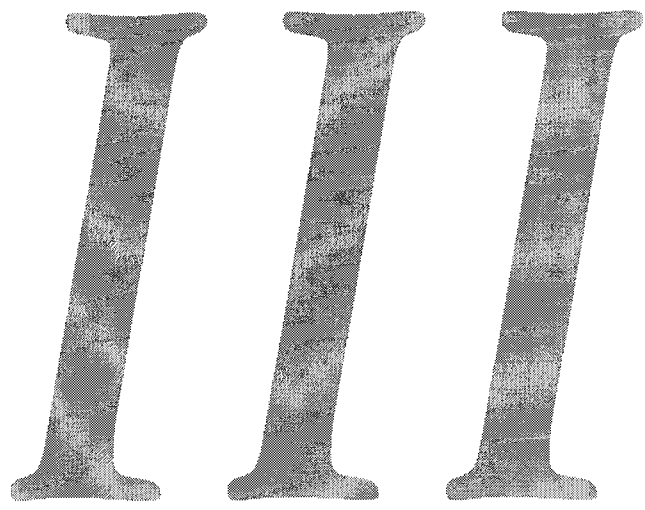
Until the establishment of the Psycho-Social Unit, ECHO had mostly been concerned with distribution of material aid. With the new focus on psycho-social assistance, an overview had to be established and new working methods developed. Monitoring of psycho-social aid was developed on the basis of an analysis of levels of intervention. However, it is recommended that quality assurance should be built into the psycho-social projects already in the planning phase. Also, plans for sustainability should be encouraged by the donor.

In the Psycho-Social Unit we saw it as our main task to support the NGOs by providing professional input, supervision and conceptual frameworks in the midst of a chaotic reality of war and destruction. The evaluation which we carried out at the end of our mission and which is presented on the following pages should be seen as another attempt at creating more overview and clarity.









**THE STUDY: BENEFICIARIES  
TRAUMATIZED SOULS**

---



### **III. INVISIBLE EFFECTS OF WAR: TRAUMATIZED SOULS**

---

War has profound effects on the whole human being, traumatizing not only bodies but also souls. While for years it has been accepted practice to deliver bandages, medicine, food and shelter to war traumatized bodies, it is something new to include emergency care for war traumatized souls in humanitarian aid.

How can we best describe psychic war trauma as we have seen it in former Yugoslavia? In this war where neighbour was fighting neighbour, basic trust in fellow human beings was destroyed along with lives and communities. For so many, basic trust in a benign and predictable world crumbled and was replaced by hate and terror.

To re-build trust is fundamental for a real peace process to happen. Without trust there can be no reconciliation or cooperation. Re-building trust is a psycho-social process, depending both on individual psychological factors and on socio-political factors. Psycho-social programmes, therefore, gain a special significance for the peace process.

In the study which we are presenting here, we attempt to evaluate the effects of the pioneering psycho-social programmes for victims of war initiated by ECHO in 1993. Our overall objective is to ascertain how or if these programmes influenced re-building of trust and cooperation.

Our study was carried out in the period from 20 September to 7 November 1995, that is, during the last few weeks preceding the Dayton Peace Agreement of 21 November 1995. During that period, the peace process had already begun to move forward, and there was cautious optimism that the end of the war could be near. However, fighting was still going on in September and at the beginning of October, particularly in western Bosnia and Herzegovina. NATO strikes were conducted against the Bosnian Serbs on 4 October. On 12 October a cease-fire agreement was reached which generally held throughout the rest of our data-collection period. Thus, our study was carried out in a historical context which was slowly changing from war to peace, although not many dared believe that peace would really come.

#### ***Purpose***

Within the overall framework of evaluating the peace-building capacities of psycho-social programmes, we shall examine a number of factors in more detail:

- Socio-demographic background, traumatic experiences and trauma symptoms of beneficiaries
- Motivation for joining the psycho-social programme
- Participation in activities and evaluation of the benefit of these activities
- Outcome of participation in the psycho-social programme.

## **Material**

Our sample includes 2,291 beneficiaries of seven ECHO psycho-social programmes in Bosnia-Herzegovina and Croatia. The programmes were implemented by the following European NGOs:

- *Bosnia Aid* – a German NGO which had established centres for protection of women and children in Tuzla: Project Amica.
- *Centro Regionale d'Intervento per la Cooperazione* (CRIC) – an Italian NGO which in collaboration with four national NGOs carried out a project in Rijeka of psychological support to refugee and displaced women, children and families.
- *Eurocités* – a French NGO which ran a programme in Sarajevo for social support to the most vulnerable inhabitants of the city.
- *Gruppo Volontariato Civile* (GVC) – an Italian NGO which carried out a programme in Tuzla for war-traumatized women in collaboration with Project Amica.
- *Handicap International* – a French NGO which carried out a programme of psychological support to refugees and displaced people on the Adriatic Coast.
- *Marie Stopes International* (MSI) – a British NGO which carried out a large emergency programme of assistance for refugee and displaced Bosnian women through self-help groups and field service teams. The programme included 58 women's centres in Bosnia-Herzegovina (in Bihac, Mostar, Sarajevo, and Western Herzegovina) and Croatia (on the Adriatic Coast and in Slavonia).
- *Oxfam* – a British NGO which had established centres for refugee, displaced and local war-traumatized women in Tuzla.

The seven NGOs reached an estimated 25,000 beneficiaries, which means that our sample represents around 10% of the selected NGOs' beneficiaries.<sup>1</sup>

We chose to include the above-mentioned NGOs in our study because they all provided organized psychological support at different levels of intervention. We excluded NGOs working with children, as children would not be able to complete our questionnaires.

We distributed 2,500 questionnaires, which means that the return rate was around 90%. This is an astonishingly high rate, and could partly be attributed to the fact that we represented the donor. Of course, this should also be taken into account in the interpretation of the answers: there might be a tendency to "please" the donor by over-emphasizing positive results. However, we also felt that the staff was highly motivated and cooperative.

For both ethical and professional reasons, we have not attempted to make comparisons between NGOs: our main focus was on the beneficiaries regardless of the programme in which they participated.

<sup>1</sup> - Some of the seven NGOs also distributed medical or other types of material aid to a large number of beneficiaries. We have not included these beneficiaries in our estimate, as our primary interest is psycho-social assistance.

## **Method**

We chose to carry out this investigation as a quantitative "consumer study" building on the beneficiaries' own perception and evaluation of the programme they participated in. We also chose to base our data collection exclusively on self-administered questionnaires, as we wanted to reach as many beneficiaries as possible in order to obtain a good representative sample.

It would have been valuable to supplement the questionnaires with qualitative interviews, but time and resources did not allow this. We did, however, also carry out a staff study a few weeks later, in order to throw more light on the results from the beneficiary study. We shall examine the staff study in Chapter IV.

The questionnaire was constructed on the basis of experiences from a pilot study of 200 MSI beneficiaries in Slavonia and Western Herzegovina carried out in January–February 1995. Questionnaires developed by Batja Mesquita, UNICEF, and Norwegian People's Aid were also a valuable source of inspiration as well as comments by Dr. Søren Buus Jensen, WHO.

The coordinator and psycho-social assistant distributed the questionnaires by assembling leading staff members of each NGO and having them complete a questionnaire in order to become acquainted with its format. The purpose of the study was explained and questions were clarified. The staff was asked to distribute the questionnaires as randomly as possible, that is, to all beneficiaries attending the programme during the following few days.

It was underlined that it was entirely voluntary for beneficiaries to complete the questionnaires, and that the anonymity of the beneficiaries should be protected as far as possible. However, as some beneficiaries were illiterate, assistance was needed for them to complete the questionnaire, a fact which naturally hindered full anonymity.

The NGO staff were positive towards the study and promised their full cooperation, which was later proven by the high return rate of questionnaires mailed to us.

In the presentation of our findings, we have chosen to comment and interpret results as we present them in order to ensure the readability of the text.

## A. GENERAL FINDINGS: A STUDY OF THE TOTAL SAMPLE

In the following we shall examine and comment on the principal data on all 2,291 beneficiaries.

### *Socio-demographic data*

The most frequent characteristics among selected social background factors for the beneficiaries are shown in Figure III.A.1:

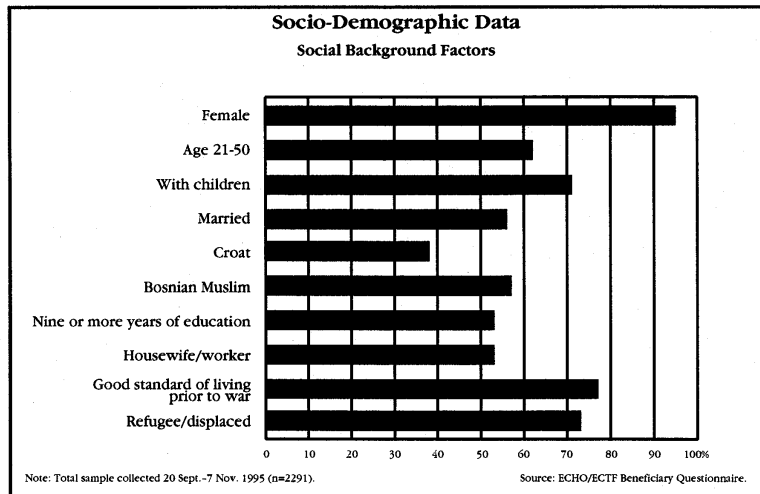


Figure III.A.1. Selected socio-demographic characteristics of beneficiaries in Bosnia-Herzegovina and Croatia.

It is not surprising that almost all beneficiaries are women as they are specifically targeted by the projects. Before the war, 60% were living together with a spouse, as opposed to 37% at the time of the study. Fifty-seven per cent lived with their children before the war, as opposed to 47% now. Five per cent lived alone before the war, as opposed to 14% at present.

It is remarkable that three-quarters of the beneficiaries answered that they had a good standard of living prior to the war and that more than half have nine or more years of education: former Yugoslavia was not a poor country, and its population was well educated. However, this fact contributes to the sense of social degradation felt by many refugees and displaced people. (Displaced people have been forced to leave their homes; refugees are displaced people who have crossed a national frontier.)

Asked about what was most difficult on arrival, most refugees and displaced people emphasized worries about the fate of family members, loss of home and difficult living conditions.

We have also chosen a number of factors indicating social vulnerability in this socio-political context. Figure III.A.2 shows their magnitude.

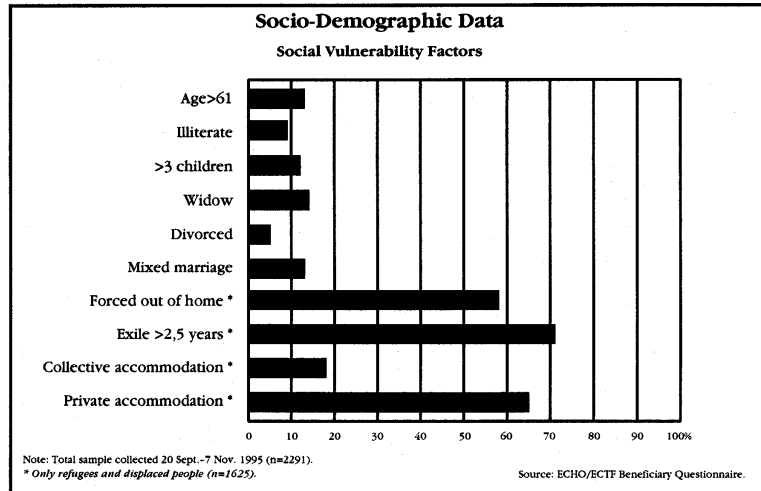


Figure III.A.2. Some social factors indicating increased vulnerability among beneficiaries in Bosnia-Herzegovina and Croatia.

The rate of mixed marriages (13%) corresponds closely to the rate (12%) found in statistics covering the entire population of former Yugoslavia in 1962–82 (Botev, 1994). Mixed marriages and their children are less vulnerable in large cities, but may also suffer direct or indirect persecution there (Agger, 1996).

In spite of the generally high level of education, it is noteworthy that we find an illiteracy rate of 9%. The women without any schooling mostly come from the countryside in Bosnia-Herzegovina. We also note that most of the refugees and displaced people have been exiled for a long period of time, thus adding to their feelings of hopelessness and frustration.

Most of the refugees and displaced people live in private accommodation, and although this is generally thought to be better than life in a collective centre, experiences have shown that long-term stays as “guests” even among family members can become extremely burdensome. In collective centres the refugees/displaced people at least have a right to their own room even if they have to share and usually have better access to humanitarian aid than those living in private accommodation. Moreover, in collective centres there is a possibility of sharing and socializing with people who are in a similar situation.

Before entering the psycho-social programme, beneficiaries tried to help themselves by working (27%), by concentrating on survival (18%), by socializing (12%), by caring for their family (10%), and in a variety of other ways. These were answers to an open question which were later categorized.

### Traumatic experiences

In the following chart, we show the rate of primary and secondary traumatization suffered by the beneficiaries.

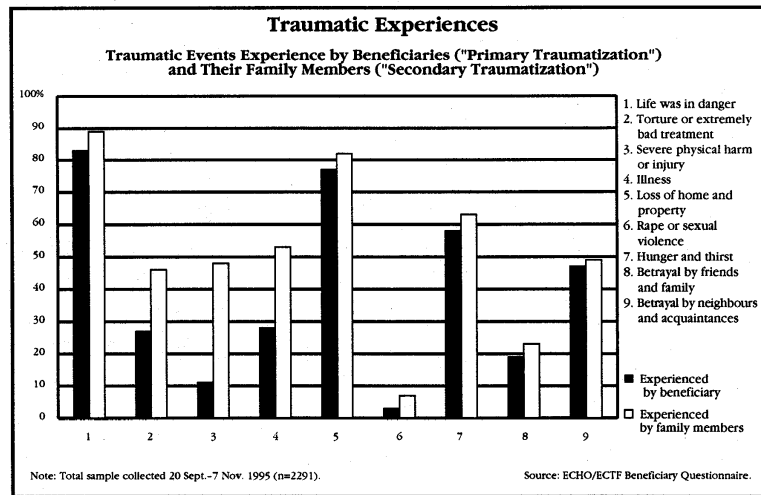


Figure III.A.3. Primary and secondary traumatization of beneficiaries in Bosnia-Herzegovina and Croatia.

Traumatization can be described from different perspectives. One perspective describes the distance of the stressor (the factor causing stress) from the "object" (a person, a couple, a family, a group, a society). Another dimension describes the frequency of the stressor event. A third dimension describes the context in which the stressor event takes place.

The distance of the stressor from the object describes how close the person (or couple/family/group) is – physically, psychologically and/or socially – to the stressor event. In primary traumatization, the person is the direct target of the stressor: for example tortured, injured, raped people.

In secondary traumatization, the stressor event is the primary traumatization of someone else: the person is traumatized through the traumatization of another person (couple/family/group...) with whom he or she has a close relationship (Agger & Jensen, 1996).

In Figure III.A.3 it is noteworthy that stressors such as "life was in danger" and "loss of home and property" have been experienced by around 80% of all beneficiaries and their family members. Thus, the beneficiaries have not only experienced these stressors themselves (primary traumatization) but they have also had to cope with the suffering of their family members (secondary traumatization). Often a person belongs to a large, extended family and therefore also feels very affected by what happens to, for example, cousins and uncles.

The stressor events are continuous and they happen in a context of a war in which neighbours turned against each other. This also explains why almost half of the beneficiaries and their family members have experienced "betrayal by neighbours and acquaintances".



Based on the answers to our Staff Questionnaire and data collected by Petrović (1996), we estimate that a large number of beneficiaries (25–50%) have also suffered the trauma of losing a family member. “To lose my dearest one” is considered worst of all by many of the women writing their spontaneous comments in the questionnaires.

Below, regional distributions of some of the traumatic experiences are shown:

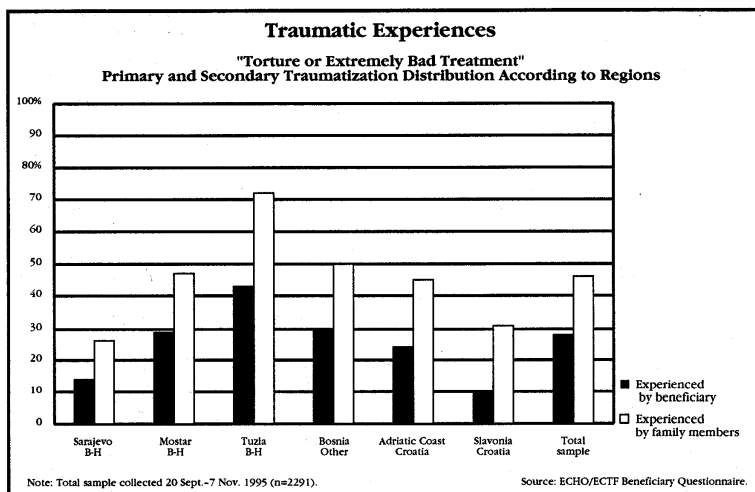


Figure III.A.4. Regional distribution of torture or maltreatment experiences of beneficiaries and their family members.

The high rate of torture and extremely bad treatment in the Tuzla region probably reflects the presence there of many refugees and displaced people from Bratunac, Vlasenica and Srebrenica, all towns in which gross human rights violations took place.

Regional distribution of loss of home and property is shown in the following:

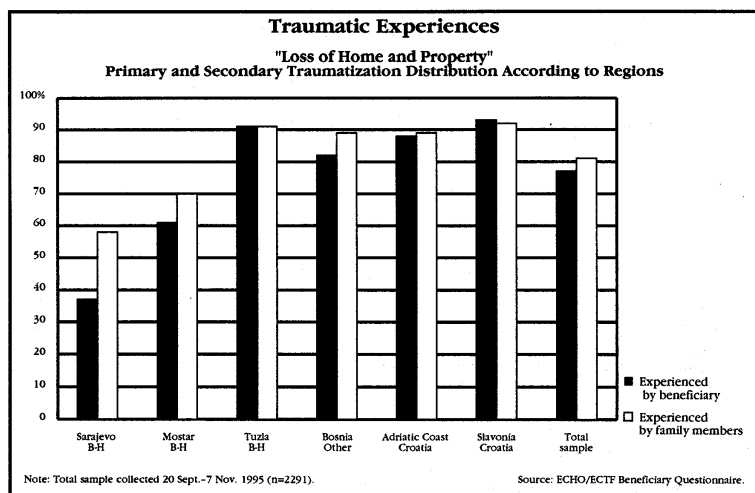


Figure III.A.5. Regional distribution of loss of home and property to beneficiaries and their family members.

The relatively low rate of loss of home and property in Sarajevo is consistent with the low rate of refugees and displaced people found in our data (21%). Most of the beneficiaries in Sarajevo have stayed in their own home, although under siege.

The rate of rape or sexual violence reported by the beneficiaries in various regions is shown in the following chart:

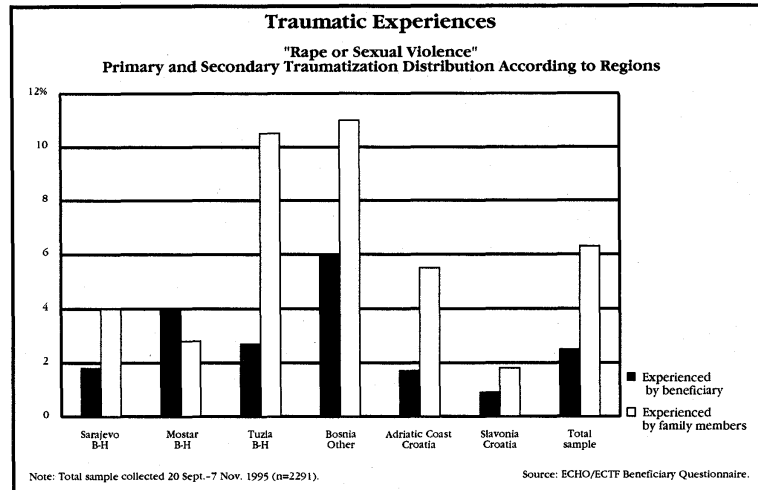


Figure III.A.6. Regional distribution of rape or sexual violence experienced by beneficiaries and their family members.

The questions about rape and sexual violence of self or family members were not answered by 20% of the beneficiaries. The "not answered" rate to these questions ranked as the highest of "not answered" rates for all nine trauma questions. This is of course important information indicating that the topic of sexual violence is difficult to approach for various reasons. The highest rate of rape or sexual violence is found in "Bosnia other" and is reported by women who are refugees and displaced people in Western Herzegovina. In Tuzla, beneficiaries also reported high rates – but only for family members.

It is well-known that traumatic experiences are often reported as happening to someone else. In an investigation by Norwegian People's Aid in Tuzla of 158 women receiving psycho-therapeutic treatment, 6% of the women reported an experience of rape or sexual violence (Dahl, 1996). The rate of 3% reported in our study by beneficiaries (6% for family members) should probably be seen as an indication of how difficult it is to acknowledge this experience, especially when answering a questionnaire in a setting where anonymity cannot be totally ensured. However, sexual abuse must be seen in the context of multiple traumatization.

The regional distribution of hunger and thirst is shown in the following chart:

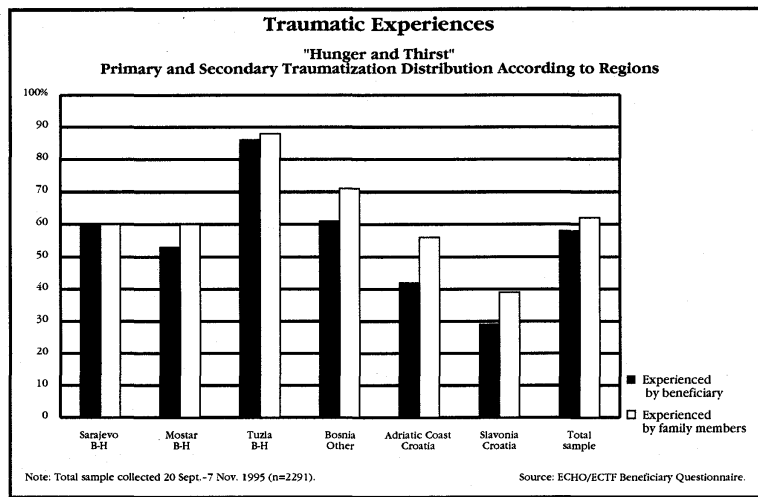


Figure III.A.7. Regional distribution of hunger and thirst experienced by beneficiaries and their family members.

Tuzla is one of the regions in which beneficiaries and their family members have suffered most from hunger and thirst, reflecting the number of refugees and displaced people from severely war-affected areas, but other regions have also suffered widespread physical deprivation of this kind.

The following chart shows the regional distribution of betrayal by neighbours and acquaintances:

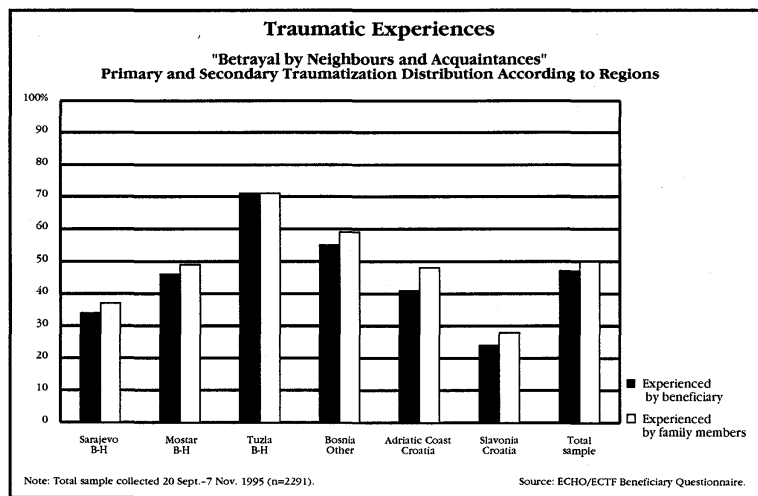


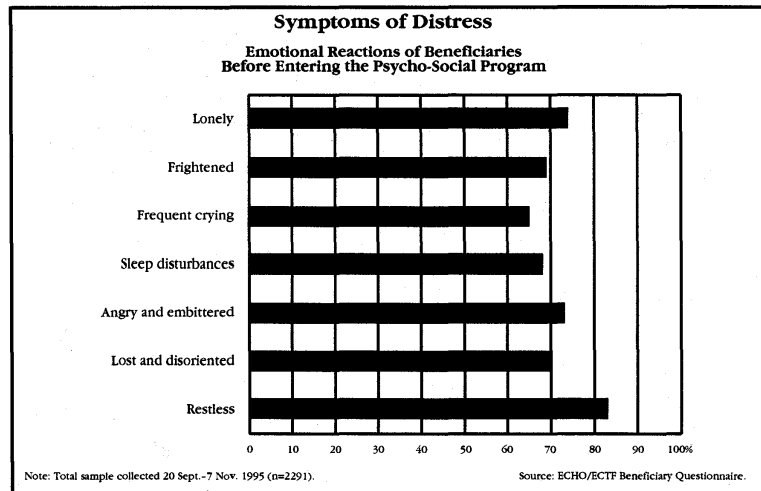
Figure III.A.8. Regional distribution of beneficiaries' and their family members' experience of being betrayed by neighbours and acquaintances.

The "betrayal rate" of neighbours and acquaintances is 2-3 times that of friends and family. The Mostar betrayal experiences probably reflect the antagonism

between East and West, while the rate found on the Adriatic Coast could reflect the experiences of refugees and displaced people who have been ethnically cleansed.

### **Trauma symptoms**

Among the many symptoms of distress reported by the women, we have chosen to ask beneficiaries about the following seven which were the most frequently reported in our pilot study:



*Figure III.A.9. Emotional symptoms of distress reported by beneficiaries before entering the psycho-social programme. On average, each beneficiary experienced 5-7 symptoms, indicating a high degree of traumatization.*

In addition, many beneficiaries reported suicidal thoughts in their spontaneous written comments. The beneficiaries generally have most of the symptoms shown in Figure III.A.9 in a syndrome-like state which could also be described as utter demoralization (Frank & Frank, 1991) characterized by "helplessness (no one will help me), hopelessness (no one can help me), accompanied by anxiety, depression and loneliness" (Hougaard, 1996 p. 75). These symptoms, which are general for patients seeking psychotherapy, also have a good prognosis (ibid.).

The beneficiaries reported suffering from almost all of the above-mentioned symptoms before they asked for help by entering a psycho-social programme. The data indicate that they are multi-traumatized and multi-symptomatic. An important feature of this emotional state is the belief that "no one will or can help me". It has often required a major effort by psycho-social programmes to motivate people to enter the programme.

### **Motivation for seeking help**

Ninety-five per cent of all beneficiaries state that they entered the psycho-social programme because they needed to be together with other people. Eighty-six per cent also state that they needed help, and 79% that they needed comfort. The need for contact, help and care were thus, in retrospect, the main motivation of almost all beneficiaries for becoming part of a psycho-social programme. Some also add in spontaneous comments that they needed material support, something to do, or to avoid thinking of the war.

It is a general impression from our experience with various psycho-social programmes that activities or material aid can provide an acceptable “excuse” for entering the programme, and that the need and motivation for psychological help will develop gradually as a trusting relationship is built up between the beneficiary and the programme. Thus, material aid and occupational activities are important ingredients in a psycho-social programme. Likewise, delivery of humanitarian aid could also be combined with psycho-social assistance.

Forty-five per cent of the beneficiaries have been in the programme for less than six months, 21% for 6–12 months, 30% for 12–24 months and 4% for more than 24 months.

The beneficiaries indicate that they continue in the programme because they get what they need. Almost all indicate that they feel better and more relaxed (95%), and that they get contact with (97%) and understanding (91%) from others.

### ***Benefit of the various activities***

In the following chart the participation rate in the various activities offered by the programmes is shown. The beneficiaries’ evaluation of these activities is also shown:

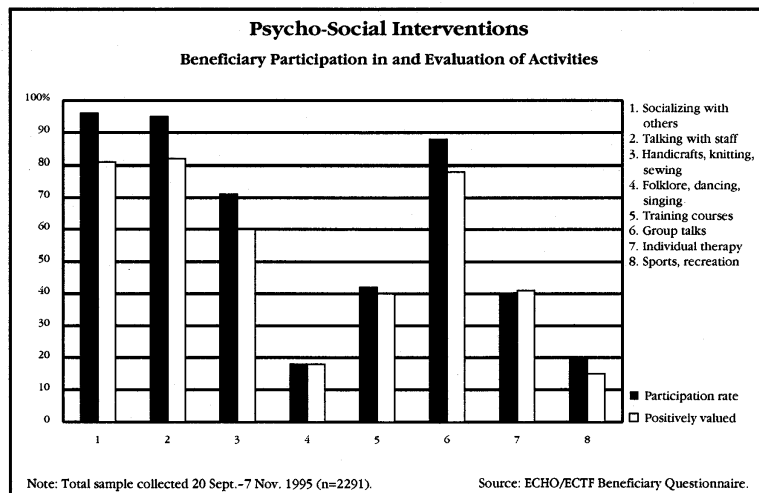


Figure III.A.10. Beneficiary reports of activities they have participated in and their evaluation of the benefit of those activities.

The activities offered by the programmes reflect an adaptation to the needs of the beneficiaries. As related by the former Programme Director for Marie Stopes International:

*“It’s what the women want...that is what the women were saying, that it is nice to sit around, and from Central Bosnia they have a tradition of sitting around in the evening, knitting and talking, so that this notion of sitting around, it’s a very powerful thing.”*  
(McKeown, 1995)

It is notable from the chart shown above that close contact in “healing circles” is evaluated highest by the beneficiaries: socializing with others, talking with staff, group talks and handicrafts.

In the following chart the healing factors have been grouped in a pyramidal structure:

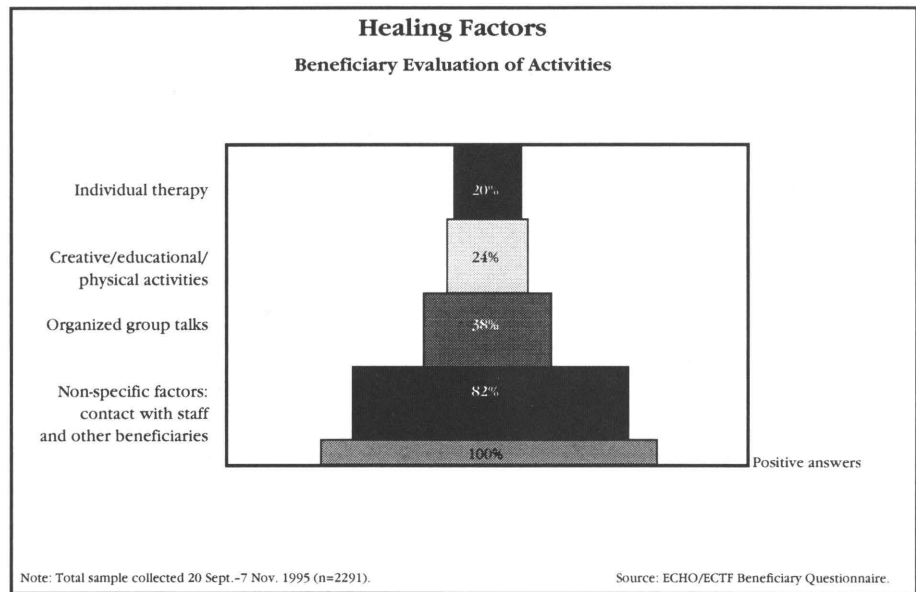


Figure III.A.11. The healing power of activities evaluated by beneficiaries.

Socializing with others and talking with staff are non-specific factors which provide contact, warmth, care and acceptance. These factors are encouraged by the creation of a safe space, a room, a centre, in which beneficiaries can feel welcome and where they can meet each other, meet caring staff members and begin re-building trust. These factors are valued most positively by the beneficiaries (82%).

However, such non-specific factors are also relevant in organized activities such as group talks, creative, educational and physical activities, and individual therapy. These organized activities were evaluated as considerably less healing by the beneficiaries.

It can tentatively be concluded that the greatest need of war-traumatized people is to find a space in which trust in fellow human beings can be re-established and where normal human relationships can be formed. The activities offered in this space are less important than the general atmosphere of communal healing.

### **Outcome**

Eighty-three per cent of responding beneficiaries report that participation in the programme was of great or considerable help to them. The programme also seems to reduce all initial symptoms: about 90% report that they are less lonely, that they have achieved more inner peace and are in a better mood. Viewed as a crisis intervention, the programme seems to have attained its goal: to keep people going even under extremely difficult circumstances.

However, there is a problem with anger and bitterness. Only 68% report being less angry and bitter. Although this is a relatively high rate, changes in level of aggression are reported significantly less often than changes reported for other symptoms (anxiety, depression and loneliness). It seems to be more difficult to work with aggressive feelings in the context offered by psycho-social programmes. This is of course also related to the social and political context in which the programmes are operating. However, anger and bitterness are precisely those feelings which ignite revenge and contribute to the continuation of war. Anger and bitterness are serious obstacles to reconciliation and co-existence. On the other hand, aggressive feelings also involve energy which could become a positive force.

Programmes do appear to move beneficiaries to a certain degree towards reconciliation by helping them reduce anger and bitterness. It could, however, be concluded that more opportunities should be provided for positive reframing of anger and bitterness in a socially constructive direction (e.g. testimony work, protests against the war, human rights advocacy), and that this development would be a substantial improvement of the programmes.

## **B. REGIONAL FINDINGS**

We shall now turn our attention to selected areas in Bosnia-Herzegovina and Croatia which all have their special characteristics. The complicated pattern of war and ethnic cleansing have resulted in local conditions varying considerably. The psycho-social programmes operating in the different regions seem to have been flexible and sensitive to the diverse needs of their beneficiaries, adjusting their approach to the local situation.

First, data from three Bosnian cities will be analysed: the "besieged city" of Sarajevo, the "divided city" of Mostar and the "tortured city" of Tuzla. We shall then proceed with analysis of data from three regions: the Bihac enclave in Bosnia; and the Adriatic coastal region and Slavonia – both of which are regions in Croatia.

### ***1. The besieged city – Sarajevo***

The data from Sarajevo reflect the situation of siege which this town suffered for three-and-a-half years. The most intensive and prolonged Serb bombardments were aimed at Sarajevo, and the siege impacted on each and every person's life at all levels. According to Bosnian government sources, an estimated 10,000 people in Sarajevo were killed and 50,000 were wounded. However, the siege also seriously traumatized the very essence of the city. How this really affected its inhabitants can only be assessed in the future.

Our data from Sarajevo were collected from 21 to 29 October 1995. At that time, the siege was gradually being lifted, and humanitarian aid could reach the city practically unhindered through Bosnian Serb territory. Civilians were being allowed to cross the "Brotherhood and Unity" bridge linking the Serb and government-controlled parts of Sarajevo, although it did require strenuous effort to obtain a permit to cross.

### Traumatic experiences

A superficial look at our data could indicate that the beneficiaries of Sarajevo are not as traumatized as those in other areas. Their rate of reported traumatic events is lower than found in almost all other areas.

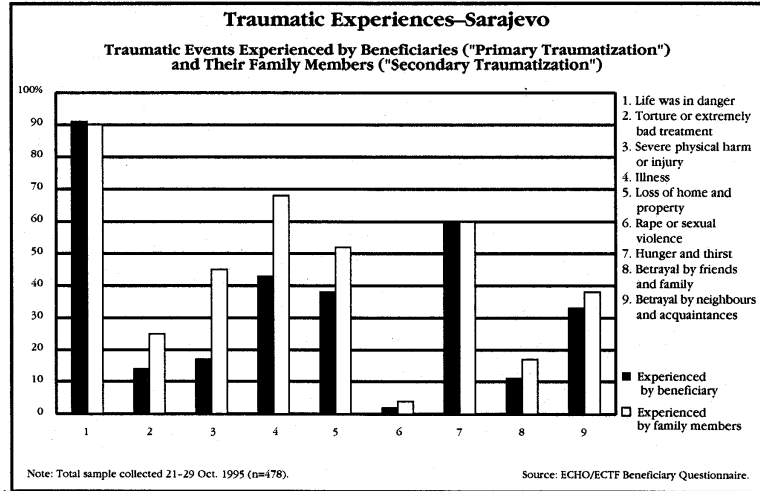


Figure III.B.1 Primary and secondary traumatization of beneficiaries in Sarajevo.

The dominating element in the lives of beneficiaries is probably not a single traumatic event. Prolonged exposure to a life-endangering situation with lack of basic necessities is the overall picture. Deterioration of the social and cultural life of the city has also been an important element in the traumatic experiences of this population.



## Socio-demographic data

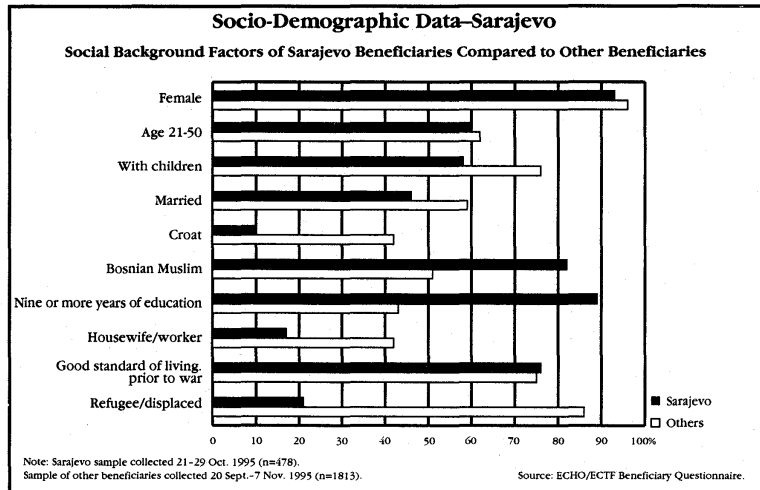


Figure III.B.2. Selected socio-demographic characteristics of beneficiaries in Sarajevo compared to characteristics of other beneficiaries in Bosnia-Herzegovina and Croatia.

As seen in Figure III.B.2, the rate of unmarried beneficiaries is higher in Sarajevo than in the rest of the sample. Many are also alone due to the departure of family members. Therefore, psycho-social programmes also acquire a role as basic social support network.

Twenty-four per cent of the beneficiaries have a university degree, which makes Sarajevo's people the best educated among all our beneficiaries. Only 20% of the Sarajevo beneficiaries are refugees/displaced people, and of these 71% come from Serb-controlled parts of Sarajevo.

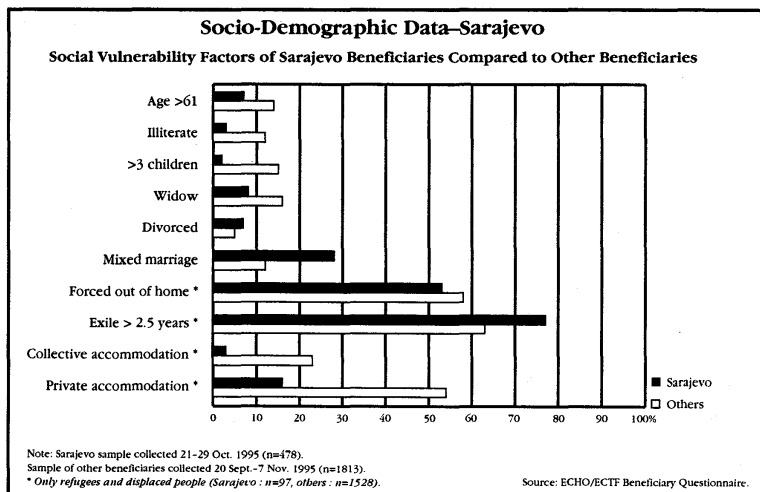


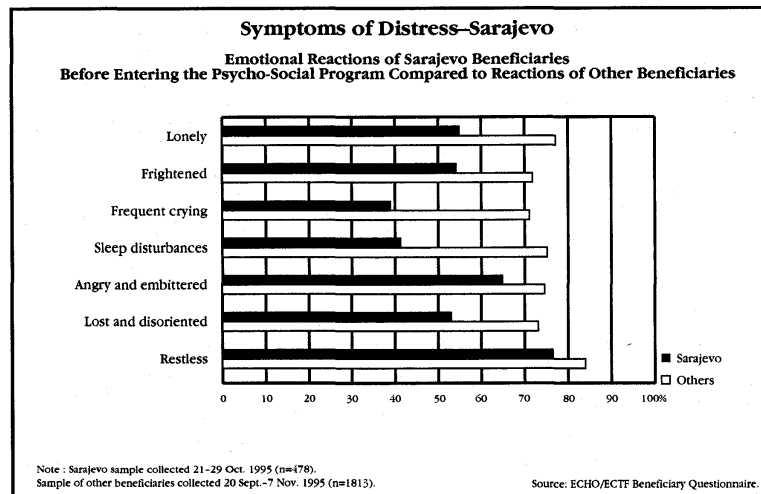
Figure III.B.3. Some social factors indicating vulnerability among beneficiaries in Sarajevo compared to other beneficiaries in Bosnia-Herzegovina and Croatia.

There is a low incidence of social vulnerability factors among the Sarajevo beneficiaries, as shown in Figure III.B.3. This – in combination with the high

educational level and other protective factors – might partly explain why we found a lower incidence of stress symptoms here than in the rest of the beneficiary sample.

When asked how they tried to help themselves in a difficult situation, 32% answered that they got involved in work activities, 17% concentrated on survival, 14% cared for their family, while 11% kept up hopes. The coping pattern seemed overall to be active: not many stated that they despaired or gave up.

### **Trauma symptoms**



*Figure III.B.4. Emotional symptoms of distress reported by Sarajevo beneficiaries before entering the psycho-social programme. The symptoms of the Sarajevo beneficiaries are compared to the symptoms of other beneficiaries in Bosnia-Herzegovina and Croatia.*

Restlessness, anger and bitterness dominate the emotional profile of our beneficiaries before they entered the psycho-social programme. The prevalence of these emotions indicates that the beneficiaries were in a state of alert due to on-going exposure to life-threatening events. With a decrease in dangerous stimuli and a change in the state of alert, other feelings might emerge such as hopelessness, helplessness and depression (at the time of writing, at the end of March 1996, reports of this development have already been received).

At the time of investigation, basic utilities such as gas, water and electricity had just recently been restored, so there was also a new spirit of hope among people which could have influenced our findings.

### **Benefit of psycho-social activities**

The psycho-social programmes in Sarajevo seem to reflect the needs of the population for social, cultural and educational activities, in the midst of siege and a lack of basic necessities. Therefore, we find a higher rate of creative and educational activities than in other areas. Many beneficiaries also participate in group work, thereby creating new social networks.

Beneficiaries seem to value these activities highly, as seen in Figure III.B.5. However, we also note that beneficiaries attach most value to the informal interaction with other beneficiaries and with staff:

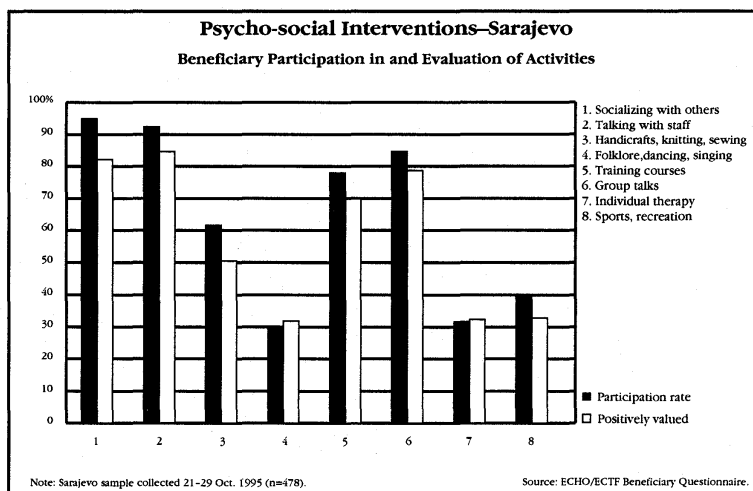


Figure III.B.5. Beneficiary reports of activities they have participated in and their evaluation of those activities.

The Sarajevo experience challenges basic assumptions, e.g. whether it is meaningful to rank needs in a hierarchy, with some needs being seen as more fundamental than others. The Sarajevo beneficiaries seemed to need human contact, culture and development just as much as food and drink.

## 2. The divided city – Mostar

Mostar is an ancient town at the Neretva river symbolized by its bridge, which was built in 1566 and survived many wars, although it did not survive this one. On 9 November 1993 at 10:16 a.m. the bridge was deliberately destroyed by Croat gunfire.

In 1992, during the first six months of the Bosnian war, the Serbs shelled the city until they were pushed back by the Bosnian Croat army (HVO). In April 1993, war broke out between Muslims and Croats in the town, and this war lasted nearly a year, that is, until the Washington agreement was signed on 18 March 1994.

In our sample of beneficiaries from Mostar, we find people who have fled from two wars. Those who fled in 1992 state that they fled because they were ethnically cleansed by the Serbs. Those who fled in 1993 state that they fled because they were ethnically cleansed by either the HVO or the Muslim army.

Both the Croat and Muslim sides have committed atrocities against each other, and at the time of our investigation, from 22 to 28 October 1995, the town was divided into a Western side held by the Croats and an Eastern side held by the Muslims.

The decision to present the data from Mostar West and East separately, and to attempt comparisons between them is not meant to justify the division. We are searching for facts: the wounds which must be healed, the feelings and the needs of the beneficiaries.

### ***Socio-demographic data***

The boundary between Mostar West and East is rather artificial and is a result of street fights rather than the previous location of ethnic groups. This is illustrated by the following two tables, where we can see that about half of the refugees/displaced people among our beneficiaries moved from one side of the river to the other, but that they stayed in the town. However, in our Mostar East data we find considerably more refugees than in Mostar West.

Home Town	TOWNS FROM WHICH REFUGEES AND DISPLACED WERE EXPELLED	
	MOSTAR EAST	
	Number of refugees/displaced	%
Mostar West	31	52.54
Stolac	7	11.86
Nevesinje	5	8.47
Other places	15	25.43
Not answered	1	1.7
<b>TOTAL</b>	<b>59</b>	<b>100</b>

*Table III.B.1. Place of origin of displaced people in Mostar East.*

Home Town	TOWNS FROM WHICH REFUGEES AND DISPLACED WERE EXPELLED	
	MOSTAR EAST	
	Number of refugees/displaced	%
Mostar East	18	52.94
Other places, Herzegovia	11	32.35
Other places, Bosnia	5	14.71
Not answered	0	0
<b>TOTAL</b>	<b>34</b>	<b>100</b>

*Table III.B.2. Place of origin of displaced people in Mostar West.*

The fact that there has been such interchange between the two sides leaves us with hope that the town might eventually be reunited.

In the following chart, selected social background factors of beneficiaries in Mostar West and East are shown:

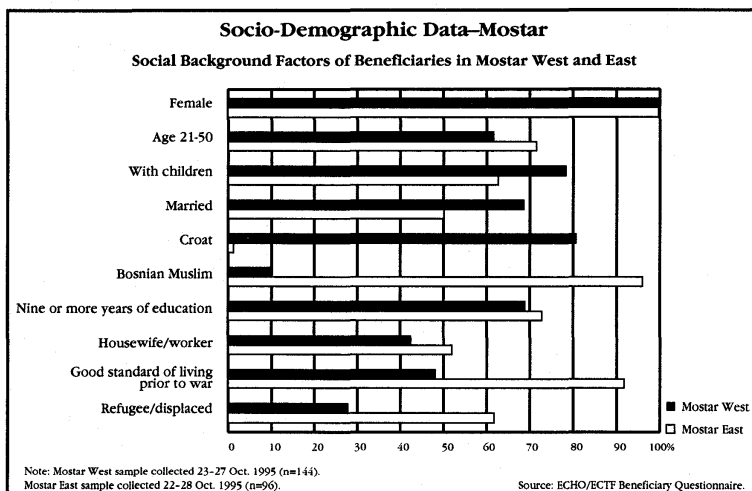


Figure III.B.6. Selected socio-demographic characteristics of beneficiaries in Mostar West compared to characteristics of beneficiaries in Mostar East.

It is notable that only one ethnic Croat in our sample is living on the Eastern side, while we find 11% Muslims on the Western side. Probably this is due to the harshness of living conditions in Mostar East: Croats would probably attempt to flee to the Western side if at all possible. However, twice as many beneficiaries in Mostar East as in West state that they had a good standard of living prior to the war.

If we look at the social vulnerability factors found on the two sides, we note in Figure III.B.7 that the programmes on the Western side deal with more elderly women, with more widows, and with more mothers of large families. On the Eastern side, the beneficiaries are characterized by a long period of exile, and by the traumatic experience of being forced out of their homes. We also find more mixed marriages on the Eastern side.

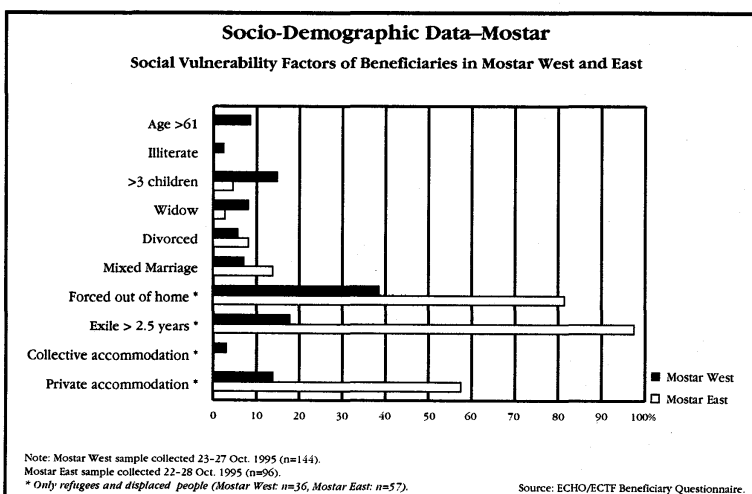


Figure III.B.7. Some social factors indicating vulnerability among beneficiaries in Mostar West compared to beneficiaries in Mostar East.

The general impression from the spontaneous comments written in the questionnaires is that the situation for refugees/displaced people in Mostar East was more difficult than in West. There was no collective accommodation in East, and throughout the questionnaires, the women comment on their suffering: "I was living proof for many people that it was possible to survive", as one woman from Mostar East wrote. However, the situation in Mostar West was also difficult, as illustrated by another woman: "I begged on the streets."

**Traumatic experiences**

As shown in the following two figures, considerably more traumatic events - both primary and secondary - were reported by beneficiaries in Mostar East. Their "traumagram" is dominated by the experiences "life was in danger", "hunger and thirst", "loss of home and property" and a very high rate of being "betrayed by neighbours and acquaintances":

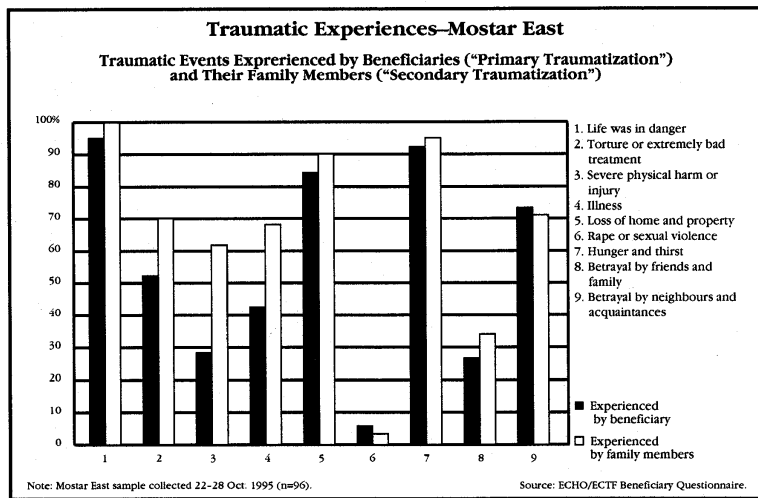


Figure III.B.8. Primary and secondary traumatization of beneficiaries in Mostar East.

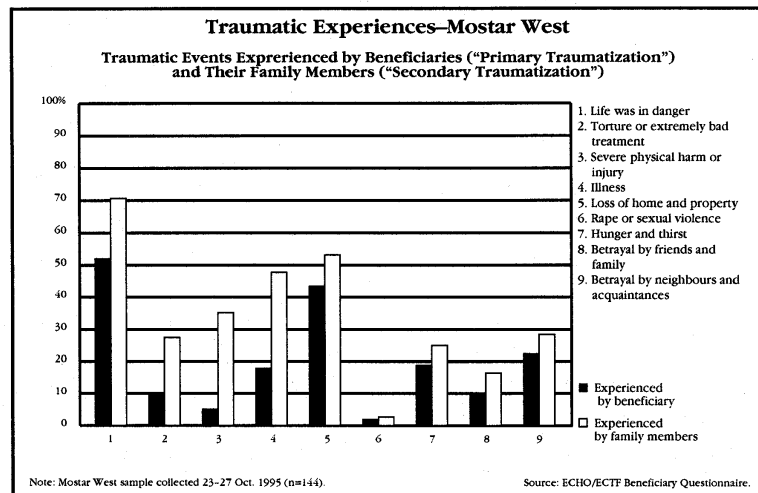


Figure III.B.9. Primary and secondary traumatization of beneficiaries in Mostar West.

Mostar East was shelled constantly by the HVO for about six months, and every building was damaged. It is estimated that about 70% of the living space in Mostar East has been destroyed.

The experiences of Mostar West beneficiaries are dominated by the same type of traumatic experiences but at a lower rate. Again we find danger, homelessness, hunger and betrayal as the most frequent traumatic experiences. This means that both sides share the same kind of suffering. There are no qualitative differences between their traumatic experiences, only quantitative ones.

### **Trauma symptoms**

As seen in Figure III.B.10, Mostar East beneficiaries reported a higher rate of all distress symptoms than Mostar West beneficiaries before entering the psycho-social programme. The only exception is loneliness, which is considerably more frequent in Mostar West.

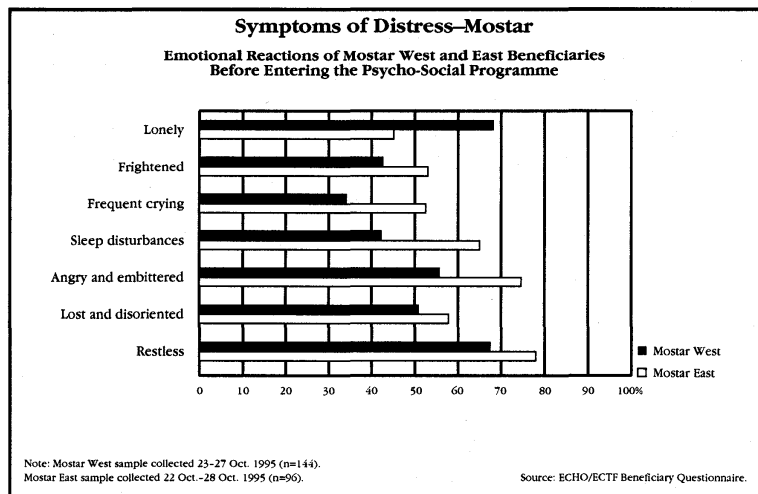


Figure III.B.10. Emotional symptoms of distress reported by beneficiaries in Mostar West and East before entering the psycho-social programme.

Several observers have noted that the communal spirit in Mostar East was better, maybe due to the continuous fight for survival. This could be one explanation of the lower rate of perceived loneliness in East than in West. Another explanation could be that the beneficiary population in Mostar West had a higher rate of local women who felt their social structures were collapsing as many friends and family members left the city.

### **Benefit of psycho-social activities**

As in other regions, beneficiaries in both sides of the town valued highly the opportunity to meet other women in an atmosphere of warmth and acceptance. "There are so many of us with the same problems," wrote one woman. There were no significant differences between the two sides in this respect.

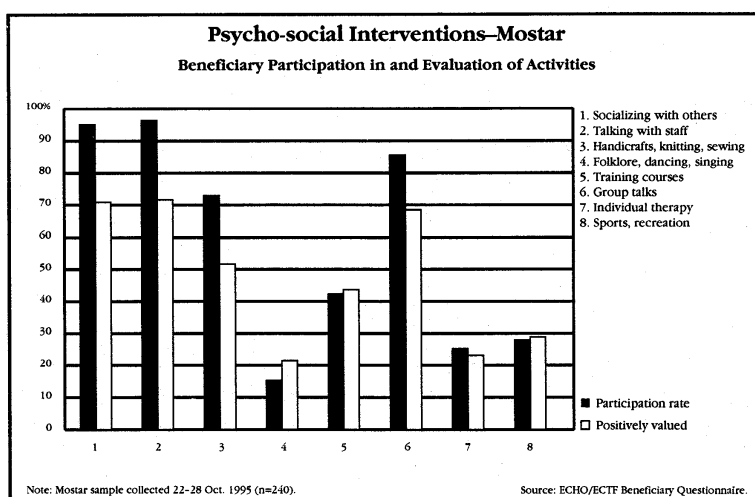


Figure III.B.11. Beneficiary reports of activities they have participated in and their evaluation of those activities. The sample includes both Mostar West and East beneficiaries since no significant differences between the two sub-samples were found.

The state of division in Mostar is a real challenge to psycho-social programmes. Through such programmes, people on both sides could have the opportunity to work through their own traumatic experiences, so that they might develop the capacity to approach people from the other side – realizing that their suffering is universal.

This process should start as soon as possible in order to avoid hardening of hate and bitterness. NGOs could have a leading role in this, working on both sides. However, it is not so easy. Special events are held by the women in both parts of the town and they would undoubtedly like to join together, but the administrations remain further apart than our target group (MSI progress report, January 1995).

It is to be hoped that the spirit of mutual support which has been introduced in the programmes on each side of the front line can spread across the river and eventually include those on the other side. As one woman wrote: "I want the war to stop so that future generations do not experience it."

### 3. The tortured city – Tuzla

Most regions have experienced certain types of traumatic situations, but it seems as if Tuzla and its neighbouring villages have experienced them all. Tuzla was the first city to receive a major influx of refugees in the spring of 1992, when Serbian paramilitary forces committed atrocities against the Muslim population in nearby villages. Tuzla has dealt with many wounded people, and it has been under siege several times. It was surrounded by Serbs, but it was also suffering because Croats from Herzegovina were obstructing the delivery of humanitarian assistance to the town.

One of the worst events of the war occurred in Tuzla when a grenade exploded in a cafe and killed 70 young people in May 1995. This happened only a few



months before the fall of the enclaves in Eastern Bosnia, Zepa and Srebrenica, which brought a new stream of refugees to Tuzla.

At the time of our study, 25 October–7 November 1995, the situation was calm, and fighting had died down all over Bosnia-Herzegovina.

**Socio-demographic data**

When people flee from their homes, they usually try to find the safest place. How much safety they are able to establish for themselves will depend on their individual, social and economic resources. Although Tuzla was designated as a “safe haven”, it was anything but safe. The following chart shows some social background factors of beneficiaries in Tuzla which may indicate why they became refugees there:

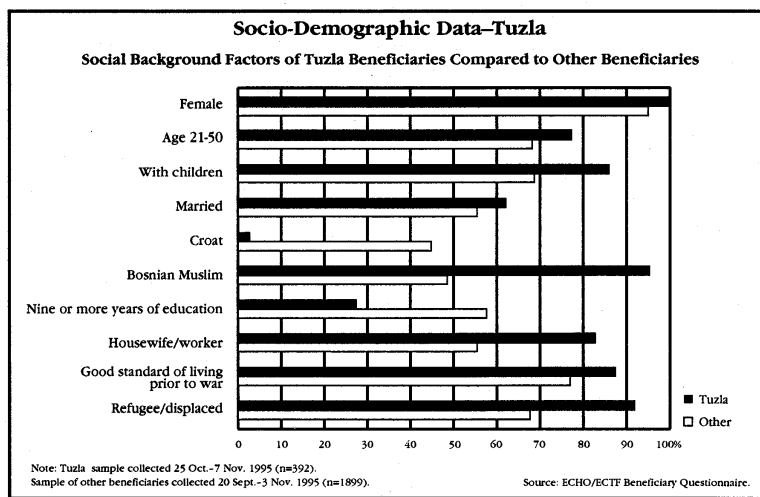


Figure III.B.12. Selected socio-demographic characteristics of beneficiaries in Tuzla.

Almost all Tuzla beneficiaries are refugees/displaced people, mainly rural people from surrounding villages and small towns. They have less schooling than most of the other beneficiaries. Below, in Figure III.B.13, we see that they have an illiteracy rate of 12%:

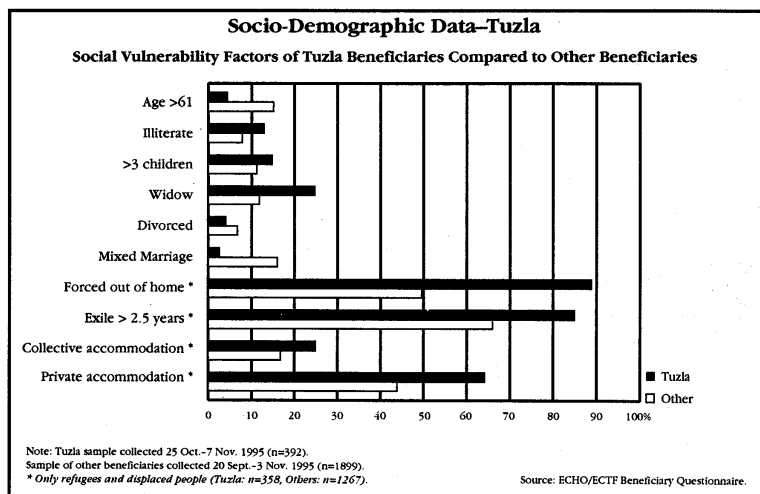


Figure III.B.13. Some social factors indicating vulnerability among beneficiaries in Tuzla compared to other beneficiaries in Bosnia-Herzegovina and Croatia.

Tuzla beneficiaries show a high rate of vulnerability factors: more have been forced out of their homes than in other regions of our study. We also find a higher incidence of young widows, probably due to the atrocities, mass executions and detention which happened not only during the fall of Zepa and Srebrenica in 1995, but also two or three years earlier in villages such as Bratunac and Vlasenica. Twenty-five per cent of the beneficiaries came from Bratunac and 21% from Vlasenica in 1992–93. Seventeen per cent are recent refugees from Srebrenica.

The presence in this region of a high rate of social vulnerability factors also indicates that social services to this region should be given priority.

### ***Traumatic experiences***

Tuzla beneficiaries seem to have experienced the same range of traumatic events as found in other regions, but at a higher rate: life-threatening situations, loss of home and property, hunger and thirst, and betrayal by neighbours and acquaintances:

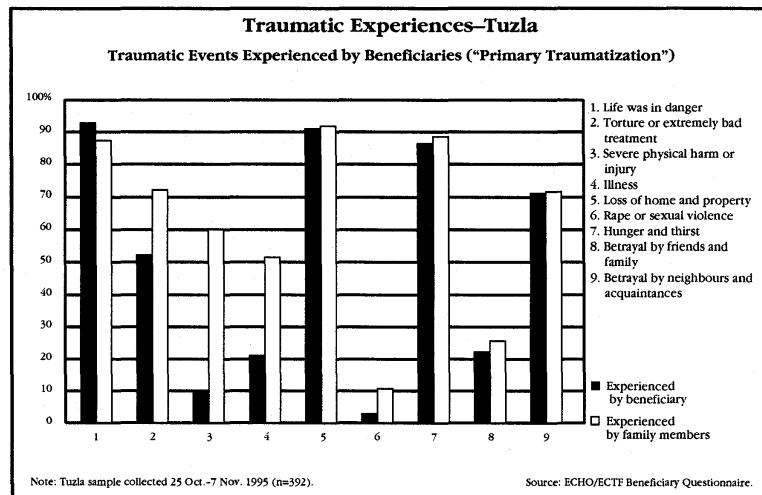


Figure III.B.14. Primary and secondary traumatization of beneficiaries in Tuzla.

The most notable finding is that more than 50% of beneficiaries (and 70% of their family members) have been exposed to torture or extremely bad treatment. A characteristic of Tuzla beneficiaries is also the exposure to multiple traumas, each of which has a high stress impact.

Sinanovic and Pasagic (1996) found in a study of 100 female refugees from Srebrenica that the average number of traumatic events experienced by a refugee was about eight, and they included: death or disappearance of family members; detention in concentration camps; witnessing rape, torture and executions; chronic shortage of food; long-term isolation, and frequent changes of residence. Upon arrival in Tuzla, these women had to live with a constant fear of what had happened to their husbands and sons (a fear which they are still living with at the time of writing).

### Trauma symptoms

As seen in Figure III.B.15, the rate of trauma symptoms among Tuzla beneficiaries prior to entering the psycho-social programme was much higher than in any other region.

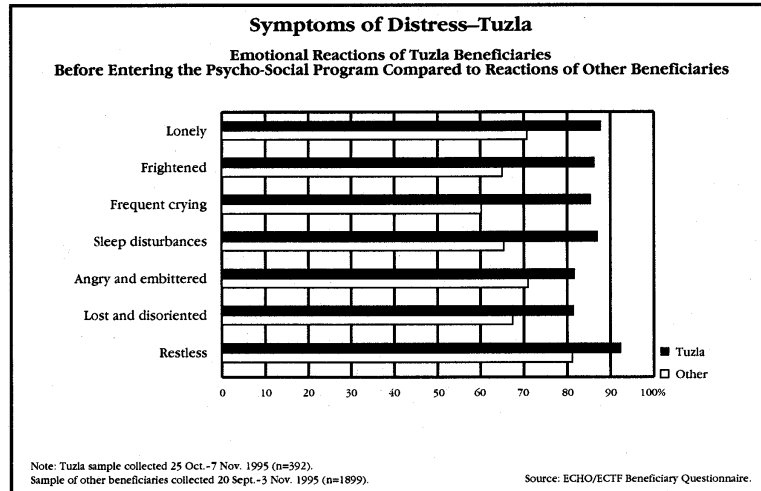


Figure III.B.15. Emotional symptoms of distress reported by Tuzla beneficiaries before entering the psycho-social programme. The symptoms of the Tuzla beneficiaries are compared to the symptoms of other beneficiaries in Bosnia-Herzegovina and Croatia.

The high rate of symptoms was probably due both to traumatization and to the lack of resources in the recipient community for dealing with such numbers of refugees. Moreover, the community was also itself under stress. In 1995 there were an estimated 400,000 UNHCR beneficiaries in the region.

Sinanović and Pašagić (1996) found in their investigation that 80% of the women from Srebrenica suffered from severe depression, and that many of the women had lost the will to live (“decrease of general life ability”, p.3).

The beneficiaries commented on their situation when they arrived in Tuzla in the questionnaires: “My husband was arrested, my only son killed, my daughters expelled, I was without any means”; “Loss of my children: two sons are killed, one daughter slaughtered”; “I had two sons; one is missing, the other is killed. I spent one year in a concentration camp. Here I feel relieved although it is very difficult for me to live in collective accommodation”; “The most difficult thing was to realize that I have lost my family and that I have become a tree without roots – a refugee.”

### Benefit of psycho-social activities

A considerable number of beneficiaries had suicidal thoughts before they entered the psycho-social programme, and they joined the programme to get help and understanding. “I needed a place where I could openly express my anger and bitterness”, as one woman writes.

The most valued activities are handicrafts and group talks, as shown in Figure III.B.16. The great emphasis on handicrafts in this region is probably due to the large number of rural women among the beneficiaries:

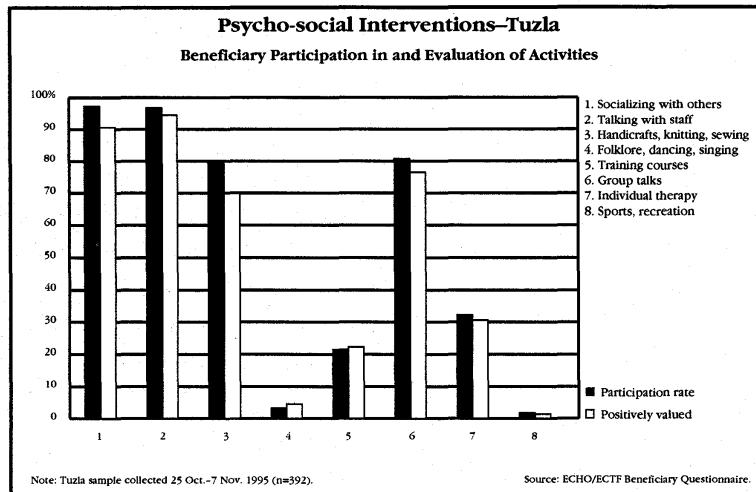


Figure III.B.16. Beneficiary reports of activities they have participated in and their evaluation of those activities.

Non-specific factors such as socializing with others and talking with staff are valued highly by all women. Group activities and informal contacts are of major significance for helping this population of heavily traumatized beneficiaries: “Since I joined this programme everything became better for me, I do not cry any more, I get comfort, friends, socializing, and we also get packages that help us survive,” as one woman explained. Many women state that they have become stronger and that they have regained the will to live: “I feel much more prepared to survive.”

The Tuzla experience seems to prove that there are no limits to the coping capacities of a community. Not only did the community survive a series of crises without disintegrating, but it also managed to maintain a universal value system which emphasized ethnic tolerance much more than any other region of Bosnia.

#### 4. The divided enclave – Bihac

The Bihac “pocket”, which is inhabited primarily by Muslims, was cut off for three years by Bosnian and Croatian Serbs, and was isolated from the rest of government-held territory. The pocket also gave shelter to many Muslim refugees who fled to Bihac when the border areas were captured by Bosnian Serbs. The long siege by exterior forces was accompanied by a serious internal, inter-ethnic conflict between forces loyal to the Bosnian government and those loyal to the businessman, Fikret Abdić. The conflict between Muslims led to tragedies within families with family members turning against each other, and it also led to new flows of refugees. During the war, living conditions deteriorated, and the many ruins found in Bihac are remnants both of poverty and of shelling.

At the time of our study, from 20 September to 25 October 1995, the military situation had changed dramatically, and Bihac was no longer encircled. Access to the area was now free, and security, economy and infrastructure had improved considerably. People had begun to return to their homes (more or less voluntarily), and psycho-social programmes had to respond to these new demands.

In the examination of the data collected in Bihac, we will make comparisons to data collected in Western Herzegovina. The situation of Western Herzegovina resembles in some aspects the Bihac context, with a large number of refugees/displaced people settled across the region and sparse accommodation capacities. Moreover, most of the refugees/displaced people accommodated in Western Herzegovina are from Central Bosnia, and they are also victims of two wars: the first in which Muslims and Croats were allies against the Serbs, and the second in which Muslims and Croats turned against each other.

### **Socio-demographic data**

Among the Bihac beneficiaries we find a high rate of young girls in comparison to the Western Herzegovina beneficiaries, among which there are many elderly women. Probably this is one of the reasons for the higher level of schooling found in Bihac, where there are many students among the beneficiaries. In Western Herzegovina, the programmes are exclusively targeting refugees/displaced people, while the programmes in Bihac include a considerable number of local women (40%) (see Figure III.B.17):

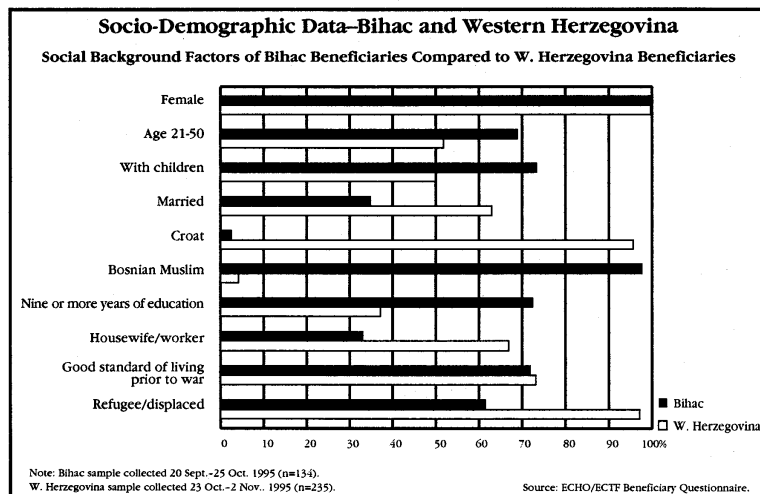
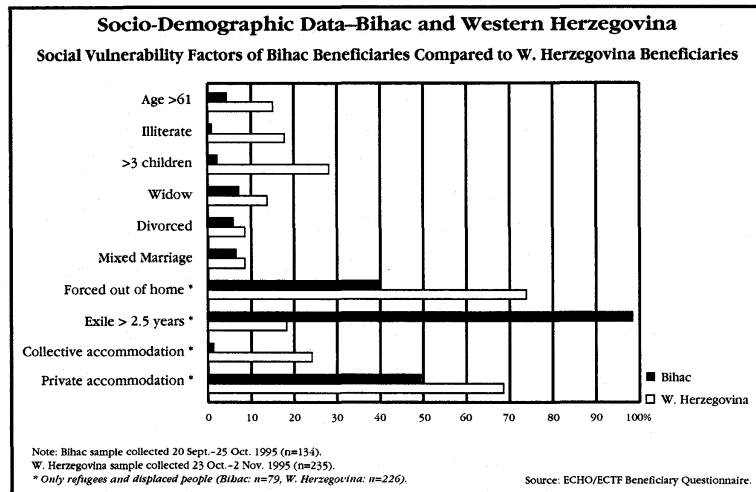


Figure III.B.17. Selected socio-demographic characteristics of beneficiaries in Bihac and Western Herzegovina.

Among social vulnerability factors, we find that the beneficiaries in Western Herzegovina have a higher rate on almost all variables except divorce and length of exile. The higher rate of divorce in Bihac could be related to the inter-ethnic war in the enclave where the "front line" sometimes went straight through families (see Figure III.B.18):



*Figure III.B.18. Some social factors indicating vulnerability among beneficiaries in Bihac and Western Herzegovina compared to other beneficiaries in Bosnia-Herzegovina and Croatia.*

Refugees/displaced people in both Bihac and Western Herzegovina did not come from far away: about 50% of the Bihac refugees came from Bosanska Krupa, from which they were expelled by the Serbs during the summer of 1992; about 50% of the Western Herzegovina beneficiaries came from Central Bosnian towns, from which they were expelled by the Muslim army in 1993.

Both groups of refugees/displaced people mention that they had great difficulties adapting to the new environment even though they came from nearby. Often they did not feel welcome or understood by their hosts, who were also themselves very short of resources. This opens ethical questions about such resettlement.

Fourteen per cent of the Western Herzegovina refugees/displaced people mention that they tried to help themselves and their families by praying to God. This is the only area in which we have found such strong religious feelings among our beneficiaries.

***Traumatic experiences***

The traumatic experiences follow the general pattern found in our beneficiaries: a high rate of life-endangering experiences, loss of home and property, hunger and thirst, as well as feelings of having been betrayed. The rate of betrayals is higher in Bihac than in Western Herzegovina, probably due to the inter-ethnic war there (see Figure III.B.19):

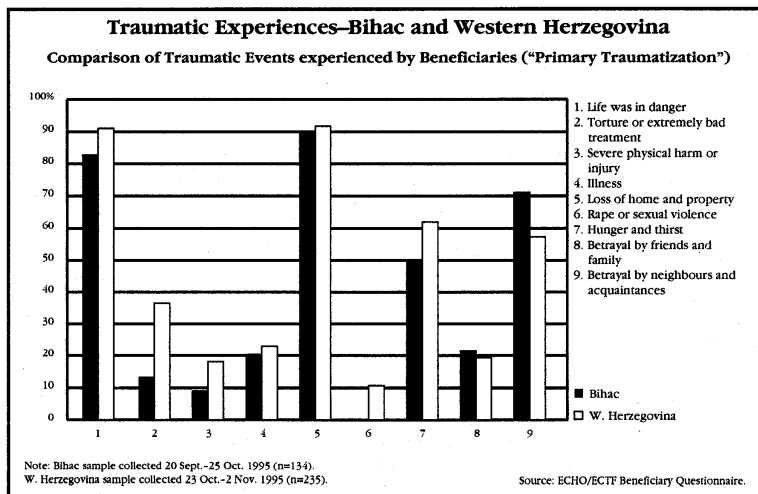


Figure III.B.19. Primary traumatization of beneficiaries in Bihac compared to Western Herzegovina beneficiaries.

In the questionnaires, Western Herzegovina refugees/displaced people comment on experiences of torture, betrayals by neighbours, husbands who were taken to concentration camps, and even women and children being taken as hostages.

### Trauma symptoms

The rate of distress symptoms prior to entering the psycho-social programme is almost twice as high in Western Herzegovina as in Bihac. This is probably related to the higher frequency of traumatic experiences among Western Herzegovina beneficiaries (see Figure III.B.20):

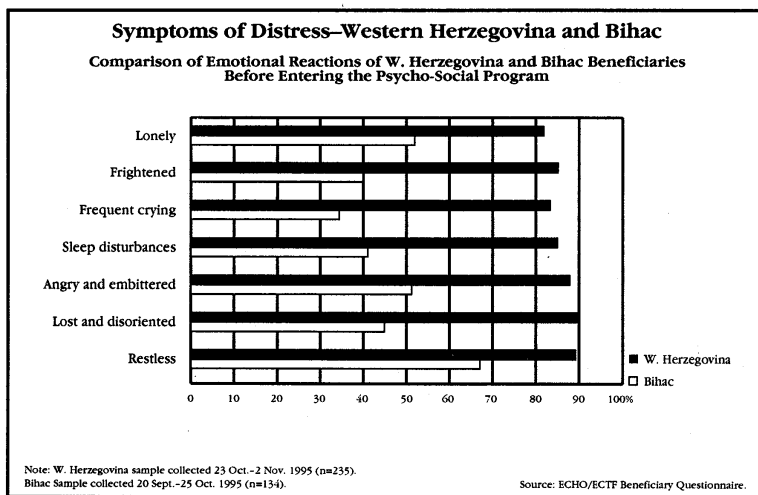


Figure III.B.20. Emotional symptoms of distress reported by Western Herzegovina and Bihac beneficiaries before entering the psycho-social programme.

The lower rate of symptoms reported by Bihac beneficiaries could also be related to their age: they are younger and have more resources for coping with their situation.

Western Herzegovina beneficiaries report that prior to entering the psycho-social programme they felt “humiliated, lost and half-crazy”; “humiliated and homeless”; that their “life was falling apart.”

***The benefit of psycho-social activities***

Bihac and Western Herzegovina beneficiaries comment that they attend the psycho-social programme because they get human contact and understanding. The following two charts show the rate of participation in the various activities offered in the programmes and the beneficiaries’ evaluation of those activities:

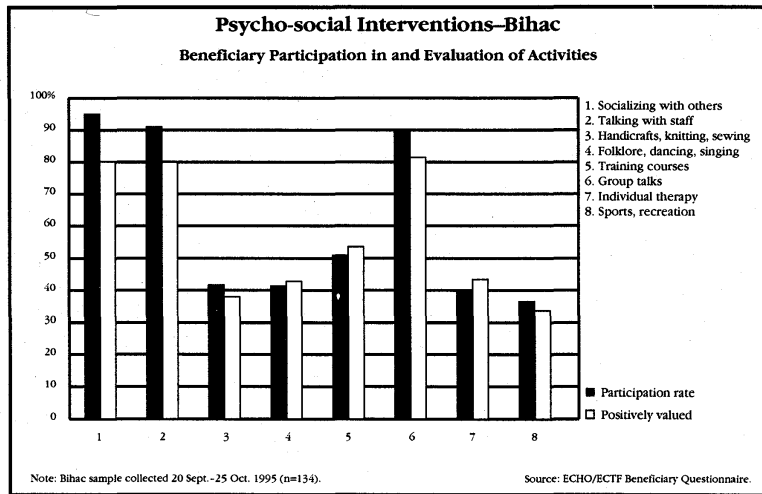


Figure III.B.21. Beneficiary reports of activities they have participated in and their evaluation of those activities.

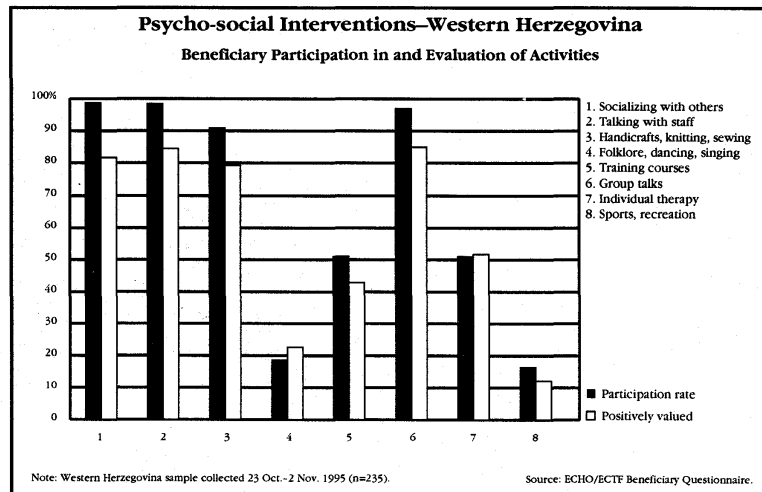


Figure III.B.22. Beneficiary reports of activities they have participated in and their evaluation of those activities.

The different preferences, e.g. twice the rate for handicraft activities in Western Herzegovina, and twice the rate for folklore, dancing and singing activities in Bihac, are probably mostly the result of differences in age between the two



groups. However, in Bihac, where there are many local women among the beneficiaries, we also find some similarities to the Sarajevo beneficiaries in their need to restore a cultural and social environment. In that sense, the programme helps people in the community survive, not only emotionally, but also culturally. The different emphasis on activities in the various regions demonstrates the importance of flexibility in psycho-social programmes, and the necessity of following the needs and cultural habits of the beneficiaries. It is especially important to strengthen the traditional self-healing methods in rural Bosnian communities, one of them being to knit or sew in a safe circle of women.

### ***5. Sunshine and desolation – The Adriatic Coast***

We are now moving to Croatia, to the coastal region from Rijeka in the north to Dubrovnik in the south. This is a traditional tourist area, and one of the first consequences of the war was that tourists stopped coming. This had a disastrous effect on the Croatian economy. However, it did mean that there was plenty of accommodation for displaced Croats at the beginning of the war, and for Bosnian refugees at a later stage.

Initially, local people on the coast showed a great deal of solidarity with the refugees/displaced people, but this gradually dwindled along with the deterioration of the local economy, which had depended so heavily on tourism.

At the beginning of the war in Bosnia, when both Bosnian Croats and Muslims fled to the coast from Serb attacks, the refugees shared a common destiny. However, after the war started in Bosnia between Croats and Muslims in 1993, Muslim refugees who were sheltering in areas exclusively inhabited by Croats on the coast suffered various types of persecution.

After the peace agreement in 1994 between Croats and Muslims, conditions for Muslim refugees on the coast gradually became better. At the time of our study, from 8 October to 3 November 1995, the main concern was repatriation of the refugees after dramatic changes in the military situation. Bosnian Croat refugees were worried about being sent (involuntarily) back to parts of Western Bosnia which had now come under government control. Bosnian Muslim refugees were also being sent back to Bosnia, and refugees were in general anxious about their future.

#### ***Socio-demographic data***

Due to the accommodation facilities, many more beneficiaries in this region live in collective accommodation. Hotels built for enjoyment and vacations became inhabited by people who did not want to be there and who were longing for their homes and villages far from the sea.

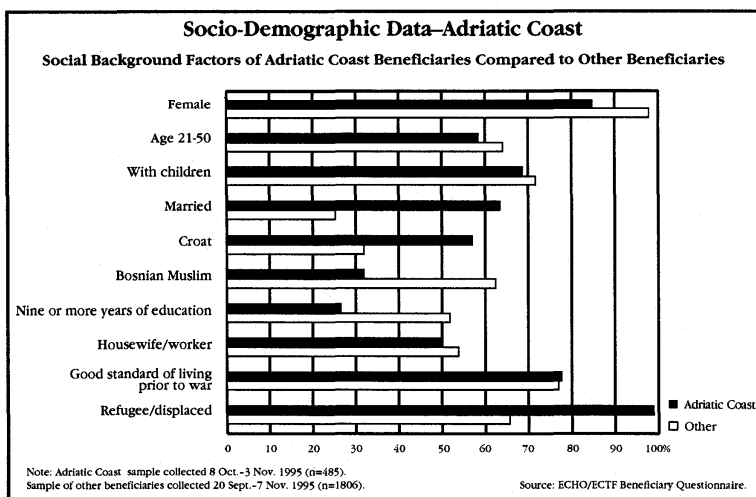


Figure III.B.23. Selected socio-demographic characteristics of beneficiaries on the Adriatic Coast compared to characteristics of other beneficiaries in Bosnia-Herzegovina and Croatia.

Some of the psycho-social programmes on the coast provide family therapy, and we therefore find a number of males among the beneficiaries. During the long period of exile, younger and more resourceful refugees managed to leave collective accommodation and start a new life. For this reason the hotels have turned more and more into “old people’s homes”.

Obviously, these elderly refugees have the greatest needs for assistance and this is reflected in the age distribution of beneficiaries on the coast: 20% are more than 61 years old. Due to this we also find a higher rate of widows here than in the rest of the sample (see Figure III.B.24):

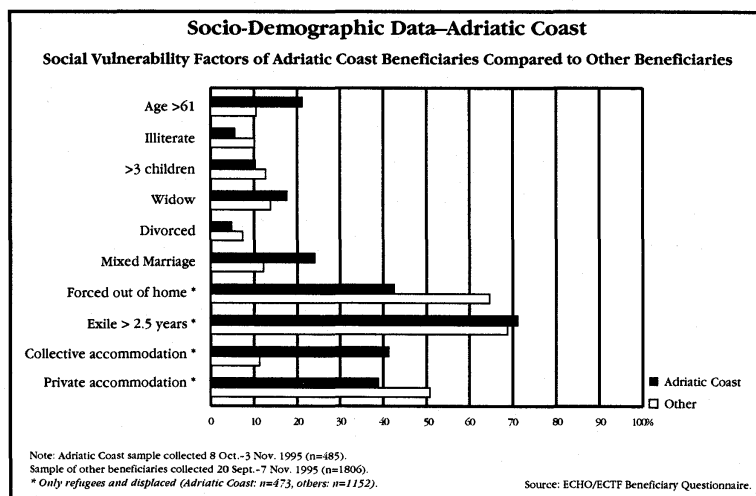


Figure III.B.24. Some social factors indicating vulnerability among beneficiaries on the Adriatic Coast compared to other beneficiaries in Bosnia-Herzegovina and Croatia.

A long period of exile – experienced by many beneficiaries as prolonged and endless waiting – characterizes this population. We also find twice as many mixed marriages here as in the rest of the sample. Petrović (1996) found 37% mixed marriages among refugee women on the Adriatic Coast. Almost all of these women came from Sarajevo, which before the war had more than 40% mixed marriages.

In our study, 23% of the refugees came from Sarajevo and 19% came from Vukovar and the former Sector East. Beneficiaries state in the questionnaires that they felt lost and disoriented when they arrived and that it was difficult to adjust to the new environment. They also state that they “tried not to hate”, and that they needed help.

There are many single mothers among the beneficiaries. Usually the husband stayed in Bosnia to fight in the army. These mothers tried to concentrate on survival and the care of their children, and often had no contact with their husbands for long periods.

### ***Traumatic experiences***

The dominating traumatic experience of Adriatic Coast beneficiaries is “loss of home and property”, exceeding even “life in danger”. This is probably due to the long period of exile, which meant that many of the refugees left home before the worst war activities started (see Figure III.B.25):

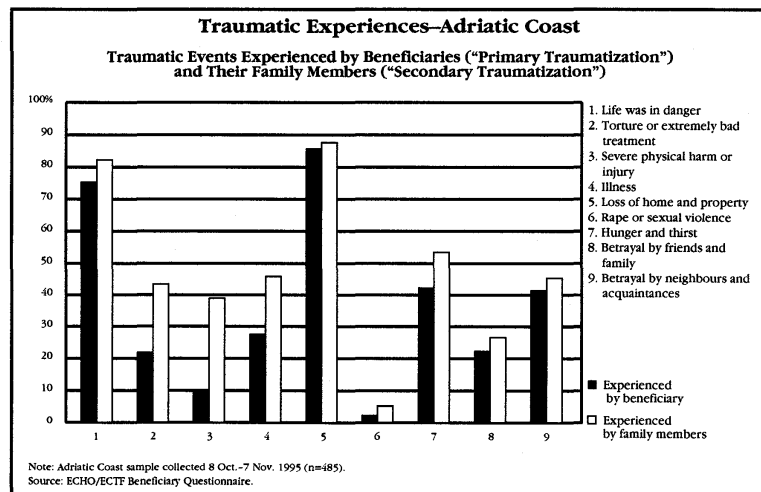


Figure III.B.25. Primary and secondary traumatization of beneficiaries on the Adriatic Coast.

Petrović (1996) found in her investigation of refugee women on the Adriatic Coast that 38% had lost a family member in the war.

### Trauma symptoms

If we compare the symptoms of distress shown by beneficiaries before entering the psycho-social programme with those shown by the rest of our beneficiaries, we find indications of more depression and a lower energy level: loneliness, fear, crying and sleep disturbances are more frequent in this region than in others (see Figure III.B.26):

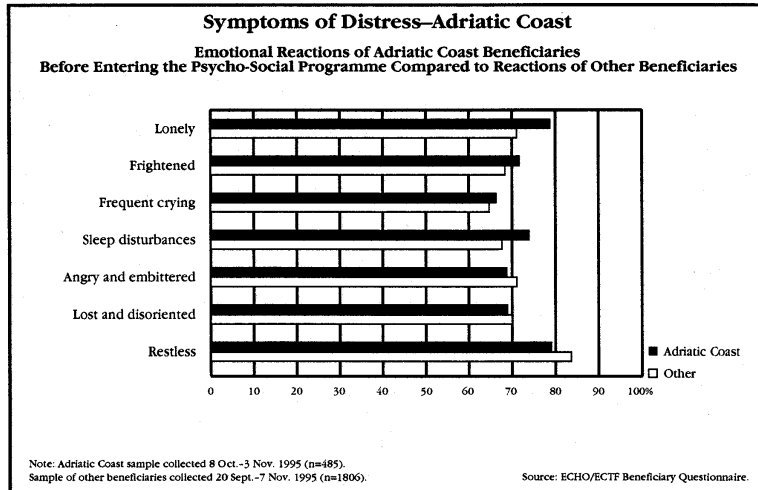


Figure III.B.26. Emotional symptoms of distress reported by Adriatic Coast beneficiaries before entering the psycho-social programme. The symptoms of the Adriatic Coast beneficiaries are compared to the symptoms of other beneficiaries in Bosnia-Herzegovina and Croatia.

A long period of exile in a situation which does not stimulate development may lead to emotional numbing, something which should be taken into consideration when planning refugee policy on the political level.

### Benefit of psycho-social activities

The favourite activities of the beneficiaries follow the pattern found in most other regions, as shown in Figure III.B.27:

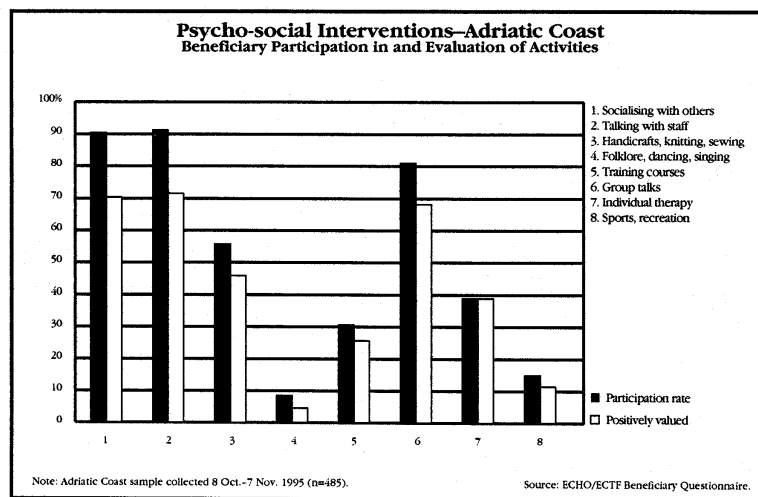


Figure III.B.27. Beneficiary reports of activities they have participated in and their evaluation of those activities.

The beneficiaries comment on their participation in the programme writing that: "I have started a new life", "I get support, understanding", "I feel better when I manage to get rid of my sorrow", "I would go mad at home."

### 6. The forgotten land – Slavonia

Slavonia was one of the first battlefields of the war in Croatia. In particular, the Eastern and Western parts were affected by large-scale combats, while the central parts of Slavonia were more peaceful and therefore became a place of refuge for many war victims.

The first Bosnian refugees to arrive were from Bosanska Posavina, an area on the other side of the Sava river which for centuries had been a link between Bosnia and Croatia, e.g. Slavonski and Bosanski Brod were practically one city with many people living in Bosanski Brod and working in Slavonski Brod. The war has, therefore, directly affected this part of Croatia much more than the Adriatic Coast.

At the time of our study, from 2 to 27 October 1995, the beneficiaries were overwhelmingly preoccupied with the peace process. Twenty-five per cent came from Bosanska Posavina, and they feared that they would never be able to return if this area became part of Serb territory after a peace agreement. Feelings of anger and betrayal were widespread.

#### Socio-demographic data

The beneficiaries in this region are almost all refugees and displaced people, two-thirds of whom are Croats and one-third Muslims. Previously they were mainly housewives or workers. Their level of schooling is comparable to the level found in Tuzla (see Figure III.B.28):

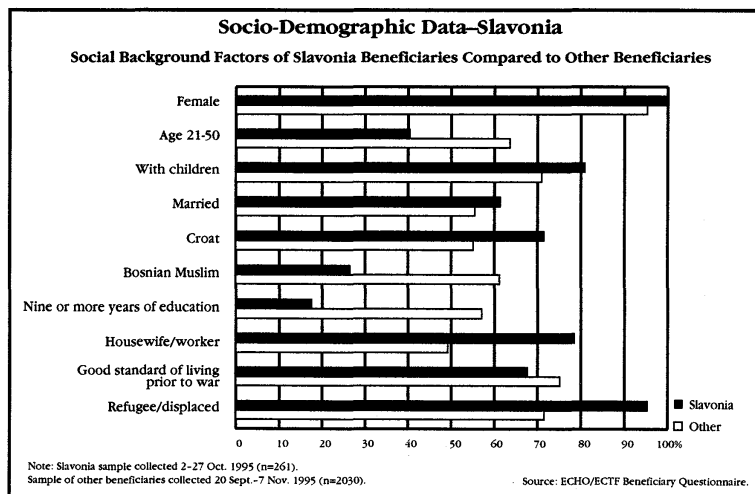


Figure III.B.28. Selected socio-demographic characteristics of beneficiaries in Slavonia.

As shown in the following chart (Figure III.B.29), the rate of illiteracy (28%) is four times higher than found among the rest of our beneficiaries. The rate of elderly women is the highest of all regions, and there is also a higher rate of widows among these beneficiaries than found elsewhere.

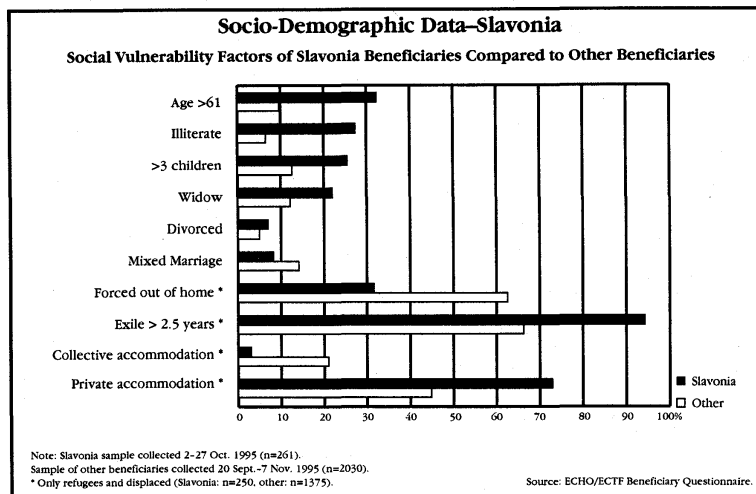


Figure III.B.29. Some social factors indicating vulnerability among beneficiaries in Slavonia compared to other beneficiaries in Bosnia-Herzegovina and Croatia.

The Slavonia beneficiaries reflect one of the most painful problems of Croatia, namely care of the elderly. Elderly people can only survive if their family or their community have enough resources to support them. It will be very difficult for them to return to their homes before the reconstruction of villages has reached an advanced stage, and social welfare and health services have been re-established. Many of the elderly fear that they will not live long enough to see that happen.

### Traumatic experiences

As shown in Figure III.B.30, the loss of home and property is the most frequent traumatic experience. Many of the beneficiaries' families have lived on their farms for generations, and their main goals – to which they devoted their lives – were to raise children and improve their standard of living. Therefore, the loss of home and property is not only a material loss, but is experienced as a loss of their whole life, something which cannot be rebuilt at their advanced age.

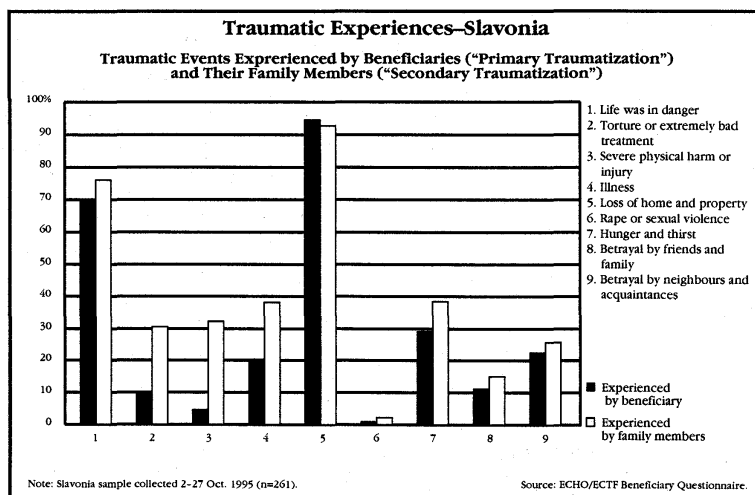


Figure III.B.30. Primary and secondary traumatization of beneficiaries in Slavonia.

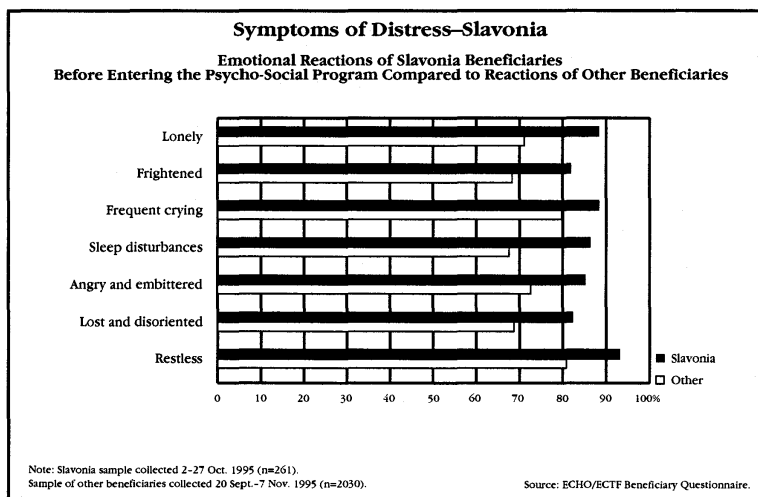
However, some beneficiaries also related experiences of torture in our questionnaires:

*“On 2 May 1992 I was arrested together with 70 of my fellow citizens and taken to a large warehouse which served as a concentration camp. I was tortured there: they extinguished cigarettes on my arms. I was in the first group of 25 people that were exchanged. One of my fellow-prisoners committed suicide when we got to Croatia. On the bus that was taking us there, I learned that my brother, father and seven more people had been killed by a grenade that hit our house. One of my sons had witnessed it, and he remained in a state of shock for a long time. Now I wonder if he is normal. My mother was arrested as well. She was tortured and ordered to give all her money to them.”*

In her study of displaced and refugee women in Slavonia, Petrović (1996) found that 52% had lost a family member.

### **Trauma symptoms**

The feeling of having lost their whole life could be an explanation of the very high trauma symptom rate found among these beneficiaries on all variables prior to entering the psycho-social programme (see Figure III.B.31):



*Figure III.B.31. Emotional symptoms of distress reported by Slavonia beneficiaries before entering the psycho-social programme. The symptoms of the Slavonia beneficiaries are compared to the symptoms of other beneficiaries in Bosnia-Herzegovina and Croatia.*

The women here seemed to feel that they had no prospects and no control over their lives. Their trauma symptom rate is higher than that of our other beneficiaries. As some of the women comment spontaneously in the questionnaires: “I was humiliated and hurt”; “I could not trust anyone”; “I had lost the will to live”; “I was alone, lost and depressed.”

### ***Benefit of psycho-social activities***

The most valued activities in this region are, once again, informal contacts with staff and other beneficiaries. However, we also find a 100% participation rate in organized group talks, that is, support groups facilitated by the staff (see Figure III.B.32):

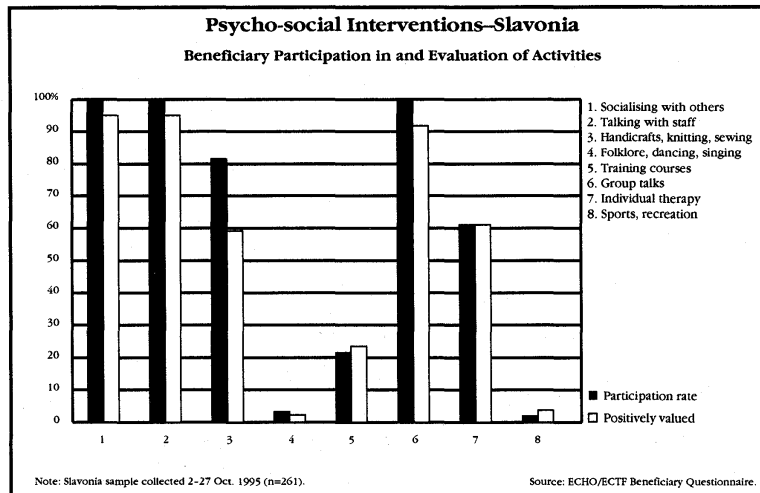


Figure III.B.32. Beneficiary reports of activities they have participated in and their evaluation of those activities.

It is notable that the participation in individual therapy is higher here than in other regions. Self-healing activities such as handicrafts are also valued highly, as found in other regions among rural women.

We shall conclude this journey through the regions with a comment from a Slavonian beneficiary:

*“This centre is another home, we create an image of a better future and cure our souls.”*

### **C. CONCLUSIONS**

Returning to the objectives of this study, including an overall examination of results covering the whole sample of beneficiaries, and a more detailed study of six regions, we shall now attempt to draw some general conclusions.

We asked three basic questions:

- Did the psycho-social programmes reach the target group?
- Did the programmes reduce trauma symptoms and help beneficiaries cope better?
- Which psycho-social interventions were most helpful, according to the beneficiaries themselves?



### ***Reaching the target group***

The main target group of ECHO psycho-social assistance was from the beginning defined as “women who had suffered serious psychological trauma”. After examining the data collected from 2,291 beneficiaries, we can conclude that almost all beneficiaries were women who had been seriously traumatized by multiple stressful experiences and suffered from a multitude of psychological symptoms.

### ***Reduction of trauma symptoms***

On the basis of reports by the women themselves, we conclude that the major symptoms of the women prior to entering the psycho-social programme were depression, anxiety, isolation and aggression accompanied by suicidal thoughts. In general, the programmes seemed to reduce all of these symptoms. However, aggression (“anger and bitterness”) was reduced less than other feelings. It will be a challenge for psycho-social programmes to deal with these feelings in a constructive way. Anger and bitterness may become serious obstacles to a reconciliation process. However, the energy associated with these feelings may also lead to advocacy, empowerment and self-organization.

The beneficiaries did seem to cope better with their situation after entering the psycho-social programme. From the women’s statements we conclude that the programmes helped them re-establish a kind of “normality” in the midst of loss and chaos.

### ***Benefit of activities***

The various organized activities offered by psycho-social programmes were planned on basis of the culture and needs of the beneficiaries. It is therefore not surprising that 90% of the beneficiaries are satisfied with the activities they participate in. Ten to 20% participate in educational and cultural activities, and 20–40% participate in group and individual counselling/therapy.

However, the greatest benefit of the programmes seems to be their capacity to create a new social network in which beneficiaries can get human contact, care and empathy. These qualities, which mostly are related to the environment and atmosphere created by the staff, seem to be the basic “healing factors”.

The most important factor in choosing activities is to adapt them to local culture and needs. Counselling and therapy are appreciated by motivated women, and should be offered as an internal or external referral possibility when the basic social environment has been created. This environment is typically established in a safe space, e.g. a centre where beneficiaries can meet and connect with each other.



# IV

**THE STUDY: STAFF  
CARING FOR THE CARERS**

---



## **IV. CARING FOR THE CARERS: TRAUMAS OF CARING FOR THE TRAUMATIZED**

---

Under war conditions, mental health professionals are exposed to the same stressors as the people they are supposed to help. Everyone is in it together. The staff are also subjected to shelling, ethnic cleansing and loss of their dear ones. At the same time, these "wounded healers" must help others keep going while trying to look after themselves (Agger & Jensen, 1994; Smith, Agger, Danieli & Weisaeth, 1995). Moreover, caring for trauma victims can in itself be traumatizing, even under normal peaceful conditions.

In the field of post-traumatic stress, it is widely recognized that the traumas of victims also have an impact on therapists. Different concepts have been used to describe this situation, e.g. "countertransference" (Danieli, 1980; Wilson & Lindy, 1994), "vicarious traumatization" (McCann & Pearlman, 1990), or "compassion fatigue" (Figley, 1995).

However, although mental health professionals may be exposed to all these stressors, their reactions need not necessarily be counterproductive. Under conditions of collective siege a mutual feeling may develop, inspiring some mental health professionals to turn their work into a "survivor's mission", giving meaning and scope to an otherwise hopeless situation.

In the following pages we highlight this complex situation by presenting a picture of 167 NGO staff members working in Sarajevo and on the Adriatic Coast. The data from Sarajevo were collected at a historical moment: 3–13 days after the peace agreement was signed in Dayton, Ohio on 21 November 1995. The data from the Adriatic Coast were collected a little later, 9–18 days after the Dayton Agreement. Thus, while the data on beneficiaries were collected during the last months of the war, the data on staff were collected under conditions which did, at least, offer a hope of peace after more than four years of war and destruction.

### ***Purpose***

The main purpose of the staff study was to examine the following:

- Similarities and differences between staff and beneficiaries with respect to socio-demographic background and traumatic experiences
- Training, supervision and other support for the staff
- Similarities and differences between staff and beneficiaries with respect to evaluation of the effects of various psycho-social interventions
- Staff members' evaluation of long-term effects of their psycho-social programmes.

## **Material**

Our staff sample includes 165 national and two international NGO staff members. In order to obtain material as diversified as possible, we have chosen NGOs working in two quite different regions: in the besieged city of Sarajevo in Bosnia, and on the Adriatic Coast in Croatia. The staff members work in five ECHO NGOs:

- In Sarajevo the sample includes 105 staff members working in Eurocités, France Libertés, Marie Stopes International and Médecins du Monde. Their educational background was: nurse (23%), teacher (16%), medical doctor (14%), social worker (11%), psychologist (10%), other medium level technical education (26%).
- On the Adriatic Coast the sample includes 42 staff members working in Handicap International and Marie Stopes International. Their educational background was: teacher (26%), psychologist (19%), medical doctor (19%), psychiatrist (5%), nurse (3%), social worker (2%), other medium level technical education (26%).

In the total sample of 62 from the Adriatic Coast, we have also included 20 staff members working in other psycho-social NGOs.

## **Method**

The coordinator assembled key staff members of the various NGOs separately, both in Sarajevo and on the Adriatic Coast, and she explained the purpose of the study. Most of the staff members had recently been involved in distribution and completion of the beneficiary questionnaires, and were familiar with the first pages of the staff questionnaire, which are similar to the beneficiary questionnaire.

The staff were also asked to complete three psychometric tests: the Impact of Events Scale – Revised, the Peri's Dissociation Scale, and the Symptom Checklist 90 – Revised<sup>1</sup>. The purpose of this sub-study was to assess the level of post-traumatic stress disorder (PTSD) symptoms, dissociation and distress among the staff.

It was emphasized to the staff that it was of major importance also to learn about them: about their background, their traumatic experiences and their evaluation of the work they were doing. The staff seemed to welcome this opportunity to express their feelings and thoughts about their work.

The coordinator, thereafter, sat with the staff while they completed the questionnaires. This usually took about one hour, during which the staff frequently asked for clarification of questions. Some staff members discussed questions with each other or looked at each other's answers. Therefore, it had to be emphasized that this was a private process and that anonymity should be respected.

It was obvious that the process of answering the questionnaire was stressful for some staff members. The coordinator therefore chose, for ethical reasons, to conclude the meetings with an hour of group talk in which all staff members had the opportunity to express their feelings and thoughts while completing the questionnaires.

1 - This sub-study is carried out in collaboration with Professor John P. Wilson, Cleveland State University. At this moment only preliminary results from Sarajevo are available.

In these group sessions many staff members – especially in Sarajevo – expressed their sadness about the devastation which the war had effected on their lives. At that historical moment, a few days into the peace process, it seemed as if they were examining their life accounts: What have I lost, what have I gained? For the majority, the losses far exceeded the gains.

The coordinator felt the general atmosphere in the group sessions to be dominated by a heavy feeling which contained both depressive and aggressive elements. In a very concrete way she experienced how the trauma of these staff members impacted on herself and interacted with her own “compassion fatigue” after more than two years of fieldwork.

Some staff members said that the war experience had given them new altruistic values: to care for others instead of pursuing personal gains and material possessions. These staff members radiated a singular aura of compassion and energy, lending inspiration to others around them, including the coordinator.

At the end of the session, the staff were given questionnaires for distribution to other staff members, and they were asked to follow the same procedure as the coordinator had followed with them: explanation, being present while questionnaires were being completed, and a concluding group talk.

## A. SARAJEVO

One hundred and five NGO staff members completed the questionnaires in Sarajevo. The situation in the city at the time of our study (24 November – 4 December 1995) was still very difficult. Although fighting and shelling had stopped, and some freedom of movement had been secured for civilians, basic amenities such as water, gas and electricity had not been restored in sufficient quantities.

### *Socio-demographic data*

In Figure IV.A.1 are shown some social background factors of Sarajevo staff members. Data on Sarajevo beneficiaries are also shown for comparison:

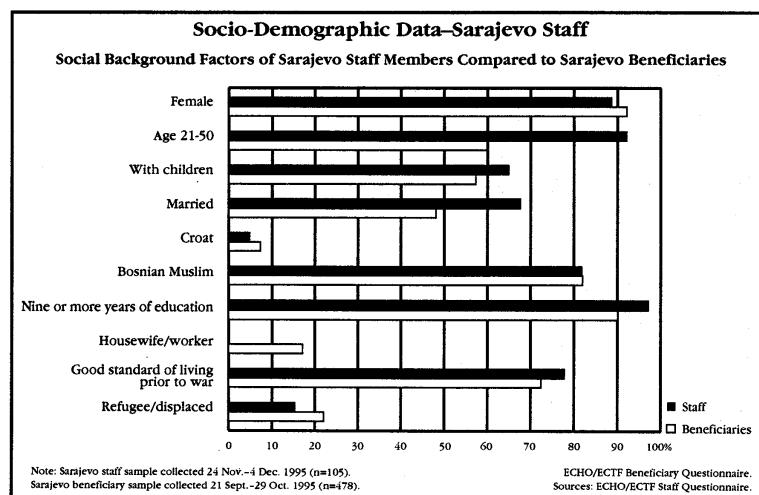


Figure IV.A.1. Selected socio-demographic data on Sarajevo staff members working in psycho-social projects compared to data on beneficiaries in Sarajevo.

It appears that staff and beneficiaries have a very similar socio-demographic background, except for age and marital status.

As seen in the following Figure IV.A.2 the average age of beneficiaries is higher than that of the staff due to the number of elderly people assisted by the programmes. The rate of single people (unmarried, widows, divorced) is also higher among beneficiaries than staff:

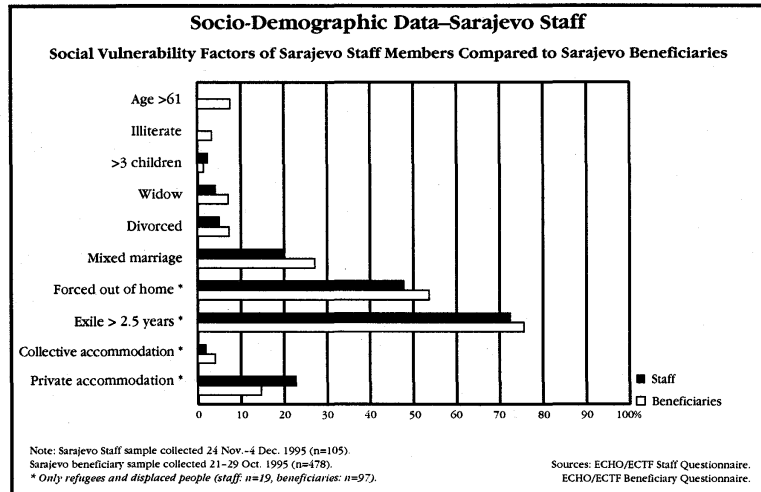


Figure IV.A.2. Some social factors indicating vulnerability among staff members in Sarajevo.

Among the 18% of staff members who are refugees or displaced people, the stressor factors seem to be rather similar to those faced by the beneficiaries.

When we look at place of origin, staff and beneficiaries are again similar: 11 (about 70%) of the refugee/displaced staff members come from Serb-controlled parts of Sarajevo (from where 70% of refugee/displaced beneficiaries also originate).

Refugee/displaced staff members typically indicate that they had to leave their homes to save the lives of themselves and their children: "Serbian soldiers threatened us and told us to leave Serbian land", "Massacres, maltreatment and looting."

Upon arrival in the government-controlled part of Sarajevo, what was found to be most difficult was: "to be a refugee in my own city, to be able to see my home and not to live in it." Another staff member writes: "I could only feel emptiness."

Nearly all staff members tried to help themselves and their family by working: "by working constantly", "by organizing life in a good way, being constantly active", "by doing things and taking jobs that I would not even dream of doing before the war."



In their active coping with a difficult situation, the staff reacted differently from the beneficiaries. Less than one third of beneficiaries in Sarajevo indicate that they worked to help themselves and their families. This difference in coping pattern (which is an expression of greater resources and protective factors among the staff) probably explains to some extent why the staff became employees and not beneficiaries of psycho-social programmes.

### **Traumatic experiences**

The staff members had a whole spectrum of traumatic experiences, as demonstrated in Figure IV.A.3:

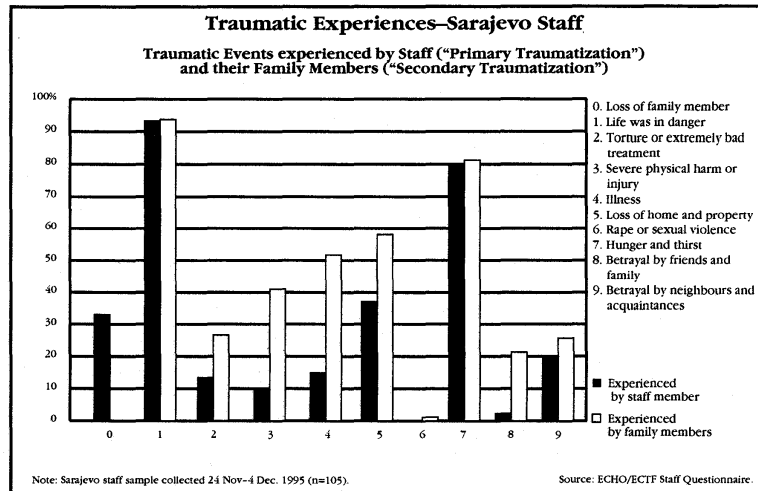


Figure IV.A.3. Primary and secondary traumatization of staff members working in psycho-social.

When we look at traumatic experiences we find more similarities than differences between staff and beneficiaries in Sarajevo (see Figure III.A.3.). However, the staff have been less ill than the beneficiaries. The better physical health of the staff is probably related to age and maybe also to their different coping pattern.

### **Trauma symptoms**

From the preliminary findings of the sub-study in which three psychometric tests were employed, it appears that the war has had a greater stress impact on the 48 staff members who work as counsellors and therapists than on the 57 providing basic social services such as home visits, physical therapy, and nursing care for the elderly and invalids.

As demonstrated above, staff members in Sarajevo shared almost all the traumatic experiences of their clients. On top of this, counsellors and therapists also had to contain the emotional reactions of their clients and provide empathy, care and warmth in a situation where there was limited access to supervision and support for themselves.

### **Training and other support**

Thirty-nine per cent of the counsellors and therapists indicated that they did not participate in any training programmes, 45% did not receive any regular supervision, and 42% did not have any peer group support. One staff member wrote that she needs “verbal support, recognition and understanding, and exchange of experiences”. However, 71% stated that the support they received was adequate.

Regular training programmes have been provided by, for example, UNICEF since October 1992, and by the International Rescue Committee (IRC) since July 1993. The WHO has since October 1994 (within the framework of the Regional Model for Mental Health) offered systematic training at different levels. Catholic Relief Services (CRS), Médecins Sans Frontières-Holland (MSF), and Marie Stopes International (MSI) have also provided the NGO staff with training programmes. However, there still appears to be a need for further training and support.

### **Evaluation of psycho-social interventions**

Thirty-one per cent of all 105 staff members conduct support groups (“group talks”), and 46% provide individual therapy. In addition to these interventions, staff facilitate socializing between beneficiaries (64%), talk with beneficiaries (95%), conduct handicraft workshops (47%), organize folklore, dancing, singing(14%), provide training courses (43%), and organize sports and recreational activities (16%). Other activities mentioned are: supervision of support group leaders, and work with parents and teachers of traumatized children.

The benefits of these interventions are valued somewhat differently by staff and beneficiaries, as shown in Figure IV.A.4:

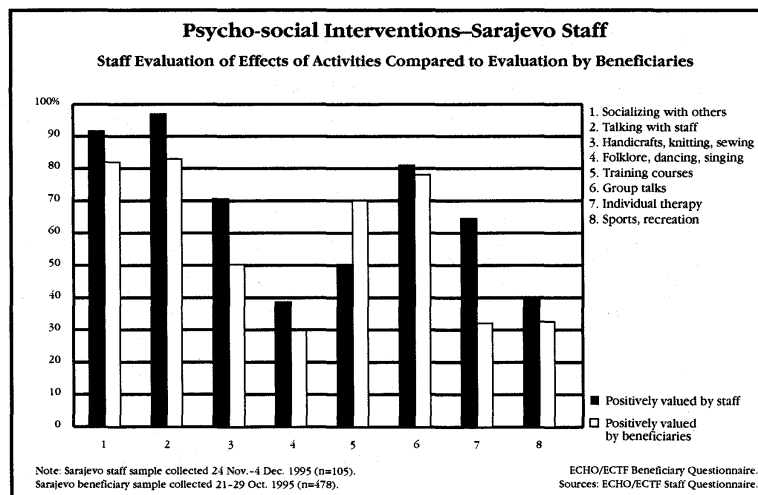


Figure IV.A.4. Evaluation by staff members in Sarajevo of the healing effects of the activities offered by psycho-social projects. Staff members' evaluation is compared to the Sarajevo beneficiary evaluation of the effects of the same activities.

The greatest difference concerns the positive value attached to individual therapy, with twice as many staff members as beneficiaries valuing this intervention as positive. However, one must be careful not to draw far-reaching conclusions from this finding. Only 32% of the beneficiaries actually received individual therapy and 84% of these felt that it helped them considerably or very much. Thus, the lower positive value attached to individual therapy by beneficiaries in general may also be related to lack of knowledge about this type of help.

Another reason may be the great significance people in this besieged city placed on maintaining a sense of urban, cultural activity. Often psycho-social programmes were the only possibility for that, whereby these community-oriented elements became more emphasized than, for example, individual therapy.

Figure IV.A.5 shows the evaluation by staff of changes in beneficiaries, compared to beneficiaries' own evaluation of changes:

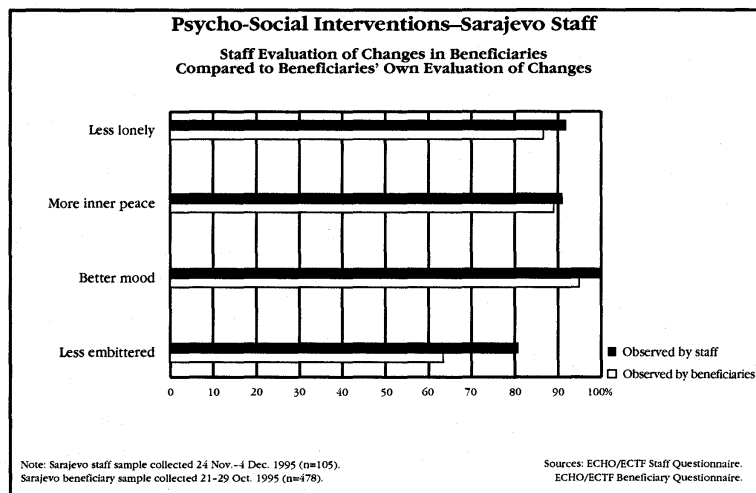


Figure IV.A.5. Evaluation by staff members in Sarajevo of the positive changes in the psychological state of beneficiaries after having received assistance from the psycho-social project. Staff members' evaluation is compared to beneficiaries' own evaluation of the benefits of the project.

It appears that considerably more staff members believe that the aggressive feelings of their beneficiaries have diminished than do the beneficiaries themselves. As mentioned earlier, the psycho-social programmes seem to have more problems dealing with the anger and bitterness of their beneficiaries than with other emotional reactions. Tentatively, this could partly be explained by a lack of awareness on the part of the staff about the degree of anger and bitterness felt by their beneficiaries. As staff and beneficiaries share many characteristics, the staff might also themselves harbour angry and bitter feelings without knowing how to handle these difficult emotions, making it painful to acknowledge and work with the same emotions in their beneficiaries.

Staff members have commented on other changes they have noticed in beneficiaries: "They look better", "They are more open", "Feelings of security, self-esteem and confidence in others have increased", "They have returned to the community as a social category", "They think and talk about the future". Ninety-eight per cent of the staff members (and 89% of the beneficiaries) attribute the positive changes to the programme.

## B. THE ADRIATIC COAST

The Adriatic coastal region includes psycho-social programmes operating all the way along the Adriatic Coast from Rijeka to Dubrovnik. The staff questionnaire was completed by 62 NGO staff members during the period 30 November–9 December 1995. At that time, many refugees were being resettled in other hotels along the coast, or in other parts of Croatia. Some Bosnian Croat refugees were being resettled in former Sectors North and South. However, the Bosnian Muslim refugees were often left with no other choice but to return to Bosnia-Herzegovina. The situation was characterized by uncertainty about the future, and the refugees had to cope with far less humanitarian aid than before.

### *Socio-demographic data*

Figure IV.B.1 shows some social background factors on staff members from the Adriatic Coast. Data on beneficiaries from the Adriatic Coast are also shown for comparison:

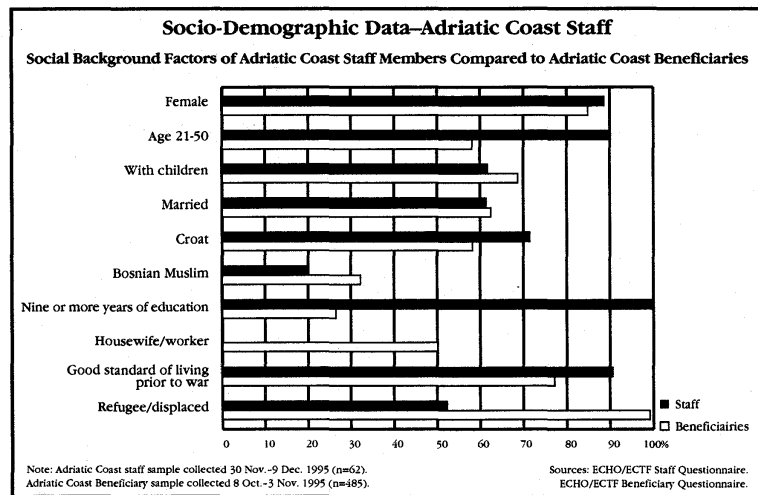


Figure IV.B.1 Selected socio-demographic data on Adriatic Coast staff members working in psycho-social projects compared to data on beneficiaries on the Adriatic Coast.

In contrast to the situation in Sarajevo, a greater number of social background factors are different for Adriatic Coast staff and beneficiaries. The ethnicity of staff and beneficiaries differs, with more Croats among the staff than among the refugees. This probably reflects the number of Bosnian Muslim refugees who fled to Croatia.

The rate of refugees/displaced people among staff is only about half the beneficiary rate. Among the 33 refugee staff members, 18 (55%) come from Serb-

controlled parts of Sarajevo. Many of these are mothers with young children who were evacuated to the coast in an organized way in 1992. Seven (20%) come from Mostar and left in 1992 due to shelling. The staff is much better educated than the beneficiaries, and had a better pre-war standard of living (including, for some, summer houses on the Adriatic Coast), which also enabled them to establish a better refugee life than the beneficiaries.

As shown in the following Figure IV.B.2, there are fewer social vulnerability factors in the background of the staff than in that of the beneficiaries:

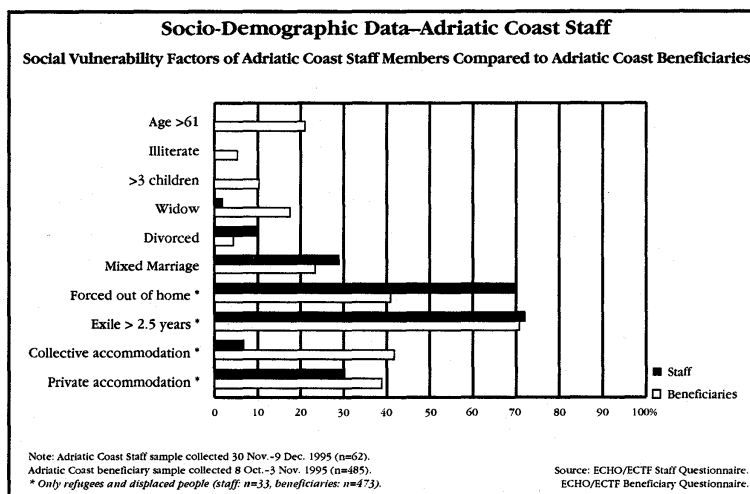


Figure IV.B.2. Some social factors indicating vulnerability among staff members on the Adriatic Coast compared to beneficiaries on the Adriatic Coast.

The rate of mixed marriages (around one quarter of marriages) is almost the same for staff and beneficiaries. One staff member writes that her mixed marriage “did not cause problems between us or within the family, but certain individuals from the environment that I arrived in (and where I used to live before) reacted by being aggressive or by rejecting us”. Another staff member states: “I will have no problems as long as a unified Bosnia model exists, but if it is divided I will not know where I belong or where I can live.”

Refugee staff members found life on the coast difficult to start with: “I was away from my family, except for my daughter, and all the others remained in the hell of Sarajevo”; “I feared for my husband and my relatives who remained in Sarajevo, and I experienced rejection and aggression in the community I arrived in”; “I felt a sense of helplessness and hopelessness”; “what was most difficult was to realize I was a refugee, just a number...”.

Like the Sarajevo staff, almost all Adriatic Coast staff used work as their most common coping strategy: “I tried to help myself and my family by working and thus gaining positive energy which I passed on to the children and my family back in Sarajevo”; “I helped myself by joining any activity available”; “I helped myself by personal engagement and by being completely occupied by this job.” Adriatic Coast staff and beneficiaries differed strikingly in this respect, just as Sarajevo staff and beneficiaries did. Only 20% of Adriatic Coast beneficiaries used work as a coping strategy.

### Traumatic experiences

Traumatic experiences of Adriatic Coast staff and their family members are shown in Figure IV.B.3:

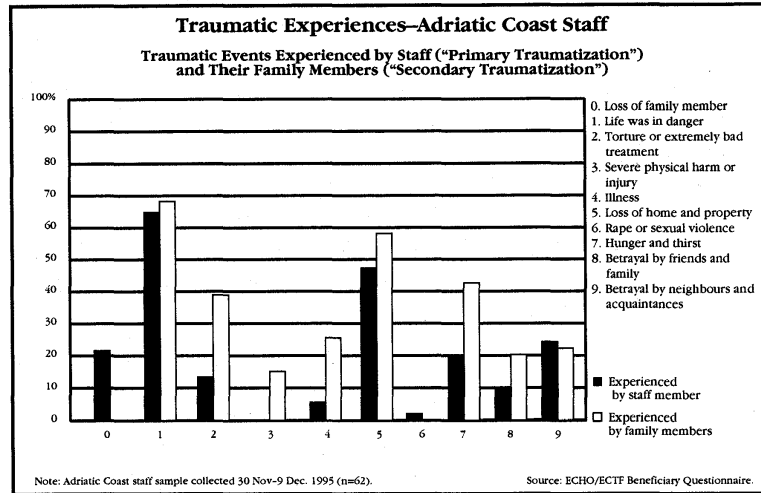


Figure IV.B.3. Primary and secondary traumatization of staff members working in psycho-social projects on the Adriatic Coast.

The Adriatic Coast staff have had far less traumatic experiences than the Sarajevo staff. Those who are refugees left the war zone at an early stage, and therefore did not have the same rate of life-endangering experiences. It is notable that the rate of feeling “betrayed by friends and family” is higher among Adriatic Coast staff than Sarajevo staff. This may be a symptom of “survivor’s guilt” among the Adriatic Coast staff. Feelings of having betrayed their families by leaving Bosnia are projected into phantasies of being betrayed. As contact with their families in Bosnia is so sparse, testing these phantasies against reality is difficult to achieve. This underlines the importance of re-establishing contacts both with family members and colleagues in order to facilitate re-building of trust.

The Adriatic Coast staff have also had fewer traumatic experiences than their beneficiaries. On all parameters the staff have far lower rates: e.g., half the rate of “torture or extremely bad treatment”, “hunger and thirst”, “loss of home and property”, “betrayal by friends and family” and “betrayal by neighbours and acquaintances.”

Thus, while the Sarajevo staff and beneficiaries mostly share the same traumatic experiences, the Adriatic Coast staff have a quite different background in this respect from their beneficiaries.

### Trauma symptoms

In their spontaneous written comments in the questionnaires, the Adriatic Coast staff appear to be less bitter and angry than both their Sarajevan colleagues and the Adriatic Coast beneficiaries. The results from the sub-study using psychometric tests are not available yet.

### **Training and support**

Thirty per cent of the staff had not participated in any training programme (39% in Sarajevo), 32% did not receive regular supervision (45% in Sarajevo), and 35% did not have any peer group support (42% in Sarajevo). The staff mostly ask for more case supervision: "more concrete experiences to be passed on to us by teachers". However, 57% state that the support they receive is adequate (71% in Sarajevo).

It is a paradox that the Sarajevo staff seem to be more satisfied with the support they receive than the Adriatic Coast staff. A tentative explanation could be that the Sarajevo staff were still in a survival mode and could not yet allow themselves to care about their own needs.

### **Evaluation of psycho-social interventions**

Sixty-three per cent of staff members conduct support groups ("group talks"), and 72% provide individual therapy. This is nearly twice the rate of the Sarajevo staff. In addition, staff facilitate socializing between beneficiaries (81%), talk with beneficiaries (90%), conduct handicraft workshops (42%), organize folklore, dancing and singing (6%), provide training courses (24%), and organize sports and recreational activities (27%). It appears that the Sarajevo staff organize twice as much singing, dancing and training as their Adriatic Coast colleagues.

As shown in Figure IV.B.4, and as we have also found in Sarajevo, beneficiaries seem to rate the benefits of individual therapy much lower than the staff.

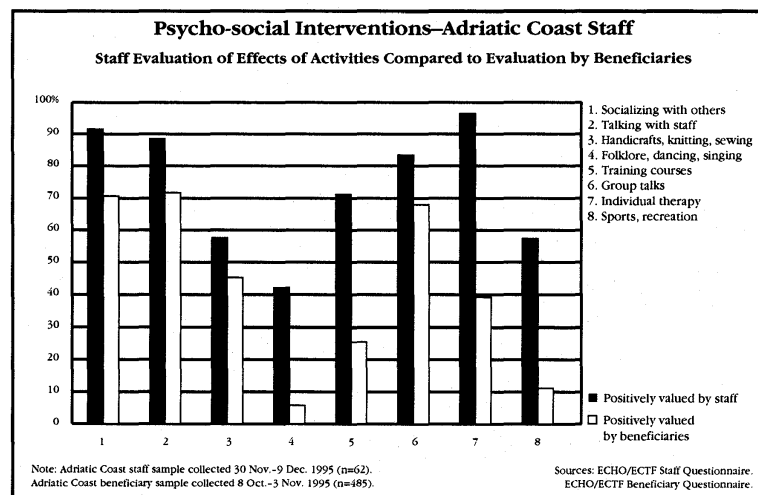


Figure IV.B.4. Evaluation by staff members on the Adriatic Coast of the healing effects of the activities offered by psycho-social projects. Staff members' evaluation is compared to the Adriatic Coast beneficiary evaluation of the effects of the same activities.

There are also discrepancies between staff and beneficiary evaluations concerning a number of other activities, most strikingly with regard to training courses.

Figure IV.B.5 shows the staff evaluation of changes in beneficiaries, compared to beneficiaries' own evaluation of changes:

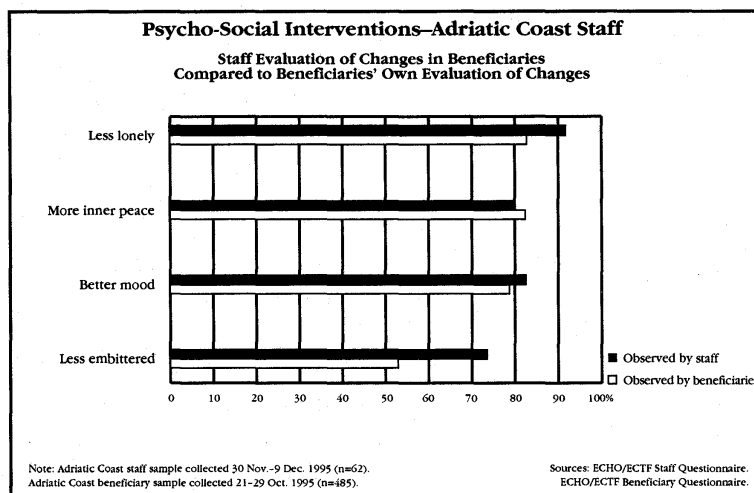


Figure IV.B.5. Evaluation by staff members on the Adriatic Coast of the positive changes in the psychological state of beneficiaries after having received assistance from the psycho-social project. Staff members' evaluation is compared to beneficiaries' own evaluation of the benefits of the project.

There is a discrepancy between staff and beneficiary evaluations concerning aggressive feelings which follows the same pattern as found in Sarajevo: staff believe that beneficiaries have become much less bitter and angry than the beneficiaries themselves feel.

Staff members comment on other changes they have observed in beneficiaries: "They have gradually become more open and they have no shame about what they feel or think"; "They realize that they are not isolated and that somebody cares for them"; "They search for meaning, a goal"; "They start to fight for their rights and a new status." Eighty-six per cent of the staff members (and 69% of the beneficiaries) attribute the positive changes to participation in the psycho-social programme.

### C. CONCLUSIONS

Returning to our original questions, we shall now attempt to draw some general conclusions.

#### **Wounded healers?**

In both Sarajevo and on the Adriatic Coast, the staff shared a wide spectrum of background factors with their beneficiaries, although this was much more pronounced in Sarajevo than on the Adriatic Coast.

The similarities and differences between staff and beneficiaries should be acknowledged in any type of training, supervision or other support given to staff under war conditions. Teachers and supervisors should be conscious of the dynamics of "wounded healers". When helpers and beneficiaries are in the same situation, this can lead to a feeling of solidarity and mutual commitment. This also



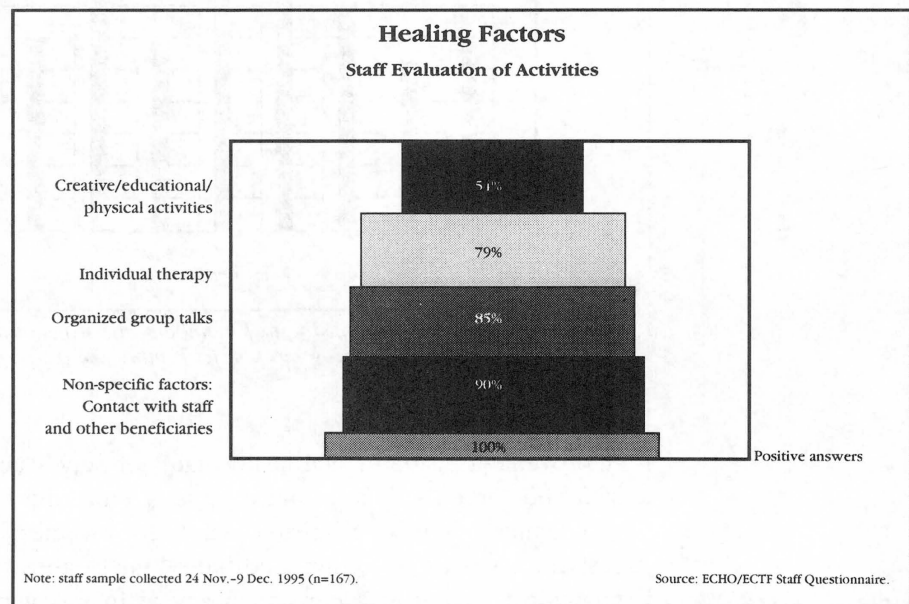
facilitates identification and empathy with the beneficiaries and the development of trust between helper and beneficiary.

However, this can also lead to over-identification and confluence with beneficiaries, resulting in difficulties with establishment of a professional distance, as a result of which helpers may either become enmeshed with the problems of beneficiaries or become too distant to avoid dealing with their own, similar and painful problems.

However, it is also important to acknowledge why the staff did not themselves become beneficiaries: confronted by tremendous problems, they did not give up but coped with the situation in an active and engaged manner. This is an important resource which the staff can transmit to their beneficiaries and which any training or supervision should reinforce. Many activities in psycho-social programmes can be carried out by lay people, if only they receive adequate training, supervision and support.

### ***Healing factors?***

Both in Sarajevo and on the Adriatic Coast there seemed to be a discrepancy between staff and beneficiaries concerning the benefit of various psycho-social intervention methods. Most prominent is the different weight given to individual therapy. In the following chart, the healing factors as conceived by the staff are grouped in a pyramidal structure (see also Figure III.A.11 for comparison with beneficiaries):



*Figure IV.C.1. The "healing power" of activities evaluated by staff members.*

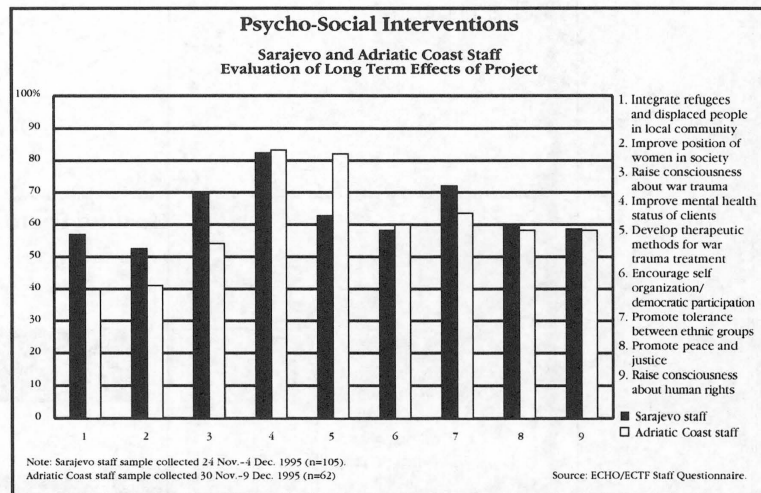
Staff and beneficiaries seem more or less to agree on the benefit of “non-specific factors” such as contact, warmth, care and acceptance. However, staff attach twice as much importance to group talks, and creative, physical and educational activities as beneficiaries do. Staff attach three times as much value to individual therapy as do beneficiaries.

These differences may partly be due to a lack of consciousness or knowledge among beneficiaries about the therapeutic value of these activities. However, the prominent importance which beneficiaries attach to the non-specific factors does correspond with research on the general outcome of various forms of psychotherapy (Frank & Frank, 1991).

This does not imply that group talks, organized activities or individual therapy are not important elements in a psycho-social programme. However, it does suggest the significance of implementing these interventions in an atmosphere of empathy, warmth and care, in a setting where provision has been made for creating a basic social support network among beneficiaries.

### ***The traumatized society***

The staff in both Sarajevo and on the Adriatic Coast were also asked to consider the longer-term societal impact of their programme. The answers are shown in the following Figure IV.C.2:



*Figure IV.C. 2. Evaluation by staff members in Sarajevo and on the Adriatic Coast of professional and socio-political impact of the psycho-social project.*

Improvement of the mental health status of beneficiaries is rated highest by the staff and somewhat less significance is given to the socio-political effects of the programmes. Maybe a greater emphasis on these aspects of psycho-social assistance would give angry and bitter beneficiaries an opportunity to use their aggressive energy in a constructive way. In this way, the programmes would become truly psycho-social: addressing the needs of both the traumatized society and of its people.





# V

## **SUMMING UP CONCLUSIONS AND RECOMMENDATIONS**

---



## **A. CONCLUSIONS**

Even during the first months of the war in Croatia in the summer of 1991, national mental health professionals were beginning to offer psychological assistance to the many displaced people fleeing from the fighting in former Sectors North, South and East.

Also in Serbia-Montenegro, at an early stage of the war, the professionals set up services for the refugees arriving there.

When the war spread to Bosnia in the spring of 1992, the Bosnian mental health professionals followed the same pattern, attempting to offer any assistance they could provide to the many war-traumatized people.

Former Yugoslavia had a developed system for social and mental care, and many well-educated professionals were available for assisting the traumatized refugees. However, the system was not prepared for responding to the needs of such a large number of people living under severely stressful conditions. Moreover, the system gradually deteriorated as the war developed.

Although mental health professionals were available, most of them were not trained in the treatment of trauma victims. Mental health and social services were mainly provided in institutions, and there was a lack of community-oriented services. National NGOs and grassroots movements were scarce.

It took a while before international organizations began responding to the psycho-social needs of the refugees and displaced people. An organized response was not initiated until the end of 1992, when news of the torture and rapes happening in former Yugoslavia became known all over the world.

In the middle of 1993, the European Community Humanitarian Office (ECHO) began financing psycho-social assistance, and it has since then funded more than 25 European NGOs providing psycho-social assistance to victims of war in former Yugoslavia. In addition, ECHO has financed a number of national NGOs through the UNHCR.

The Psycho-Social Unit was established in July 1993 in the framework of the European Community Task Force (ECTF), which was created to support ECHO's actions in the field.

The professionals working in the Psycho-Social Unit provided training in trauma therapy and supervision of staff for national mental health professionals and NGOs. However, this type of assistance was a new challenge not only for national mental health professionals, but also for the international professional community: crisis intervention and trauma therapy in a European context of war and ethnic cleansing was unknown territory.

Therefore, the Psycho-Social Unit was active in the development of strategies of intervention which corresponded to the new demands. However, first an overview had to be established of what was actually being done by the numerous organizations which gradually began to flow into the zone, and four subsequent overviews of the situation were published by the Unit.

After two years of emergency action by psycho-social NGOs in the field, the need was felt to review the practice which had developed. This practice had to a large degree been a response to urgent demands and it became crucial to investigate whether adjustments were needed.

It also became important to examine lessons learned especially with respect to transferability of the psycho-social strategies developed in this special context.

Therefore, the Psycho-Social Unit initiated a large-scale evaluation study of ECHO-financed psycho-social programmes collecting data on 2,291 beneficiaries and 167 staff members. The data were compiled during the last months of the war, from 20 September to 9 December 1995, with nine NGOs participating in the study.

The data on beneficiaries were analysed on the basis of both the total sample, and of a more detailed examination of six regions in Bosnia-Herzegovina and Croatia. The data on staff members were analysed separately but compared to data on beneficiaries.

In the presentation and interpretation of results the following main conclusions were reached:

- The psycho-social programmes managed to reach their target group: women who had suffered serious psychological trauma.
- In general, the programmes succeeded in considerably reducing the psychological pain felt by the women, although nearly one third remained angry and bitter.
- It is a special challenge for the programmes to help women find constructive channels for their aggression as part of a peace-building process.
- The most important psycho-social intervention is to establish a space in which women can create new social networks and make contacts, receive care and find understanding. The content of organized activities is secondary to this fundamental requirement.
- Staff have had the same type of traumatic experiences as their beneficiaries. However, the coping pattern of the staff has been different and more appropriate.
- Training, supervision and support of staff should address the traumatic background factors which staff, under war conditions, share with their beneficiaries. However, the different and more adequate coping pattern of the staff should also be acknowledged and reinforced.



- Many basic care-giving and social network activities can be organized by non-professionals if they receive training, supervision and support.
- The staff seem to attach more importance to organized activities – especially individual therapy – than do the beneficiaries. In training and supervision the value of non-specific factors such as contact, care and empathy should be emphasized.
- Staff members seem to be most concerned with individual effects of the programme, and not to be so focused on the wider social and political effects of their interventions.

## **B. RECOMMENDATIONS**

### ***1. Adjustments of further psycho-social field action both in former Yugoslavia and in other contexts***

- An overall policy should be outlined before psycho-social field action is instigated in a country, including aims, priorities and methods.
- Systematic needs and resource assessments should be carried out at regional levels in order to secure maximum coverage with the means available.
- Decisions on funding should be based on policy and needs and made in close cooperation between experts and donors.
- Projects should include a quality assurance mechanism from the very beginning. Project proposals should therefore include a description of how the NGOs will measure the impact and quality of their actions.
- Project proposals should also include plans for how the NGOs will ensure continuity between emergency and rehabilitation phases, i.e. sustainability.
- Psycho-social programmes working from a model which includes establishment of a “centre”, or other types of care-giving environments which encourage the development of social networks, should be given priority.
- An orientation towards peace-building and human rights advocacy should be encouraged in areas of ethnic conflicts and war.
- In conflict areas, both national and international staff (including aid workers) should be given training, supervision and support, in recognition of the traumatizing effects of working under stressful conditions.
- Monitoring of projects should be carried out by mental health professionals who participate in formulating policy, needs assessments and quality control.

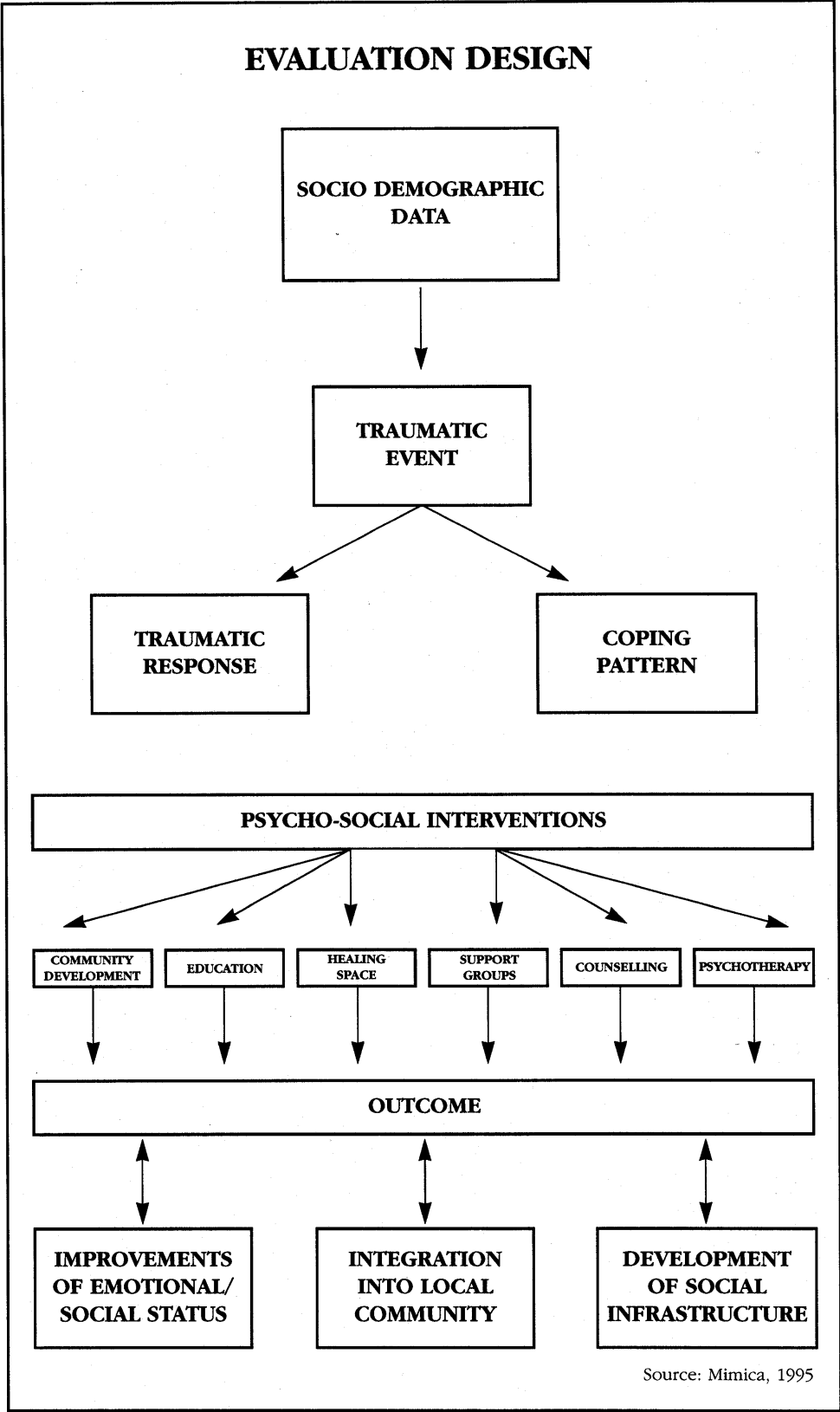


Figure V.1. Project evaluation model.

## ***2. Recommendations for standard evaluation procedures for psycho-social field action***

As shown in Figure V.1, standard evaluation of psycho-social field action should include the following elements:

- Information about the socio-demographic background of beneficiaries, i.e. social networks, cultural customs (including self-healing practices), relation to host community.
- Information about the traumatic events experienced by the beneficiaries and their response to them, i.e. trauma symptoms and coping pattern.
- Information about strategies employed by the psycho-social programme to alleviate trauma symptoms and change inadequate coping patterns, i.e. by creating “centres” (communal healing structures), educational activities, support groups, counselling, psychotherapy.
- Information about changes in emotional and social status of beneficiaries. This can be assessed through self-reporting by beneficiaries, observations by staff, or through standardized psychometric instruments (however, this is dubious in non-western cultural contexts).
- Information about how the programme impacts on the surrounding social context, i.e. on integration of beneficiaries into the local community, on development of the social infrastructure.



## **REFERENCES**

---



## REFERENCES

---

- Agger, I. (ed.) (1996). *Mixed marriages. Marriage and ethnicity in a context of ethnic cleansing*. Brussels: ECHO (forthcoming).
- Agger, I. (1994). *Theory and practice of psycho-social projects for victims of war in Croatia and Bosnia-Herzegovina*. Zagreb: ECTF & University of Zagreb.
- Agger, I. & Jensen, S.B. (1994). Determinant factors for countertransference reactions under state terrorism. In J.P. Wilson & J.D. Lindy (eds.), *Countertransference in the treatment of PTSD*. New York: The Guilford Press.
- Agger, I. & Jensen, S.B. (1996). *Trauma and healing under state terrorism*. London: Zed Books.
- Agger, I., Vuk, S. & Mimica, J. (1995). *Theory and practice of psycho-social projects under war conditions in Bosnia-Herzegovina and Croatia*. Brussels: ECHO/ECTF.
- Antiwar Campaign Croatia (1992). *Report on the activities of Antiwar Campaign Croatia for the period: July 1991–December 1992*. Zagreb: paper.
- Botev, N. & Wagner, R.A. (1994). Seeing past the barricades: Ethnic intermarriage in Yugoslavia during the last three decades. *Anthropology of East Europe Review – Special Issue*, 11 (1-2), 27-35.
- Dahl, S. (1996). Personal communication.
- Dahl, S. & Schei, B. (eds.) (1995). *Helping women - the hidden victims of war: It does make a difference! Norwegian People's Aid's psycho-social centre for displaced women and their families in Zenica, Bosnia & Herzegovina. Report and evaluation, 1993–94*. Oslo: Norwegian People's Aid.
- Danieli, Y. (1980). Countertransference in the treatment and study of Nazi Holocaust survivors and their children. *Victimology: An International Journal*, 5, 355-367.
- ECHO (1992). *Annual Report*. Brussels: European Community Humanitarian Office (ECHO).
- Figley, C.R. (1995). *Compassion fatigue*. New York: Brunner/Mazel.
- Francišković, T., Moro, L. & Palle-Rotar, D. (1993). *Clinical picture of refugee*. Paper presented at European Consultation on Care and Rehabilitation of Victims of Rape, Torture and Other Severe Trauma of War in the Republics of Ex-Yugoslavia, 17-19 June 1993, Utrecht.

- Frank, J.D. & Frank, J. (1991). *Persuasion and healing*. Baltimore: Johns Hopkins University Press (3rd ed.).
- Hougaard, E. (1996). *Psykoterapi: Teori og forskning (Psychotherapy: Theory and research)*. Copenhagen: Dansk Psykologisk Forlag.
- ICRC & UNHCR (1992). *The displaced in Yugoslavia. Situation update no. 1.*, 9 January. Yugoslavia: UNHCR and ICRC Public Information Offices.
- Išpanović-Radojković, V., Bojanin, S., Rudić, N., Rakić, V. & Lazić, D. (1993). *Children and young people - victims of war in former Yugoslavia (1991–1993)*. Paper presented at European Consultation on Care and Rehabilitation of Victims of Rape, Torture and Other Severe Trauma of War in the Republics of Ex-Yugoslavia, 17-19 June 1993, Utrecht.
- Jensen, S.B. & Wilson, J.P. (1996). *The WHO Regional Model for Mental Health under war conditions in former Yugoslavia*. *Journal of Stress Medicine*, October (in press).
- Kaličanin, P., Bukelić, J., Išpanović-Radojković, V. & Lecić-Toševski, D. (eds.) (1993). *The stresses of war*. Belgrade: Institute for Mental Health.
- Marie Stopes International (1995). *A community based emergency programme to facilitate survival, recovery and renewal for the traumatized women of Bosnia. Phase II: Report for period: October 1994–January 1995*. Split: paper.
- Mazy, C. (1996). Personal communication.
- McCann, L.L. & Pearlman, L.A. (1990). *Vicarious traumatization: A framework for understanding the psychological effects of working with victims*. *Journal of Traumatic Stress*, 3, 131-150.
- McKeown, P.T. (1995). Personal communication.
- Mesquita, B. (1994). *Outline and background of an assessment schedule: Psycho-social programme for women in Bosnia-Herzegovina*. Zagreb: UNICEF, paper.
- Mimica, J. & Stubbs, P. (1995). *Between relief and development: Theories, practice and evaluation of psycho-social projects in Croatia*. Submitted for publication to *Community Development Journal*.
- Moro, L. (1996). Personal communication.
- Moro, L. & Vidović, V. (1992). *Organizations for assistance to displaced persons*. In E. Klain (ed.), *Psychology and psychiatry of a war*. Zagreb: Faculty of Medicine, University of Zagreb.
- MSF/WHO (1995). *Recommendations from First Workshop on the Role in Health Issues of International Organizations in Conflict Areas of the Countries of Former Yugoslavia*, 2-3 February, Geneva.



- Orley, J. (1996). Personal communication.
- Petrović, S. (1996). Study in reproductive health: Self-reported symptoms of gynecological morbidity in refugee and displaced population of Croatia and Bosnia and Herzegovina. Split: Marie Stopes International, paper.
- Sarajlić, N. (1996). Personal communication.
- Sinanović, O. & Pašagić, I. (1996). Characteristics of traumatization and psychological reactions in Srebrenica female refugees. Paper presented at First European Conference on Traumatic Stress in Emergency Services, Peacekeeping Operations and Humanitarian Aid Organizations, 17-20 March, Sheffield.
- Smith, B., Agger, I., Danieli, Y. & Weisaeth, L. (1995). Emotional responses of international humanitarian aid workers. In Y. Danieli, N.S. Rodley & L. Weisæth (eds.), *International responses to traumatic stress*. New York: Baywood Publishing Company.
- Stuvland, R. (1996). Personal communication.
- UNICEF (1994). UNICEF questionnaire for women and girls. Zagreb: UNICEF, paper (August).
- UNHCR (1991). *Guidelines on the protection of refugee women*. Geneva: UNHCR.
- UNHCR (1992a). *The displaced in Yugoslavia. Situation update no. 2*. 18 February. Belgrade, Zagreb, Sarajevo and Geneva: UNHCR.
- UNHCR (1992b). *Emergency report: Displacement in former Yugoslavia*. 2 June. UNHCR, UNICEF and WHO.
- UNHCR (1993). *Social services mission 19.11-1.12.1992 and 11.12.92-3.1.93. Former Yugoslavia (focus on Bosnia): Practical guidelines for implementation, a community-based approach*. Geneva: UNHCR, paper.
- UNHCR (1995). *Information notes on former Yugoslavia*, 9, 10, 11, 12. Zagreb: UNHCR.
- WHO (1992a). *WHO mission on the mental health needs of refugees, displaced persons and others affected by the conflict: visit to Serbia, Vojvodina and Hungary, 16-22 December 1991*. Geneva and Copenhagen: WHO, paper.
- WHO (1992b). *WHO mission on the mental health needs of refugees, displaced persons and others affected by the conflict: visit to Croatia and Austria, 24 January-1 February 1992*. Geneva and Copenhagen: WHO, paper.
- WHO (1995). *Annual report 1994*. Zagreb: WHO.
- Wilson, J.P. & Lindy, J.D. (eds.), (1994). *Countertransference in the treatment of PTSD*. New York: The Guilford Press.



**APPENDIX I**  
**ECHO/ECTF BENEFICIARY QUESTIONNAIRE**

Questionnaire No.  
Programme:

Date:  
Area:

**FIRST WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT YOUR BACKGROUND**

1. I am:       Female       Male
2. My age is: .....
3. The number of school classes I completed is: .....  
(primary and secondary school)
4. I have .....children
5. I am:       Single       Married       Divorced       Widow/er
6. I define myself as:  Bosnian Muslim       Croatian  
                                  Serbian       Other (Please specify) .....
7. My spouse defines  
him/herself as:       Bosnian Muslim       Croatian  
                                  Serbian       Other (Please specify) .....
8. If you and your spouse are not of the same nationality,  
did that create any problems for you or your family?  
                                  yes       no       I don't know
9. If yes, what kind of problems?  
.....
10. Are you a refugee or displaced?  
                                  yes       no      (if no, proceed to question 20)
11. If you are a refugee or displaced, where were you living before the war?  
Country: ..... Place: .....
12. My occupation was: .....  
My spouse's occupation was: .....
13. I was living (tick all relevant boxes):  
                                  Alone       With my spouse  
                                  With my children       With my parents/parents in law  
                                  With my brother(s)/sister(s)       With other family members
14. My standard of living was:  
                                  Bad       Reasonable       Good       Very good
15. My housing situation was:  
                                  Bad       Reasonable       Good       Very good

**NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT WHAT HAPPENED TO YOU DURING THIS WAR**

16. If you are a refugee or displaced person when did you leave your home? .....  
(write date of leaving home)

17. I had to leave my home because: .....  
(please write the most important reason for you personally)

18. What was the most difficult thing for you when you arrived?  
.....

19. How did you try to help yourself and your family?  
.....

20. Now, I live in:      my own house/flat                      collective centre  
                               private accommodation        with relatives

21. Now, I am living with (tick all relevant boxes):  
                               Alone    With my spouse  
                               With my children                              With my brother(s)/sister(s)  
                               With my parents                                With other family members

22. Have you yourself experienced (tick one box on each line):

Loss of family member	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Situation where your life was in danger	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Torture or extremely bad treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Severe physical harm or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Illness or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Loss of your house and property	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Rape or sexual violence	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Hunger and thirst	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Friends and family turning against you	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Neighbours and acquaintances betraying you	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know

23. Have any of your family members experienced (tick one box on each line):

Situation where her/his life was in danger	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Torture or extremely bad treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Severe physical harm or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Illness or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Loss of their house and property	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Rape or sexual violence	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Hunger and thirst	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Friends and family turning against her/him	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Neighbours and acquaintances betraying her/him	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know

**NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT THE PROGRAMME YOU ARE INVOLVED IN**

24. When I entered this programme I was feeling (tick one box on each line):

- |                             |                              |                             |                                     |
|-----------------------------|------------------------------|-----------------------------|-------------------------------------|
| Lonely                      | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Frightened                  | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I was crying a lot          | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I could not sleep           | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I was angry and embittered  | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I was lost and disoriented  | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I was restless              | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Other (Please specify)..... |                              |                             |                                     |

25. I joined this programme because (tick one box on each line):

- |   |                              |                             |                                     |
|---|------------------------------|-----------------------------|-------------------------------------|
| I needed to be together with other people | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I needed comfort                          | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I needed help                             | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I needed (Please specify) .....           |                              |                             |                                     |

26. When did you enter this programme? (write month and year).....

27. I continue to be in this programme because (tick one box on each line):

- |                                 |                              |                             |                                     |
|---------------------------------|------------------------------|-----------------------------|-------------------------------------|
| It makes me feel better         | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Talking relaxes me              | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I like to socialize with others | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| I get understanding from others | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Other (Please specify).....     |                              |                             |                                     |

28. I participate in the following activities (tick one box on each line):

- |   |                              |                             |                                     |
|---|------------------------------|-----------------------------|-------------------------------------|
| Socializing with others                   | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Talking with staff                        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Handicrafts, knitting, sewing, embroidery | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Folklore, dancing, singing                | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Training courses                          | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Groups talk                               | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Individual therapy                        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Sports and recreation                     | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Other (Please specify).....               |                              |                             |                                     |

29. What has changed for you since you joined the programme? (tick one box on each line):

- I am less lonely than I was before                     yes    no    don't know  
 I have achieved more inner peace                     yes    no    don't know  
 I am in a better mood                                     yes    no    don't know  
 I am not that embittered any more                    yes    no    don't know  
 Other (Please specify).....

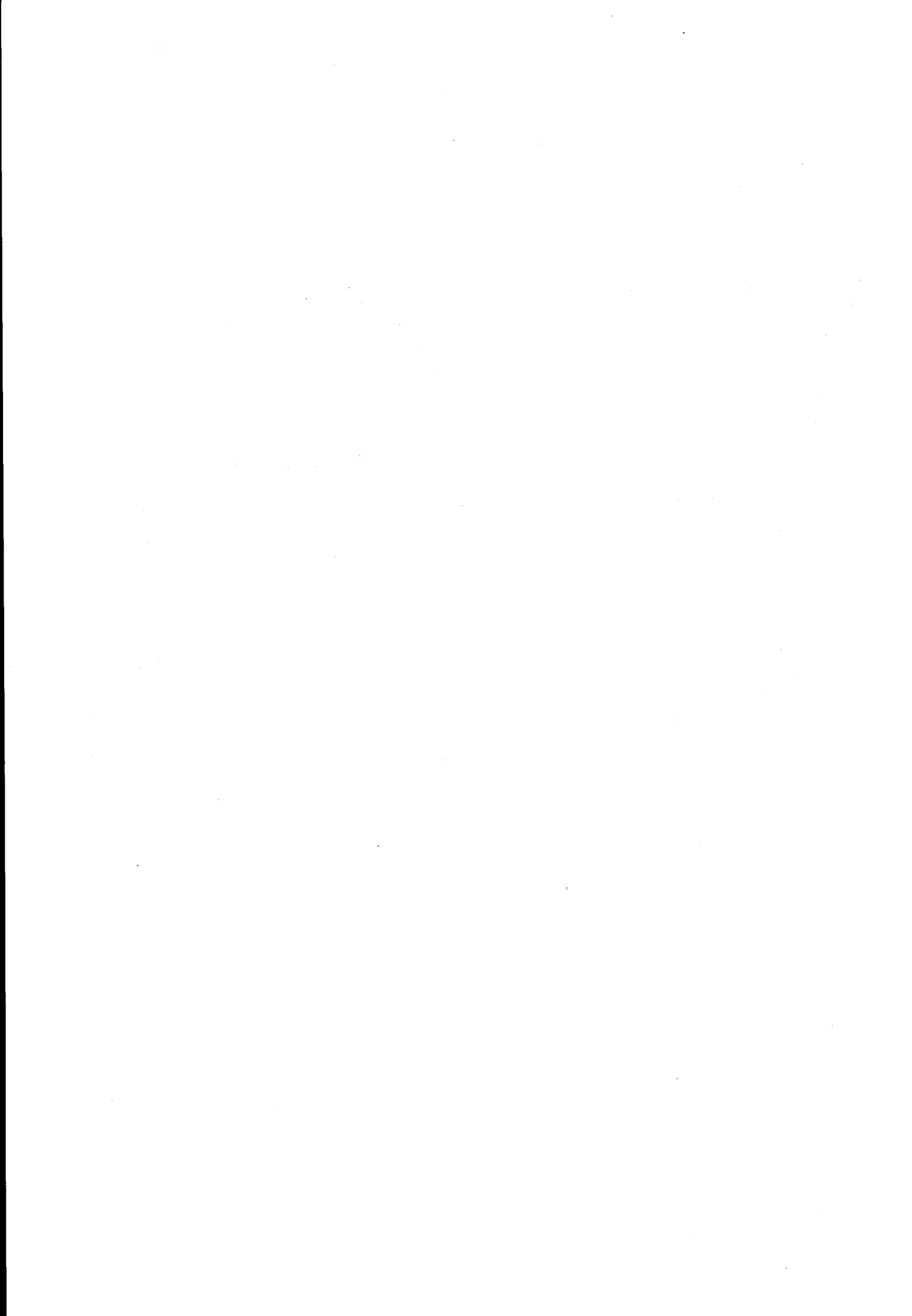
30. If you think that the change is positive, do you consider it to be a result of the programme?

- very much    considerably  
 partly         not at all

31. Which of the activities helped you most in your situation?

(tick one box on each line)

	Did not help me at all	Helped me a little	Helped me considerably	Helped me very much	I did not participate
Socializing with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking with staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handicrafts, knitting, sewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Folklore, dancing, singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training courses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group talks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports, recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify).....					





**APPENDIX II**  
**ECHO/ECTF STAFF QUESTIONNAIRE**

Questionnaire No.  
Programme:

Date:  
Area:

**FIRST WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT YOUR BACKGROUND**

1. I am:       Female       Male
2. My age is: .....
3. The number of school classes I completed is: .....  
(primary and secondary school)
4. I have .....children
5. I am:       Single       Married       Divorced       Widow/er
6. I define myself as:  Bosnian       Croatian  
                                  Serbian       Other (Please specify) .....
7. My spouse defines  
him/herself as:  Bosnian       Croatian  
                                  Serbian       Other (Please specify) .....
8. If you and your spouse are not of the same nationality,  
did that create any problems for you or your family?  
 yes       no       don't know
9. If yes, please write what kind of problems?  
.....
10. Are you a refugee or displaced person?  
 yes       no      (if no, proceed to question 20)
11. If you are a refugee or displaced, where were you living before the war?  
Country: ..... Place: .....
12. My occupation was: .....  
My spouse's occupation was:.....
13. I was living (tick all relevant boxes):  
 Alone       With my spouse  
 With my children       With my parents  
 With my siblings       With other family members
14. My standard of living was:  
 Bad       Reasonable       Good       Very good
15. My housing situation was:  
 Bad       Reasonable       Good       Very good

**NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT WHAT HAPPENED TO YOU DURING THIS WAR**

16. If you are a refugee or displaced when did you leave your home? .....  
(give date of leaving home)

17. I had to leave my home because: .....  
(please write the most important reason for you personally)

18. What was the most difficult thing for you when you arrived?  
.....

19. How did you try to help yourself and your family?  
.....

20. Now, I live in:      my own house/flat                    collective centre  
                                   private accommodation        by relatives

21. Now, I am living with (tick all relevant boxes):  
                                   Alone    With my spouse  
                                   With my children                            With my siblings  
                                   With my parents                            With other family members

22. Have you yourself experienced (tick one box on each line):

Loss of family member	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Situation where your life was in danger	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Torture or extremely bad treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Severe physical harm or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Illness or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Loss of your house and property	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Rape or sexual violence	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Hunger and thirst	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Friends and family turning against you	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Neighbours and acquaintances betraying you	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know

23. Have any of your family members experienced (tick one box on each line):

Situation where her/his life was in danger	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Torture or extremely bad treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Severe physical harm or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Illness or injury	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Loss of their house and property	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Rape or sexual violence	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Hunger and thirst	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Friends and family turning against her/him	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Neighbours and acquaintances betraying her/him	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know

**NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS  
ABOUT THE PROGRAMME YOU ARE WORKING FOR**

24. I started to work in this programme: .....  
(enter the month and the year)
25. My basic professional education was in: .....
26. During my work in this programme I have participated in training courses  
 yes       no       don't know
27. If yes, which courses? .....
28. I work in this programme as (the name of your position) .....
- 29 Do you participate in:
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Regular supervision sessions conducted by a professional | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Peer group support work                                  | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Other kind of support for care-givers                    | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Do you think the support you get is adequate?            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- If not, what kind of support would you like to get?.....
- 30 I am working with clients in the following activities (tick one box on each line):
- |   |                              |                             |                                     |
|---|------------------------------|-----------------------------|-------------------------------------|
| Facilitating socializing between clients      | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Talking with clients                          | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Handicrafts, knitting, sewing, embroidery     | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Folklore, dancing, singing                    | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Teaching in training courses                  | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Conducting support groups                     | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Providing individual therapy                  | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Organizing sports and recreational activities | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Other (Please specify).....                   |                              |                             |                                     |
- 31 What kind of changes have you observed in the clients after they joined the programme?
- |                                     |                              |                             |                                     |
|-------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| They are less lonely than before    | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| They have achieved more inner peace | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Their mood has become better        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| They have become less embittered    | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know |
| Other (Please specify).....         |                              |                             |                                     |

32. If you think that the change is positive, do you consider it to be a result of the programme?

- very much     considerably  
 partly         not at all

33. Which activities do you consider to be most helpful for the clients?

(tick one box on each line )

	Did not help at all	Helped a little	Helped considerably	Helped very much	Don't know
Socializing with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking with staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handicrafts, knitting, sewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Folklore, dancing, singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training courses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group talks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports, recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify).....					

34. How does this project (in your personal view) contribute to:

	Did not help at all	Helped a little	Helped considerably	Helped very much	Don't know
Integrate refugees/displaced people into the local community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve the position of women in society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raise consciousness about war trauma issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve mental health status of clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop therapeutic methods for treatment of war trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encourage people for self-organization and democratic participation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote tolerance between ethnic groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote peace and justice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raise consciousness about human rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please add other long term effects of this project which you observed yourself.



**APPENDIX III**

**INGER AGGER: ACTIVITIES 1993 – 1996**

---

## **Inger Agger, PhD: Activities 1993-96**

---

Psycho-social coordinator

### **I. Coordination of field action**

#### ***1993***

---

August: First overview of psycho-social projects published:  
*Psycho-Social Projects for Victims of War in Croatia and Bosnia-Herzegovina*. 27 pages.

*The Psycho-Social Working Group in Zagreb* is established (ECTF, UNICEF, WHO, UNHCR, ARC) collaborating on the article:

"Under war conditions: What is a psycho-social project?"

September: Second overview of psycho-social projects published:  
*Theory and practice of psycho-social projects for victims of war in Croatia and Bosnia-Herzegovina*. 63 pages.

October: Collaboration initiated with  
*Centre for Development of Disaster Management Information System, University of Zagreb* on data collection for third edition of overview of psycho-social projects.

#### ***1994***

---

January: Third overview of psycho-social projects published in cooperation with Centre for Development of Disaster Management Information System, University of Zagreb:  
*Theory and practice of psycho-social projects for victims of war in Croatia and Bosnia-Herzegovina*. 178 pages.

December: Fourth overview of psycho-social projects published in collaboration with Sanja Vuk and Jadranka Mimica:  
*Theory and practice of psycho-social projects under war conditions in Bosnia-Herzegovina and Croatia*. 299 pages.

#### ***1995***

---

May: ECHO, Brussels reprints and distributes *Theory and practice of psycho-social projects under war conditions in Bosnia-Herzegovina and Croatia*.



## II. National seminars and training workshops

1993

---

- July: Speaker at *8th World Congress of Balint Federation, symposium: Violation of Women in War*, 18-21 July, Zagreb. Title of lecture: "Sexual violence against women as part of political repression."
- September: Teacher at *workshop: traumas — sexual violence and interventions*, 30 September-2 October, Opatjia, arranged by Medical Centre for Human Rights and Norwegian People's Aid. Titles of lectures: "Cultural aspects of sexualized violence" and "Use of testimony in therapy."
- October: Teacher at *seminar: Workshop with war traumatized persons*, 19-22 October, Zagreb, arranged by Croatian Red Cross and IFRC Social Welfare Programme. Titles of lectures: "The use of testimony as a therapeutic method" and "The problem of the wounded healer."

1994

---

- February: *Book presentation: Theory and Practice of Psycho-Social Projects for Victims of War in Croatia and Bosnia-Herzegovina—An Overview*, 23 February, Zagreb, arranged by ECTF in collaboration with WHO Project for Rehabilitation of War Victims.
- March: *Book presentation: The Blue Room. Trauma and Testimony Among Refugee Women: A psycho-social exploration*, 20 March, Zagreb.
- April: Speaker at *ECTF Conference on Psycho-Social Care*, 14-15 April, Zagreb. Title of lecture: "Peace-building and social memory."
- Teacher at seminar at *Psychiatric Department, Clinical Hospital Centre Rijeka*, 21 April. Title of lecture: "Burn-out of professionals working with therapeutic assistance to victims of war."

June : Speaker at *34th International Gerald Grinschgl Pula Symposium, South-East- European Society for Neurology and Psychiatry*, 2-4 June, Croatia.

Title of lecture: "Trauma and testimony among refugee women: A psycho-social exploration."

October: Speaker at meeting celebrating *World Mental Health Day*, 10 October, Sarajevo.

Title of lecture: "Psycho-social assistance and peace-building."

December: *Psycho-Social Unit: Presentation of ECHO/ECTF assistance and two new books on Psycho-Social Assistance*, 7 December, Zagreb.

---

### 1995

January: Teacher at *WHO Seminar: Mostar and Mental Health*, 13-14 January, Mostar.

Title of lecture: "Women survivors and their families under war conditions."

February: *Teacher at WHO Seminar: Post-traumatic Counselling and Therapy*, 17-18 February, Mostar.

Titles of lectures: "Understanding trauma,"

"What is post-traumatic therapy?" and

"Counter-transference in post-traumatic therapy."

Teacher at WHO seminar: *Post-Traumatic therapy*, 20-21 February, Sarajevo. Titles of lectures: "Understanding trauma", "What is post-traumatic therapy?" and "Counter transference in post-traumatic therapy."

March: Workshop: *Assistance to Families Under War Conditions With Special Focus on Identity Within the Context of Mixed Marriages*, 27-29 March, Zagreb, organized by ECTF Psycho-social Unit in collaboration with WHO Mental Health Unit.

May: *Teacher at Workshop: Trauma and Healing Under War Conditions*, 16-18 May, Tuzla organized by DRC.

Titles of lectures: "Testimonies as a private and professional tool" and "Ethics, human rights and mental health."

- June: Speaker at *Dubrovnik Summer School of Trauma Psychiatry*, 11-12 June, Dubrovnik.  
Title of lecture: "Stress reactions of international humanitarian aid workers."
- September: Teacher at *DRC Seminar: Psycho- Social Work with Refugees*, 13-15 September, Montenegro.  
Title of lecture: "Psycho-social work with refugees."
- December: Speaker at *WHO Diploma Ceremony, Training Course on Post-traumatic Therapy*, Sarajevo University, 19 December.

### III. International Meetings and Conferences

#### 1993

---

- July: Collaboration with Centre for Psycho-Social and Traumatic Stress, Aalborg, Denmark on the article: "Definitions, levels of intervention and strategies of psycho-social projects for victims of war in former Yugoslavia - a proposal."
- August: Speaker at Workshop: *Psychotherapeutic Interventions with Victims of Organized Violence*, 9-14 August, Oxford arranged by Refugee Studies Programme, University of Oxford and Psycho-social Centre for Refugees, Oslo.  
Titles of lectures: "Trauma as repressive political experience" and "Therapist and client both in danger of persecution".
- October: Speaker at II. Aalborg Seminar on Psycho-Social and Traumatic Stress, 31 October-2 November, Denmark.  
Title of paper: "Sexuelle overgreb i det politiske rum - et Zagreb perspektiv (Sexual abuse in a political context - a Zagreb Perspective)."

#### 1994

---

- March: Briefing of the Commission of Experts Established Pursuant to Security Council Resolution 780 (1992), 1 March, Zagreb.
- October: Invited participant in Consultative Working Group Meeting and Joint Working Group Meeting on Gender-Specific War Crimes, 20-24 October, Geneva.

December: Invited speaker at International Criminal Tribunal for the Former Yugoslavia, 9-10 December, The Hague, organized by Physicians for Human Rights.  
Title of lecture: "Rape and sexual violence as a crime of war in the Former Yugoslavia."

### ***1995***

---

February: Invited to act as facilitator of a working group at First Workshop on the Role in Health Issues of International Organizations in Conflict Areas of the Countries of Former Yugoslavia, 2-3 February, Geneva.

May: Invited speaker at Workshop: Addressing the Psycho-social Needs of Children in Armed Conflict, 4-8 May, Harvard University, Boston.  
Title of lecture: "How therapeutic work contributes to the empowerment, participation and self-organization of beneficiaries."

October: Invited participant in European Consultation on Medical Ethical Standards in Mental Health Care for Victims of Organized Violence, Refugees and Displaced Persons, 12-14 October, Zeist, The Netherlands.

December: Invited speaker at Women, Violence and War: Actions for Peace, 14-16 December, Bonn.  
Title of lecture: "The role of psycho-social projects in the peace building process: The clean and the unclean".

### ***1996***

---

March: Speaker at European Conference on Traumatic Stress in Emergency Services, Peacekeeping operations and Humanitarian Aid Organizations, 17-20 March, Sheffield, United Kingdom.  
Title of lecture: "Trauma and intervention under war conditions in former Yugoslavia: Experience in implementation of psycho-social and mental health programme."

#### IV. PUBLICATIONS

1993

---

November: Agger, I. (1993). Enkerne vil have sort uld (The widows want black wool)", *Information*, 10 November, page 8 (Danish newspaper article and interview).

1994

---

March: Agger, I. (1994). *The Blue Room. Trauma and Testimony Among Refugee Women: A Psycho-Social Exploration*, London, Zed Books.

November: Agger, I. (1994). Trauma and testimony among refugee women: A psycho-social exploration. *Socijalna Psihijatria*, 22, 15-22.

December: Agger, I. (1994). Abused refugee women: Trauma and testimony. *Refuge*, 14 (7), 19-22.

Agger, I. (1994). Peace-building and social memory. In Arcel, L.T. (ed.), *War victims, trauma and psycho-social care* (30-40). Zagreb: ECHO/ECTE

1995

---

July: Agger, I. (1995). Aide aux victimes de guerre en ex-Yugoslavie: Une psychologue témoigne. *7 Jours Europe, Commission européenne*, 195,8.

December: Smith, B., Agger, I., Danieli, Y. and Weisaeth, L. (1995). Emotional responses of international humanitarian aid workers. In Y. Danieli, N. Rodley and L. Weisaeth (eds.), *International responses to traumatic stress: Humanitarian assistance, human rights, justice, peace and development—contributions, collaborative actions and future initiatives*. Published for and on behalf of the United Nations. Amityville, New York: Baywood Publishing Company, Inc.

Agger, I. (1995): Sarajevo begynder et sted inde i hovedet (Sarajevo begins somewhere inside of my head). *Information*, 1 December, page 9 (Danish newspaper article).

February: Agger, I. and Jensen, S.B. (1996). *Trauma and healing under state terrorism*. London: Zed Books.

March: Agger, I. (ed) *Mixed Marriages: Marriage and ethnicity in a context of ethnic cleansing. Voices from a psycho-social workshop held in Zagreb, Croatia 27-29 March 1995*. Brussels: ECHO

March: Agger, I. & Mimica, J. (1996). *ECHO Psycho-social assistance to victims of war in Bosnia-Herzegovina and Croatia: An evaluation*. Paper.

The European Community Humanitarian Office (ECHO) has been involved in psycho-social assistance for victims of war in the former Yugoslavia from an early stage. In 1993, the European Community Task Force set up a Psycho-Social Unit, based in Zagreb, to support ECHO's assistance to traumatized women and children.

Among the tasks of this unit is the development of methods to ensure the best possible therapeutic assistance to victims of war trauma. This book is an evaluation of the work so far.

## **Psycho-social assistance: a framework for survival, an aid in the peace process**



### **Early developments:**

Providing psycho-social assistance  
in war conditions

### **The Psycho-Social Unit:**

New perspectives — fostering self-help

### **The Study I:**

Beneficiaries — traumatised souls

### **The Study II:**

Staff — caring for the carers

### **Summing up:**

Conclusions and recommendations

ISBN 92-827-9102-5



9 789282 791028 >

