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Trauma and Conflict

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TRAUMA AND CONFLICT PREVENTION

A Critical Assessment of the Theoretical Foundations and Contribution of Psychosocial Projects in War-torn Societies

Yet, there remains another wall. This wall constitutes a psychological barrier between us, a barrier of suspicion, a barrier of rejection; a barrier of fear, of deception, a barrier of hallucination without any action, deed or decision.
A barrier of distorted and eroded interpretation of every event and statement ...
Today, through my visit to you, I ask why don't we stretch out our hands with faith and sincerity so that together we might destroy this barrier?

- President Anwar al-Sadat,
Statement before the Israeli Knesset,
Jerusalem, November 29, 1977

The bloody massacre in Bangladesh quickly covered over the memory of the Russian invasion of Czechoslovakia, the assassination of Allende drowned out the groans of Bangladesh, the war in the Sinai desert made people forget Allende, the Cambodian massacre made people forget Sinai, and so on and so forth until ultimately everyone lets everything be forgotten. (p. 7)

In February 1948, the Communists took power, not in bloodshed and in violence but to the cheers of about half the population. They had a grandiose program, a plan for a brand new world in which everyone would find his place. The communist's opponents had no great dream: all they had was a few moral principles, stale and lifeless. So, of course the grandiose enthusiasts won out over the cautious compromisers and lost no time turning their dream into reality: the creation of an idyll of justice for all (p. 8)

- Milan Kundera, the book of Laughter and Forgetting, 1978

ABSTRACT

My current piece of research starts with a question: how helpful is trauma resolution to the prevention of future conflicts? It argues that psychosocial relief for war trauma can contribute to sustainable peace in conflict-ridden states but that recent research is based on a limited concept of trauma that does not allow to address the wider social, political and cultural context in which war trauma takes place and in which it shall be redressed.

This paper analyses the theoretical basis of proponents and critics of psychosocial projects and draws attention to a current impasse in the debate on the relevance of trauma relief. It traces the origins of the debate within the history of trauma research, the impossibility to describe trauma and tries to overcome the impasse by pointing to this impossibility, and by using findings from empirical psychosocial research that can accommodate the role of the social, cultural and political context on a structural level. Part two takes up the initial question on the impact of unresolved trauma and ongoing conflicts and the repetition of violence. It proposes some preliminary ideas on the wider contribution of trauma relief in terms of its potential capacity to mitigate repetition of violence. The relevance of a psychosocial model of trauma is assessed in its extrapolation to political conflicts, and a comparison is drawn between individual and national elaborations of trauma within history, myth and identity, in both violent and peaceful ideologies. Contradicting earlier models that perceive conflict as the result of an error, a wrench in the human systems of social cognition or society, our research hypothesises that trauma relief may mitigate re-enactment of grief by addressing psychological functions in addition to the political-economic functions of violence.

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INTRODUCTION

Health is one of the key aims in a country's development. In the last decade, the importance of mental health has become increasingly apparent worldwide (UNICEF, 1994; World Bank, 1993). In particular, the atrocities of recent civil wars in Rwanda, Yugoslavia, and others drew attention to the detrimental impact of political violence on mental health. Since then, psychosocial projects have become a part of humanitarian aid programmes in complex emergencies by international aid organisations and NGO's, such as ECHO, UNICEF, the WHO, IRC, etc… (Agger et al, 1995; Dyer, 1996; Jensen, 1996).

In spite of their widespread recognition, the actual contribution of these projects is unclear. Though there is considerable research indicating that wars can cause serious psychological distress, (Barnett, 1999; Cairns, 1996; Chase et al, 1999; Herman, 1992; Thulesius and Hakansson, 1999; Abu-Saba, 1999; Levin, 1999; O'Brien, 1994; Vander Kolk, Weisaeth & McPharlane, 1996; Weine et al, 1995; Woodside et al, 1999; Yule et al, 1997), research that supports the effectiveness of psychosocial relief in redressing the effects of war is considerably more scarce (Blake et al, 1992; Cairns, 1996; Shalev, Yehuda & McFarlane, 2000). Nevertheless, various authors have claimed such a relationship and it has been one of the key drivers behind psychosocial intervention in war. At this point, the understanding that psychosocial interventions may contribute to interrupt the 'cycle of violence' remains intuitive and prescriptive. Logical proof of the

relationship is lacking. (Agger et al, 1995, 1999; Chase, 1999; Joshi, 1998; Nader, 2000; Taylor, 1998).

The acclaimed contribution of psychosocial projects ranges between individual mental health and post-war reconstruction. The debate between proponents and critics of psychosocial relief programmes has to be understood in the context of this continuum. Critics (Allen, 1996, 1997; Bracken, 1998; Boyden, 1994; Bouyden & Gibbs, 1997; Brett, 1996a, 1996b; Gibbs, 1997; Giller, 1998; Parker, 1996q, 1996b; McCallin, 1998; Richmena, 1997; Stubbs & Soroya, 1994; Summerfield, 1996, 1997, 1998a, 1998b) have argued that psychosocial projects medicalise distress that is fundamentally of a social nature, and creates third-world dependency by undermining local traditions of dealing with distress. In the field of proponents of psychosocial intervention in war, there is plenty of research into the effects of war on peoples' psyche, but current theories used for that purpose show serious cracks when put to the test in war-torn societies, as they fail to specify the relations between a psychological process that is described in individual and medical terms and the dynamics of social, cultural and political conflict.

little theoretical elaboration of the wider contribution of trauma relief projects, and more specifically, the establishment of a causal relation between unresolved trauma and protracted conflict, and the actual mechanisms by which this may work. In the absence of theoretical proof of the mechanisms by which trauma relief may influence conflict; and the lack of alternatives by critics, the debate on psychosocial relief for the victims of war risks to end up in a deadlock.

As there is truth in the observations of both approaches, this seeks to overcome this deadlock by analysing the features of trauma relief leading to this deadlock and at the

same time presenting an elaborated psychosocial model that allows to address the wider claim, by describing trauma in terms of the bare-bone relation between individuals and their physical and symbolic environment. The framework may have cross-cultural applicability and hold the promise to be at the same time parsimonious, redress the existing criticism and provide a basis for policy where it affects trauma of war.

PART I: EMPIRICS: CONCEPT, PRACTICE, RESEARCH

On Trauma, Psychosocial Programmes, Critique, and research on trauma and the role of the social world.

This chapter consists of four sections. The first chapter gives a theoretical background of trauma as conceived in clinical terms. Starting with the history of research on trauma and the epistemological difficulties, to the nosological classification of trauma as PTSD, to the theoretical models that describe how trauma comes about (onset, generalisation and maintenance) and the clinical intervention methods of how it can be redressed. This forms the basis of the psychosocial relief programmes for societies at war that are described in chapter two. In return, chapter three presents recent criticism of these programmes, focusing around the role of the local, cultural and societal world that is targeted by political violence, but that harbours the capacity to mitigate the effects of violence. A psychosocial model on trauma and research on social, cultural and political factors, presented in chapter four, describes how the physical, social and symbolic environment of people at war mediates between the confrontation with the horrors of war and the development of trauma.

I. MODEL A: POST-TRAUMATIC STRESS DISORDER

1. Trauma: History

The word trauma originates from the Greek word for wound and was applied for physical injury before it became used for psychological ‘injury’ by the end of the 19th century (Breuer and Freud, 1895).

By definition, trauma is a psychological ‘wound’, and a traumatic event is a major stressor, which suddenly overwhelms a person, threatens his or her life or a personal integrity, leaves no escape, and triggers accompanying horror that overwhelms the individual’s ability to understand and cope with the situation (APA, 1994; Herman, 1992; Joseph, Williams & Yule, 1997).

Over the past hundred of years, one of the most compelling questions has been about the origins of trauma. What causes it: war, rape, a serious traffic accident? If we take war, it appears that some wars like Vietnam or the Yugoslav wars caused proportionately more distress than others. Likewise, it appears from history that some individuals suffer more than. Although these findings appear to indicate that the etiology of trauma is determined by the seriousness of the situation, the individual processing of certain stimuli by an individual and the interaction between both, the uncertainty on the causes of trauma gave rise to a lot of misconceived intervention as the question of cause often became a question of guilt and scientific discourse quickly became moral discourse. As a result, so-called female patients with hysteria and soldiers with ‘combat fatigue’ or ‘shell shock’ were prescribed horrifying 'normalising programmes'. The confusion between moral and medical discourse was pre-eminent during the two World Wars. It

was often thought that soldiers suffering from traumatic stress symptoms were traitors. Extremely harsh treatments were applied to soldiers, such as electric shock ‘therapy’.

At a time when psychology was in its infancy, the causes of trauma were deemed physical. A famous definition at the time of WWI was ‘Shell Shock’. Under this theory, traumatic stress symptoms were the result of small grenade particles that would penetrate the skull and cause brain damage. But grenade particles were so small they couldn’t even be seen, and so the cause of trauma was not proven and invisible.

The Vietnam War, with its street protests and with war veterans suffering, became a watershed in the formal acceptance of trauma. This war, that was continued despite many doubts that victory was within reach, and that society had rather forgotten altogether, brought home dismayed and aimless soldiers, suffering from distress and with their plight being a painful reminder of the distressing mistakes made during the war. Like many wars, this war was fought in the name of defence. But, unlike several others, it was a war where ground troops were alienated from the goal of winning.

After many soldiers suffered at their return to the United States, a major breakthrough was achieved for those who fought for recognition of Posttraumatic Stress Disorder with the introduction of the Diagnosis in the Diagnostic and Statistical Manual of Disorders (DSM- III, 1980). The absence of an empirical definition and diversity of methodologies had made it nearly impossible to draw general conclusions on the existence of trauma. Based on this common definition, systematic empirical research of the effects of a single event on a group of people (Van Der Kolk, McFarlane & Weisaeth, 1996), came to shed light on the question whether symptoms resulted from personal weaknesses and faking or from the horrors of armed violence (Herman, 1992;

McPharlane, 2000; Verhaeghe 1998). The overwhelming number of soldiers suffering from *'combat fatigue'* or *'Shell Shock'* forced professionals to change the attribution of stress responses from personal 'weaknesses', or fake to *'normal reactions to an abnormal situation'* (Herman, 1992, Yule, 1994). Most psychiatric disorders are the reverse: they are conceived as deviations from normality.

Further empirical research brought home two conclusions. Firstly, studies of war show that some people develop PTSD whilst others don't. Secondly, the actual proportion of people that develop PTSD varies with the intensity of the stressor. Evidence confirms the existence of a direct relationship between the intensity of a stressor and its effects. This means that, whether a child loses his home, a parent, sees the parent being assassinated before his eyes and the level of brutality of the assassination can have different effects, so war and other severe stressors have undeniable consequences on people. Thirdly, the development of trauma is also related to personal and situational factors. Personality, prior traumatic experiences, family support moderate the impactof a stressful event thus the development of PTSD. How these factors interact is laid out by psychosocial models of trauma.

There are two conclusions that follow from this. Firstly, that the first criterion of the DSM diagnosis is built on these research findings. Secondly, the whole current debate on the need for trauma relief programmes originates in these twin conditions (with one side emphasising more the realist view, the other the constructivist view). It shows that the absence of a definitive etiological criterion for trauma, a 'bacteria' or 'virus' can cause great difficulties for determining the need for and evaluating the effect of humanitarian aid programmes for psychological suffering.

2. Posttraumatic Stress Disorder: Psychiatric classification

There are six diagnostic criteria for PTSD within the DSM[1] that can be grouped into three clusters of symptoms: firstly, the confrontation with a threatening event (A) and how it is experienced (B); secondly, repetition in the form of memories, dreams and physiological re-experiencing; thirdly, the disturbing impact of the event on a person's functioning. The most distinguishing feature of PTSD is repetition: a persistent re-experiencing of the traumatic event by recollections, dreams, acts, intense distress and physiological reactivity at exposure to internal or external cues that symbolise or represent an aspect of the traumatic event, differentiating PTSD from 'normal' 'grief' reactions that become resolved with time.

3. Theoretical conceptualisations

The psychiatric classification system DSM focuses on diagnostic symptoms of disorders. It deliberately avoids theories, leaving that to others to determine. Theory, per definition means guide, and we need this guide to understand how the observable symptoms of PTSD are brought about. This chapter describes three theories on the mechanisms of how a traumatic event develops into a major stressor.

[1] The first consists of two components: A) the confrontation with an event that involved actual or threatening death, serious injury or physical integrity, of the self or others; B) the person's response involved fear, helplessness and horror. The second and third criteria are the key symptoms: intrusion and avoidance. Intrusion is. The third factor is avoidance of these cues related to the traumatic event (and a numbing of general responsiveness). Numbing refers to a 'diminished interest or participation in significant activities', a 'feeling of detachment or estrangement from others' and a 'sense of foreshortened future (does not expect to have career, marriage, children, or a normal life span)'. A fourth factor was added along with the inclusion in DSM: hyperarousal. This refers to a state of hypervigilance, sleep problems, irritability and outbursts of anger… The fifth and sixth criteria that the disturbance should take longer than one month, and that it causes significant distress or impairment in the person's social or occupational life.

Classical Conditioning Theory

Conditioning theory explains generalisation of a fear response to stimuli that are categorically similar to the traumatic event. According to classical conditioning, a traumatic event (e.g. a car-accident) becomes linked to new stimuli (e.g. a car, driving, the location of the accident,…), that are initially neutral, but by their link to the fearful stimulus, can start to evoke a similar anxious response. They receive the meaning of the traumatic event and in a sense come to replace it.

Operand conditioning theory

Operand conditioning as a general model explains how learned behaviour is reinforced by punishments and rewards. It holds that the conditioned link (see above) is maintained by avoidance of the distressing stimulus, which can take the form of drug abuse, avoiding traffic, driving and in the end streets altogether, etc… This reaction in itself is a strong reinforcer of the belief that the action that was avoided would indeed be negative, since the fearfully anticipated response extinguishes by means of the avoidance itself.

Information Processing Models

Conditioning theory explains the generalisation and maintenance of fear; information-processing[2] (IP) models explain why an event causes fear or anxiety in the first place. An event evokes anxiety and is traumatic when it cannot be understood, cannot be dealt with,

[2] Information processing is used here to refer to emotional processing models as well. Emotional processing models equal IP models, but stress describe PTSD in terms of unsuccessful emotional processing. To quote Rachman (1980, p. 52): "Successful emotional processing can be gauged from the

and overwhelms the individual. In IP terms: it contains information and evokes hefty emotions that cannot be ‘processed’. Information that is incompatible with pre-existing notions about the world, cognitive schema’s that enable people to understand, predict and deal with the world that surrounds them and provide for a feeling of trust and safety (Janoff-Bulmann, 1992). A 'traumatic event shatters[3] such schema's and evokes intense anxiety and helplessness, which the individual is unable to ‘process’ adequately when the event takes place. A 'traumatic event' leaves a person not only overwhelmed by information which cannot be understood, but for which he or she has no adequate response, or is impeded to provide an adequate response, such as in the case of sexual assault. Often, patients describe the experience as swallowing their breath, being speechless, lacking the words to describe what happens. It may be assumed that it is this lack, this impossibility to know and impotence to act that causes fear; a fear that is intense or ‘raw’ (Herman, 1992; Vander Kolk ea, 1996).

In summary, a traumatic event overwhelms the individual with information that is incompatible with his ideas about the world, so incompatible that the words are lacking to describe it. It remains 'unprocessed’. It stays ‘locked’ in memory, as an isolated body, a 'Fremdkorper' (Freud, 1985), is remembered in dreams and autonomously triggered during the day, hampering peoples’ functioning.

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person’s ability to talk about, see, listen to or be reminded of the emotional events without experiencing distress or disruption”.

[3] Janoff-Bulman (1992) points to three basic such basic assumptions: (1) the world as benevolent; (2) the world as meaningful; and (3) the self as worthy. In addition, she points to ‘justice and fairness as two most important assumptions.

4. Therapy

The most striking feature of PTSD is the persistent and vivid repetition of a traumatic event. Anachronistically, past memories become a present reality. And the patient responds in ways that are maladapted to the present but could have been accurate in the past. Research indicates that repetition is greatly exacerbated by avoidance (Yule, Joseph, 1997) and is alleviated by exposure to a situation that is contrary to the event. For instance, a therapist who is very gentle and predictable may be very healing with a patient with a violent partner. According to an emotional processing model, the actual recurrence PTSD symptoms is perceived as a delayed response (Joseph et al, 1996); and the repeated intrusion as an attempt to 'work through' an experience that was left unprocessed (Freud, 1914; Rachman, 1980; Foa et al, 1996, 1997; Joseph et al, 1996).

Therapy is a post-hoc attempt to facilitate this process, to name and express recollections and emotions that were choked off. Recounting trauma in a safe environment "allows patients to realise that contrary to their mistaken ideas: (a) being in an objectively safe situation that reminds one of the trauma is not dangerous; (b) remembering the trauma is not equivalent to experiencing it again; (c) anxiety does not remain indefinitely in the presence of feared situations or memories, but rather decreases even without avoidance or escape; and (d) experiencing anxiety does not lead to a loss of control (Foa & Meadows, 1997; p. 462). This is what therapy is according to cognitive behavioural therapy, leading to fading of anxiety. The result of this process is a new outlook on life, brighter than before, but also with an implicit loss and a more differentiated reality, from total fear to a partial fear, from total sadness to partial sadness

and partial understanding. To overcome anxiety through exposure is an essential, but insufficient step to rebuild communities at war. Herman (1992): “Traumatic events call into question basic human relationships. They breach the attachment of family, friendship, love and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis… Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link an individual with her community” (1992, 50). This second phase exists of sharing of traumatic experiences, perceptions, emotions and responses with other people in a safe environment, in conjunction with mourning over loss. Most fundamental is that people feel support and genuine interest in their experience that can create a sense of belonging. Art or indigenous rites can be ways to express the experience. A new phase can be entered: to ‘regain the capability to have trust and relate to others’ (Herman, 1992), to work through trauma, overcome isolation and detachment (Matsakis, 1998; Maynard, 1997), and to mourn the loss of a former world.

II. PSYCHOSOCIAL RELIEF PROGRAMMES IN CONDITIONS OF WAR

The following chapter describes the indication of psychosocial projects, their implementation and reviews empirical data on their effectiveness[4].

Policy and Early Developments

The war in Former Yugoslavia (FRY) was the first in history in which an organised effort was made to provide psychosocial assistance. Confronted with pictures of the horrors of ruthless violence in Rwanda, Yugoslavia, Liberia/Sierra Leone, and of abandoned children, crying women, accounts of mass rape and streams of refugees in Yugoslavia, international aid organisations decided this psychological suffering warranted international assistance.

Fact-finding missions were sent to establish needs (Machel report, Warburton report) and international organisations, in cooperation with experts in mental health and NGO's went to set up programs. Agger et al (1995), estimated that, due to the severity of war, about 700.000 people (mainly, women and children) would suffer from psychic trauma in Bosnia and Croatia; and that with the existing number of mental health workers, only 1-5% of this population could be helped. The need for help was defined

[4] With regards to methodology, the following must be borne in mind. A considerable number of studies confirms that exposure to war gives a significant increase in PTSD symptoms (see Journal of Traumatic Stress). There are much less studies that show the effectiveness of psychosocial interventions under conditions of war (Cairns, 1996). In addition, the results of empirical studies are difficult to compare, because methodologically this requires randomised controlled trials (Kazdin, 1997). Often, different modes of therapy and diagnostic instruments are applied and this to different subject groups (women, children, torture victims, refugees,…), exposed to different stressors (war, torture, rape, political repression,…) in different countries and cultures.
Research findings are therefore almost impossible to compare and since there are no control groups, nor pre-intervention measurements, the results of improvements can always be explained by other variables that were outside of control (age, socio-economic background, duration between traumatic event and

following two factors. Firstly, there is the confrontation with a traumatic event and secondly, the destruction of protective elements, such as family, material goods and institutions.

Such statements are of course very problematic, as it flies in the face of epistemological research methods. The logic is as follows: (i) war causes high amounts of distress, (ii) existing support structures are demolished or insufficient; (iii) hence, aid is needed. This argument assumes a direct relation between a deprivation, a need and a provision of a good or service. The problem with such need-based thinking is that the relation between a deprivation and a need is not 1:1. Deprivation of food leads to hunger, but deprivation of safety and confrontation with violence may or may not lead to trauma and trauma resolution is a highly individual matter and may or may not benefit from direct aid.

Later critique convicts psychosocial relief of neo-imperialism (Summerfield, 1995, 1996, 1997, 1999). Arguably, this does not match with reality. From the start, mental health professionals in Croatia and other countries had started to offer mental health assistance, but they were inexperienced and quickly burnt out. Foreign aid too was organised in the form of technical cooperation, following a so-called community-based model, in which local mental health workers and teachers were trained to provide help (Richman/SCF, 1996, 1997; Yule et al, 1997). The impetus for projects was largely a response to a locally existing need (Jensen, 1996), and that the international community from the onset aimed to prevent some of the major traps, such as the creation of aid dependency, undermining local expertise, and imposition of western culture (OECD,

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therapy…). Thus, it becomes almost impossible to empirically establish causal relations between independent variables (e.g. therapy, social environment) and the subsequent clinical improvement.

1995). Instead, many projects aimed to build local capacity. For all the shortcomings, it requires little thought to realise that this goal was achieved better than in the case of the provision of food and blankets. The mistake was not to provide the aid, but to cast it in terms of needs-thinking, which is fundamentally flawed, instead of capability-thinking, in which the expansion of peoples' endowments and capabilities is the main goal, the capacity to learn, not the provision of goods.

What is the purpose of psychosocial programs? According to Agger, it is the promotion of mental health and human rights in emergencies (p. 15, Agger & Mimica, 1995). In a later definition it becomes the promotion of human rights, reconciliation, and psycho-social well-being (p. 20, Agger, Jareg, Herzberg, Mimica & Rebien, 1999). Similar to both definitions, is the recognition that existing protective factors should be enhanced and intervention shall decrease stressors at different levels. The evolution between both definitions highlights the growing awareness among professionals that psycho-social projects touch upon human rights, peacebuilding and so on in addition to psycho-social well-being. This may very well be the intention and a correct intention. But the real praxis of the psychosocial projects shows no sign in this direction. There are no data that measure the impact of these projects on the advocacy of human rights or the prevention of future conflicts. Interventions that do take this into account, such as testimony therapy, there is no coherence between the diagnosis of PTSD, and the intervention (Agger et al, 1999; Weine, Pulenovic, Pavkovic & Gibbons, 1998), no relation between the diagnostic criteria of PTSD and the therapy, which is an obvious shortcoming in light of any clinical model, where in principle there must be coherence between the cause and the alleviation of a disorder.

Coherence is present between what is described as the twofold causes of trauma – direct threat and destruction of protective factors- and what psychosocial relief is all about – removal of the first and the effects of the first and reconstruction of the second. Hence, trauma relief and reconstruction are intrinsically linked. However, the reality is quite different. Psychosocial programmes address the effects of war, but there is no direct effort to restore the social fabric, the infrastructure of society, and the institutions that enforce the law and protect against anxiety and chaos, conditions in which war lords and mafia thrive and genocide can be preached as defence against chaos. In another context, it has been shown that effective institutions are important for democracy (Putnam, Leonardi, Nanetti, 1997) and economic growth (North, 199??; Harris, 199?). In particular, the enforcement characteristics of institutions are crucial to their effectiveness and function in society. If one wants to define a framework that allows coherence, cooperation, comprehensiveness and consistency, etc…. of aid (OECD,???), to understand the structural similarity, the functional similarity of trauma relief and the restoration of good governance and good institutions can provide a solution.

Current wars do not only lead to distress in a direct fashion, through acts of aggression, they also undermine factors that function as a buffer against stress. War is not an exogenous and isolated event, with a clear and marked ending. It is often protracted, with the violence being of a structural and institutionalised nature (Galtung in: Reychler, 1997; RAND corporation). This implies that rebuilding societies should address both the psychological and societal sphere. In practice, Agger et al propose a combination of intensive psychotherapy, counselling, advocacy and mutual support, network-strengthening inventions, and community development projects.

Empirical findings: psychosocial aid in Ex-Yugoslavia 1993-1995: data and conclusions

The following paragraph describes a survey study by the European Commission's Task Force in Zagreb (Agger et al, 1996) of 185 projects, implemented by 117 organisations between 1993 and 1995. This is the widest survey to date.

Firstly, the stressors. According to the respondents of this survey (mostly women), the most harmful stressors were the loss of home and property, life was in danger (experienced by 80% of all beneficiaries and their family members) and "betrayal by neighbours and acquaintances" (experienced by nearly 50 % of respondents). Torture and extremely bad treatment had happened to about 25 % on average and up to over 42% in the Tuzla region, where the detention camps had been. Secondly, the results of the survey show an improvement on both subjective and objective measurements: beneficiaries report remission in trauma-related symptoms and an improvement in overall well-being following participation in projects. Thirdly, the conclusions. A closer examination of the data leads to a different conclusion. Three points jump out of the data, relating to the choice of target population, how feelings of frustration and anger are addressed and the what the findings tell about trauma and what is essential.

Firstly, 78% of the projects targeted women, while only 44% targeted men. Women are more vulnerable but in terms of prevention of future violence, this bias can be a serious shortcoming. As men come back from the frontline, their traumatic experiences will influence both their own well-being and that of their families. Secondly, the programs were much less effective in the reduction of frustration and anger than of anxiety and depression. In light of peacebuilding, these findings merit much more

attention then they are given. If trauma relief projects create no significant reduction in anger, how can they contribute to peacebuilding? And if programmes focus their efforts on vulnerable groups such as women and children, perceiving them as passive 'victims' in need of help, how can that have a contribution to the prevention of future conflict? Petty (1998) and Gibbs show that children in Africa are much very resilient and are often aggressors too (Cairns, 1996; Danieli, 1998). There are good grounds to believe that it is precisely 'unresolved' anger and frustration that may ignite aggression by militias and may lead civilians to support violent leaders.

Thirdly, not therapy but the social context was stated by the women as the most important in coping, motivations for seeking help and the factors that were valued in the projects. Working (27%), concentrating on survival (18%), socialising with peers (12%) or caring of family members (10%) were the main coping mechanisms prior to war. Motivations for seeking help were the need to be together with other people (95%), the need for help (86%) and the need for comfort (79%). Socialising with others and group talks were an important motivation for help.

In conclusion, trauma relief programmes decreased fear and depression but not anger; to targeted victims but not soldiers and criminals, and social support was one of the most important factors in coping and reason for therapy.

III. CRITIQUE ON PTSD PROGRAMMES IN CONDITIONS OF WAR

The model

There are basically three critiques of psychosocial programmes: (i) a rejection of the importation of 'Western approaches' to health and healing, (ii) a rejection of the phrasing of trauma within medical discourse, and (iii) a rejection of individual notions of trauma and treatments at the expense of wider social and cultural variables (see: Allen, 1996, 1997; Bracken, 1998; Boyden, 1994; Boyden & Gibbs, 1997; Brett, 1996a, 1996b; Gibbs, 1997; Giller, 1997; Parker, 1996a, 1996b, Stubbs & Soroya, 1994; Summerfield, 1996, 1997, 1998a, 1998b).

Analysis

The first critique is part of a stream in the literature called dependency theory or critique on 'neo-imperialism' within development studies. It refutes the application of Western Expertise, and claims that this will lead to dependency and marginalisation of local habits and resources. The second critique concerns the phrasing of trauma within medical discourse and rejects this on the basis that trauma does not belong within this discourse. Traumatic events cause no trauma but ordinary distress, political and economic hardship and oppression, and infringements of fundamental rights. Giller and McCallin (1998) for instance describe that joblessness and other socio-economic factors make reintegration of soldiers problematic, not trauma per se. The main argument of the second critique is that a medical diagnosis diverts the attention away from economic, political and judicial causes of distress and that these causes should be redressed in a direct

fashion. Comment: this is true, but redressing the causes of 'trauma' and suffering is not sufficient, just like redressing the effects isn't. They are two sides of intervention that are inseperable. The third critique relates to this and highlights the importance of the wider social and cultural context, in giving meaning to and providing ways to deal with the effects of distress. Rather than working on an individual level, aid, if provided, should engage with locally existing methods and the social context. Boyden and Gibbs (1994) and Gibbs (1997), underscore what local rituals can do in dealing with distress with examples of Cambodia and Mozambique.

Evaluation

The articles point to important shortcomings but give no clear alternative guidelines how to organise interventions that address these factors that are neglected.

Local methods should also not be hailed too much – they aren't always that benign (Witch prosecution, Allen, 1997).

Role of medical anthropology is very important, and these criticism are too. However, if they aim to stop psychosocial aid overall and aim reduce support to those who suffer, it would be a major step back. In fact, it would repeat history. The social world is important, and may perhaps have been neglected in the actual praxis of relief, but the social constructivism that lies at the basis of much of the critique is not only highly new in theoretical terms, it would fly in the face of the rights of local populations to support and recognition of their problems; and if it would lead to social relativism,

cannot be tolerated. In relation to coming criticism, it is important to note that psychosocial assistance at the time did not exceed 2.5 % of the total budget for humanitarian assistance to the former Yugoslavia.

There are particularities in the way that different cultures view violence, suffering and in the way they deal with them. Cultural relativism, and social constructivism in its extreme leads to no action, since any intervention is flawed. Instead, it would be a great and essential contribution of anthropology to describe the local and cultural ways in which traumatic events are understood and dealt with. And secondly, it is true that aid cannot be allowed come in the place of political inactivism in fighting the causes of trauma, and structural violence in terms of discrimination of minority rights and closure of opportunities to certain segments of a country's population. To conclude that trauma relief programmes are misplaced is a wrong conclusion. It conflates the execution of trauma programmes with their function, and it takes away one sort of aid, because another one is not provided. Providing trauma relief may be wrong where the need for a job is more urgent, and can event help to come to terms with the events, but deciding that this is therefore a reason to ignore trauma and relief altogether is logically flawed. Instead, it is essential to study the local, and culturally defined ways in which suffering form violence is expressed, and what measures would help to restore it, whether they are of a social, political, judicious, economic or individual nature. Bickering over the usefulness of western psychotherapy is useless and flies in the face of the suffering of the victims of war, and much of the cultural critique, if it is, is no less high-handed than the imperialist motives it accuses current praxis of being. Instead, here is another proposition: focus on the functions of different forms of dealing with trauma, and analyse the

epistemological difficulties, and how they lie at the basis of political conflicts as well as scientific disputes and claims over what is true.

IV. IMPACT OF THE SOCIAL ENVIRONMENT ON TRAUMA DEVELOPMENT AND HEALING

The acceptance of trauma went a long way. From the horrific ‘normalising' therapies during WWI (McPharlane, 2000), over the initial neglect of survivors of the Nazi Holocaust and Vietnam (Danieli, 1998; Nader, 1999; Shalev, Yehuda & McFarlane, 2000), to the late psychosocial projects. The DSM IV has incorporated the role of subjective experience of events in factor 1B. But it has been the brilliancy of researchers under a psychosocial model for trauma (a.o. …..), to recognise the importance of this factor and to describe the components that determine this subjectivity, to provide evidence on them, addressing the shortcomings of any model that seeks the ultimate nucleus, causal factor of trauma in the victim or his perpetrator and dichotomises a complex reality. The following psychosocial model addresses these shortcomings. It accommodates much of the earlier critique.

1. A Psychosocial Model

The model addresses the fact that there is no direct, monocausal relation between a traumatic event and the development of trauma. The core proposition is that this relation is mediated by appraisal factors. It is in this respect an information-processing model that stresses the role of inference and subjective appreciation of external stimuli. This appraisal is influenced by the social surrounding, more in particular social support, social context and wider narratives. As we shall later see, this context fulfils two essential

functions, functions that may apply across societies at large: that it provides direct social support, the tools (symbols, habits,…) to give meaning to the surrounding world, and a sense of belonging.

This context fulfils a vital function in the protection against threat and fears. In wars, what is destroyed are houses, institutions, and morality. They provide support and a sense of belonging in a material and non-material sense. In their function, we can structurally equate them. This understanding provides a framework for interventions that are coherent and comprehensive; interventions that address the individual and his needs, and society at large.

2. Empirical Research

This paragraph contains research that highlights the interaction between trauma and the role of the social world. The following factors are discussed: cognitive appraisal, relations and group therapy, social support from the environment, and social context. In a study on Israeli soldiers, Solomon and Smith (1994) find support for the role of appraisal factors. Results indicate that the degree of distress varies according to both the type of exposure and victims' explanations for it. Allen and Bloom (1994) find support for the role of relationships and group therapy, indicating a relational definition of trauma. Allen & Bloom theorise that, no matter which etiological model is applied, a fundamental aspect of traumatic phenomenology involves disruptions of an individual's relationship with the world. It supports what patients often describe as a horrific aspect of trauma: the psychological 'falling away', sense of isolation and abandonment from family and

society after trauma. This conceptualisation automatically supports the importance of group and family techniques (Allen & Bloom). As group members find that others can understand their experience, isolation decreases. As such, group therapy provides a corrective experience, with the establishment of safety and trust, parallel to the corrective experience provided by exposure therapy. Empirical research supports this model and has shown effectiveness in improving interpersonal relationships and social reintegration (Allen & Bloom, 1994; Joseph et al, 1997). Yet, where groups cannot trusted, such as in cultures where there is a stigma on rape, revealing the issue in a family or natural group context can have dangerous consequences. Nader (1999) reports a case where a brother assassinated his sister after she disclosed being raped (see also Danieli 1998). After appraisal and the group, a third factor is social support. Support is defined as the feelings that one is loved or cared about, that one belongs and the provision of information. Social support can interact via appraisal processes with meaning, attributions and coping to induce more or less distress (Joseph et al, 1997). There is widespread recognition of the role of social support within trauma research. Research shows that greater social support is associated with better outcome following toxic exposure, rape and combat (Joseph et al, 1997). A study on the Herald of Free Entreprise disaster, found that higher self-report ratings of crisis support received from family and friends are predictive of lower levels of distress and that less emotional support to be predictive of PTSD (Yule et al, 1997). In a study on Israeli soldiers that fought in the 1982 Lebanon War 1982, Solomon (1988) found that the intensity of PTSD declined when there was more perceived social support and vice versa. Interestinly, the study used 'perceived' social support. That this was effective, even if it contradicted reality points to the importance of belief systems. In a

study of 209 Bosnian refugee women, Dahl, Mutapcic and Schei show that reporting of an absent husband was associated with PTSD. In connection to the social context, there are two important studies. Firstly, Cairns (1996, 1998) reviews studies of children that showed political convictions were associated with a lower intensity and incidence of trauma symptoms. This indicates that political beliefs may protect against the development of trauma, which is much like the proposition made in part II of this thesis. Similarly, Summerfield draws attention to the Vietnam War following which US veterans were disowned by their society and this in contrasts to the Falkland War in which British veterans returned to popular acclaim. The social context or narrative determines the meaning of particular experiences and subsequent emotional reactions. In this context, Amir, Stafford, Freshman and Foa (1998) found that (i) trauma memories of victims of chronic PTSD are particularly simplistic and inarticulate and; that (ii) less articulate memory is related to more trauma-related disturbances, that (iii) narratives became longer and included less concrete descriptions in the course of therapyand (iv) less developed trauma narratives hinder recovery.

The findings support a psychosocial emotional processing model, in which images of a traumatic event are the basis for the re-experiencing phenomena or intrusive recollections of the trauma. These images can then become the subject of further cognitive activity called appraisals and reappraisals. Appraisals are thoughts about the trauma, re-appraisals are thoughts about thoughts… As such, the psychological apparatus goes through a repetitive cycle of intrusions and appraisals and re-appraisals, until such time that new models exist that are coherent with reality. The findings also support three foundations of our theoretical proposals in part two: that a traumatic memory is

inarticulate, that this memory is elaborated in a narrative, and that the level of articulation is positively associated with the level of PTSD. Hence, articulation is therapy, but it is a therapy with no end. A traumatic nucleus in memory may thus be subject to continuous interpretation and elaboration.

PART II: DISCUSSION: on TRAUMA AND CONFLICT PREVENTION

Preliminary Ideas on the Relevance of Trauma Relief for Conflict Prevention

A traumatic event is an experience that overwhelms, is beyond verbal description, and shatters pre-existing notions of the world that allow people to understand, cope with, and trust the world around them.

One can refer to these notions as cognitive schemas, basic assumptions, narratives or beliefs; the essential feature is that they provide a memory basis for an understanding of the world (Beike & Sherman, 1994). As such, they function as a protection against fundamental uncertainty (Johnson, 1999), prevent the intrusion of sudden and intense, or raw fear.

Raw fear appears to be a primal emotion that is experienced across cultures (Nader, 1999; Shalev, 2000; Yule, 2000, personal communication). A second cross-cultural characteristic is harder to conceptualise, but pertains to the relation between people and their environment at large (Deity, family, group, society, symbols, knowledge

and meaning systems). A traumatic event breaches the meanings that are embedded in wider societal knowledge systems and thus the protection systems.

It therefore causes a rupture, a cleavage between a person and his environment, leading to intense feelings of isolation, and possible guilt, shame or melancholia ('no one understands what I experienced'). What seems to be traumatic in the end, is not only the actual threatening event, but the pervasive experience of not being understood or even expelled from one's community or one's world, from one's beliefs and from the wider identity groups that share them. Whether an event will lead to the development of trauma will thus depend on the way it interacts with the body of knowledge and social environment of people.

Culture is one of the factors that constitute support by means of rituals, habits and beliefs or narratives that give meaning to life. This determines what is experienced as traumatic, how it is expressed and provides the resources to cope. Whether this is in the form of local rituals to expel terrifying or evil objects (Gibbs, 1997), individual or group psychotherapy or a gardening project for women in Soweto (reference), these different 'rituals' seek a similar function: to prevent the intrusion of anxiety and restore trust, beliefs and in-group relations. Traumatic fear and these narratives are two sides of the same coin (Galtung, 1994; Bar-On, 1999; Wistrich & Ohana, 1995), the second being an elaboration of the first.

The meaning, ascribed to a traumatic event, is always a secondary elaboration, a 'Falsche Verknüpfung' (Freud, 1995). Whilst providing an instrument to enhance coping, it at the same time repeats and represses part of the reality that happens. In the end, it is virtually impossible to establish the real traumatic basis of what happened. Does this

mean that there is no ‘real trauma’? No, it seems that that in itself is an erratic conclusion, much of the kind of many researchers in the past had done. But trauma is more complex and escapes a final symbolisation. The difficult relation does not only make it difficult to establish a causal relation, harm and a wrongdoing, in judicial terms. The second implication is that a traumatic event will therefore be the subject of continuous interpretation and re-interpretation, both of the some objects and, onto new objects in terms of a transfer of the remainder onto new images and objects (Andersen, 1999; Freud, 1905; 1912; 1915).

Just like with individuals, societies continuously produce new interpretations of history in which past heroes become present ordinary men, in light of new events. Like individuals, they produce new myths, traumatic memories and ideologies (Roth, 1995). Current changes in Zionist ideology and Israelis society are a case in point (Bar-On, 1999; Danieli, 1998; Wistrich & Ohana, 1995).

Memory, myths and ideologies can be seen as the secondary elaboration of collective traumas, a secondary elaboration that heals past wounds but in an ironic move creates new ones. For instance, the strong Zionist Jew versus the weak pre-Israel Jew; the strong German versus the humiliated German of the Post WWI, the resurrection of the Serb empire versus the subjugated Serb… Turn after turn, belligerent ideologies depict their subjects as past victims and legitimise future violence. Trauma is the often unspoken motive of ideologies that differentiate and stereotype opponents by misperception and social categorisation (Fiske & Taylor, 1991; Igantieff, 1993; Johnson, 1999). As a result, in a muddled anachronism, the present is experienced in light of the past, and ideologies encroach new people with images and emotions attached to memories of the past.

As conflict-identification theory predicts (reference…), it is identification with this mythic ideology, and a subsequent segregation from others that do not share this ideology that enables individuals to de-humanize the other and to commit acts of violence and cruelty (Cairns, 1996; Ignatieff, 1993; Johnson, 1999; Shalev et al., 2000).

In contrast to widespread belief, these misperceptions are not irrational; they are no 'logical fallacy' of our social cognition. In the dynamics of conflict, they are not jus moderating factors, an addendum to the hard-core political-economic causes of disputes. Unlike what social psychology proposes (Beike & Sherman, 1994; Fiske & Taylor, 1991), they cannot only be attributed to maladaptive cognitions, a sudden rupture of an otherwise functional system. They follow a logic, fulfil objectives (Smith, 1998). To paraphrase Keen (1997), they are a 'rational kind of madness', a madness not only driven by economic but by psychological motives. They can be called mad, because they are so in they effects and result in unsettling consequences, and because the aggressiveness cannot be explained as a just retribution for past wrongdoings. More than not, victims are in hardly any way related to the so-called aggressors. The current Kosovo Albanian has little relation with the 14th century Turk, the current Walloon has little relation with the 14th century Frenchman, and current Arabs have little to do with the times of Babylon. And yet, these references to the past act as powerful ingredients for the bomb of nationalism that can explode rapidly.

To still perceive victims as aggressors requires psychological mechanisms of transference and categorisation. These can be called rational, in that they fulfil a function: the canalisation and discharge of remnant feelings of everyday anger & frustration, lack & loss, envy & greed, fear and uncertainty, feelings that do not necessarily belong to

current objects, but are wilfully transferred from the past into the present. They are aptly exploited by political entrepreneurs, who suddenly find that the identification with a past cause can prove really virtuous. They are also wilfully transferred by followers who may find a channelling and redirection of these remnants of individual trauma. Thus, in the confluence of individual and collective trauma, myth and identity, a catharsis of emotions and a strong and unquestionable identity are provided. And so, as the speeches and ideologies of political leaders from Hitler to Milosovic and from parties in Northern Ireland to Israel indicate, a new identity is shaped and given, a new plan (see quote in the beginning), that goes back to a traumatic kernel. It provides a strong narrative, a sacred narrative, and often nationalistic narrative; with which to identify, as it erects walls of difference and misunderstanding between belligerents and provides a ready justification for the perpetration of aggressive tendencies and covers up the very anxiety, uncertainty and subjective fragmentation that is part of human existence (Johnson, 1999).

Are there therapies for such bad cosmologies? (Galtung, 1994). If trauma tends to repeat itself, do psychological insights give an indication of how helpful trauma relief may be for the prevention of future wars? In 'Erinnern, Wiederholen, Durcharbeiten', Freud maintains that to prevent repetition and acting out, remembering and working through are required, to prevent transferring of frustration and anger onto new objects and to break the cycle of violence. This involves a subjectivation of the frustration, fear and shortages of life instead of culpabilisation of the other. It may pave the way between paranoia and megalomania towards a recognition of reality, the reality that there is only one Jerusalem and three peoples wishing to inhabit it, that Albanians live in Kosovo, …

This is a mourning process, a sobering up of the joy and refuge found in glorious, triumphant and self-pitying fantasies. I would call them fantasies, just like the dreams for cars and holidays, fantasies because they often contain close to nothing of what happened and it is close to ridiculous with what ideas and images people in conflict often fool themselves. And one may indeed wonder whether political leaders in intractable conflicts really want peace (Hoagland, IHT, 07-06-01), and want to face the sober reality of an imperfect peace. Instead, it might help to mutually recognise that both parties are hit by the same condition, that they are in fact often surprisingly similar in their pain and their wishes, and that reality is a loss for both in relation to their dreams. This may provide a unifying sameness, not in self-compassion and triumph but in reality and pain. Without an effective resolution of each person's trauma, this may not be within reach. Peace agreements will break down because they fail to achieve the gains projected by collective fantasies and appropriated by violence (Keen, 1997); and conflict prevention will fail as long as both parties prefer their myths and ideologies instead of working through the subjective destitution of an often uncertain and incomplete reality.

CONCLUSION

The last decennium has seen an increasing awareness of the consequences of war on mental health and psychosocial relief has become part of international humanitarian assistance for war-torn societies. Despite this recognition, it remains unclear what the actual contribution is of the projects, not only in terms of mental health, but also in relation to the wider social and political context. This paper aimed to address this question. Therefore, it analysed the literature that formed the basis of trauma relief projects and various criticisms, finding that the debate risks to end up in an impasse on the question that characterised much of the history of trauma research: does trauma exist. This paper aims to redress this in three steps. It firstly holds that trauma is neither true nor untrue, and that at the basis of the impasse lies an epistemological impossibility to write an unequivocal definition for trauma. Instead, it analyses the relation between the real and unreal, between trauma and the elaborations of it, leading to the second and third argument. Secondly, it identifies a psychosocial model that redresses much of the critique on trauma, and allows describing the role of the social and cultural world in the development and healing of trauma. Thirdly, this relation between the traumatic kernel and the symbolic (cultural, social) elaboration of it, may allow to understand why unresolved trauma may lead to the repetition of political violence. It argues that trauma and symbolic elaboration are two sides of the same coin, and that this elaboration process may operate both on an individual and societal level. It rejects explanations of conflict in ethnical or religious terms, and holds that the expression is taken for the cause, where they were symbols that were fuelled with value at times of strife. It also rejects

explanations of conflict in terms of misperceptions, that view these take these as the result of a ‘mechanical failure’, misunderstandings. This approach is true but it is naïve; violence fulfils a function, that is why it is maintained, it fulfils a ratio, and that is not only of an economic kind (cf. May 2001 UN report on looting by neighbouring countries in East Congo). Like rationalist political economy models of violence, it argues that conflicts may fulfil psychological functions that may contribute to the protraction of conflicts. These insights may give a first step to the reply the criticism on trauma relief, and to the question of its contribution to the prevention of future conflicts.