

LEARNING IN CHAOS

Psychosocial interventions against state organised violence

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Civile er i foruroligende antal blevet de primære ofre ved krige. En af kulturpsykologiens vigtigste opgaver, er at udvikle psykosociale interventioner mod denne vold, men dette arbejde mangler ofte akademiske begreber som kan hjælpe os, når vi skal præcisere og fagliggøre vores »advocacy«-rolle. Specielt PTSD-diagnosen er blevet kritiseret for at være en medicoteknisk konstruktion importeret fra vestlige sammenhænge. Mine egne erfaringer fra jobbet som »mental health coordinator« under krigen i Kosovo viser, hvor vigtigt det er, at forstå traumatiske tilstande i både dets individuelle og dets kollektive aspekter. Til sidst gives der nogle anbefalinger til styrkelse af den kollektive hukommelse hentet fra den specielle institutionelle konstruktion – »Decentralised cooperations«.

One of the most important tasks for transcultural psychology is the development of knowledge to combat organized violence, as, e.g. civil or international wars. But the emotional engagement in societal violence often become so big, that the professional position becomes low in priority. The result is that the mental health workers intervene with their psychosocial projects without any prior professional need assessment of the local context.

Within the last years, some literature about psychosocial work with war survivors does explicate how a professional, academical work can be combined with humanitarian, civil rights and political engagement (Elsass 1998, Sveaass 2000). One of the challenges is how to keep the professional status high when advocating for a political attitude (Hastrup & Elsass 1990). Concepts of »neutrality« and »alliance« in the psychological work need to be developed including »engagement« and »enthusiasm«, without polluting the professional stand in the psychosocial work (Sveaass 2000).

In the following, some of the often used concepts in psychosocial work will be analysed, with the intention of developing a precision of the advocacy role of the transcultural psychologist. Finally a personal account of

being a »mental health coordinator« will be given as an illustration of the difficulties in praxis, ending up with a few recommendations.

The presence of violence on the international scene

Like the welfare state has created more and more clients, the international society has created more and more victims of state organized violence. Civilians are no longer »incidental« casualties but the direct targets of violence. The United Nations High Commissioner for Refugees (UNHCR) estimates that in 1960 there were 1.4 million refugees worldwide. By 1992 this figure has risen to 18.2 million. »Whereas 72% of the conflicts were between a centralised political system, or a 'state', and an ethnically distinct people or nation, only 3% of the conflicts were between states such as Iran and Iraq« (Bracken & Petty, 1998: 3).

There have been estimated 160 wars and armed conflicts in the Third World since 1945, with 22 million deaths and three times as many injured. There were on average 9 wars active in any year during the 1950's, 11 during the 1960's, 14 during the 1970's and at least 50 currently. Of all casualties in World War I, 5% were civilians, in World War 50%, more than 80% in the US war in Vietnam, and currently more than 90% (UNICEF 1986). At present the United Nations High Commission for Refugees (UNHCR) counts 18 million refugees fled across international borders, sixfold increase on 1970, but as many again are internally displaced (Summerfield, 1998: 9).

Summerfield (1998) writes that trauma projects appearing alongside food, health and shelter interventions. There has risen an ambivalence against this issue, involving an intricate web of relationships between science, public policy and media. Expatriate consultant fees are spent in a high proportion and sustainability is not considered. They have media appeal. All contribute to their popularity with donors.

Trauma projects do have an opportunity to intervene in a way that is perceived to be useful. But they need to be evaluated and to reflect critically on theoretical and practical aspects of these projects and reflect critically on the social, political and cultural aspects they are applied to. Do waraffected people derive any benefit from them?

90 % of all political conflict is internal. Duffiels (1995) reminds us that war is generally not an extraordinary and short-lived event to be seen as extrinsic to the way a society functions in »normal« times. It becomes a permanent emergency, something constant and internal that colours the whole web of relations across the society and daily calculations of its citizens. Humanitarian intervention is itself a contributor to this complexity. The effects of war cannot be separated from those of other forces: Throughout the non-Western world, structural poverty and injustice, falling com-

modity prices, unbridled environmental exploitation and landlessness are all linked to a withering away of traditional self-sufficient ways of life. Humanitarian agencies reproduce definitions of war that suit their institutional interest.

Trauma

The need for psychological counselling for war survivors was formulated just after World War 2. The first time the concept of mental health was formulated was when UN established UNICEF and WHO in the end of the 40s. In the following years mental health was slowly qualified, especially the growing focus on the psychological aspects and projects aimed at the »psychological wounds« and the notions of »trauma« and »trauma counselling« became popular. Even the campaign of »Health Year 2000« sat out guidelines for health praxises. The professional interventions within mental health were slowly qualified and ranged from individualized psychotherapy to social-based community work. In the wake of the mental health interventions vague concepts appeared and even projects that differed fundamentally from each other all used formulations as, e.g. »community based mental health work with an cultural sensitivity«.

»Loneliness, anger or bitterness, feeling frightened, feeling lost or disoriented and frequently crying« was named as »trauma symptoms«. But indiscriminate and expansive definitions naturally recruit large numbers and provide basis for claims that without more resources only the tip of the iceberg of need can be addressed. The conceptual basis for mental health work was from the very beginning vague and seductive.

The word »traumatic« has its origin in the 16th century in an exclusively physiological sense (»belonging to wounds or the cure of wounds«, Oxford English Dictionary), in the middle of the 19th century a psychological meaning was added, first with Erichsen's descriptions of railroad accidents as something that injures »the nervous system's physical as well as psychic function« (1866). During World War 1 the psychic analogy acquired its diagnoses: »shell shock« and »nervous shock«. However, it was characteristic that there was no mentioning of any »traumatic memory« in the descriptions of psychological effects of war or other very dramatic experiences. Survivors reacted with unhappiness, desperation and disturbing images from the past without a causal relation, about a repressed memory provoking symptoms.

In everyday psychopathology, however, a tradition with Ribot, Charcot, Janet and the young Freud came early into existence describing traumatic memory as a parasite, where suspending repression could normalize the pathology. Those descriptions were transferred to the psychic effects/con-

sequences of World War 1 by Kardiner & Spiegel (1947), which in short can be summarized as:

1. Traumatic neuroses are produced by the recollection of experiences, rather than by the experiences themselves.
2. Recollections take shape as pathogenic secrets.
3. Professional therapists have privileged access to the secrets and their meaning.

Today a concept of »traumatic memory« has become very important for the so-called crisis therapy. In both psychodynamic and cognitive treatment »the forgotten« is credited curative quality and the client is exposed to the forgotten, often in a cathartic form. This elevated status of »the forgotten« has brought about different forms of so-called »memory-politics«. Historians such as Young (1995) point out, that there has been three cases over the past century, where the public's management of psychological traumas have resulted in political movements: Wife battering and »domestic violence« has resulted in feminism, sexual abuse of children in incest associations and war experiences has produced different human rights movements (Herman 1992: 212).

One example is the debate concerning the so-called MPD-diagnosis, where it has been argued, that persons with multiple personality disorders have incurred traumatic memories about incest (Hacking, 1995). In the USA several political movements have emerged, for instance »False Memory Foundation« with the slogan: »Creating false memories, destroying families«. A counter movement has been established by therapists named »Continuing Medical Education«, giving courses and workshops to reestablish the criticized MPD-therapists (Hacking 1995: 123).

Post traumatic stress disorders: PTSD

The PTSD-diagnosis is a historical product of this memory-policy, about recollections of earlier experiences re-emerging in the present in form of pathological symptoms. It first appeared in 1980 in the American diagnosis system DSM-III. The reason was, that between 1964 and 1970 there were 28 million veterans, of which a majority received a number of psychiatric diagnoses like depression, general anxiety disorder, panic disorders and abuse. There were no financial resources within the psychiatric system to assist them all and the PTSD-diagnosis arose as a »service-connected disorder«, concentrating the assistance on smaller groups (Young 1995:113). With the PTSD-diagnosis a temporal-causal relation was introduced presupposing that an earlier experience caused the symptoms. If this causality was absent, the symptoms were not discernable from a number of other psychiatric classifications.

The diagnostic characteristics of PTSD can be summed up as: 1. a traumatic experience, 2. reliving the experience, 3. attempts to avoid situations, which can trigger the »reexperiences of traumatic distress or generalized numbing of responses«, 4. increased physiological arousal.

The diagnosis is criticized partly because a number of characteristics for the survivors, for instance shame and guilt experiences, are not mentioned as diagnostic characteristics, partly because as a survivor you only enter into one single diagnostic category. Herman (1992) and Lansen (1994) criticise the PTSD diagnosis for being too simple, suggesting it is supplemented with a »complex PTSD«. Straker (1987) suggests an »ongoing traumatic stress disorder«.

There are thus different efforts to gain a differentiated view on the PTSD-diagnosis. An immediate division could be mild and severe conditions. A survey by Shalev et al. (1996) shows that in mild PTSD-conditions, psychotherapy can reduce the number of symptoms. The conclusion is, however, that most methods work – »everything goes« – and that most studies are too imprecise in describing the therapeutic methods. They are characterized by »the mark of pioneering enthusiasm and lacked self-critique« (Shalev et al. 1996).

Severe PTSD-conditions, on the other hand, have not proved to be particularly suitable for treatment regardless of the method used. They often become chronic and attempts to identify the trauma and relive the connected emotions will often aggravate the condition. Already Freud (1920) mentioned that the repetitive recollection of the trauma does not necessarily give cause to improved function.

Individual and collective memory

The PTSD-diagnosis has been criticized, especially in psychosocial work with war survivors, for isolating the individual in a diagnostic system which ignores cultural and social conditions (Shalev et al. 1996). War trauma is not determined intra-psychically but psycho-socially.

The psychodynamic treatment of PTSD is contained in a concept of repressed »traumatic memory«, but much of the violence that has occurred does not need a special memory. On the contrary, it can impede the reconciliation work to have to recall all the experiences, which are obvious to most people.

But as one war survivor said: *»We do not need psychological help to remember the experiences of war; we are reminded of them daily in the form of lost arms and legs«.*

It is the individual, as member of a group, that remembers the violence. However, in the local community those experiences mutually support each other and become a common cause, even though it can be of very differ-

ent intensity and quality to the individual. Collective memory is not only a material the individual can recollect verbally, but is deposited in his behaviour, his standards and social relationships (Hawlbachs 1980, Connerton 1989). Collective memory is more a volitional act than the individual one, which is to be brought forward in the therapeutic room. The individual memories can come into conflict with the collective memories, if the local society has emphasized reconciliation work and more or less explicitly has decided to forget the misdeeds one has committed against ones neighbour.

Therefore, the more severe cases of the PTSD-diagnosis and its concept of traumatic memory should be qualified and in both collective and individual aspects. For instance, Young has (1995: 131) made a survey of empirical studies of PTSD-symptoms and showed that on locations where there is less presence of collective memories there is an increased occurrence of PTSD-symptoms.

Conclusion: There is no such thing as a universal trauma response and we must take a relativistic approach. The possibility that the Western trauma discourse imported into communities socio-culturally devitalised by war might impair their struggle to reconstitute a shared sense of reality, morality and dignity. Researchers conceptualise Post Traumatic Stress Disorder as a disease of memory, arising because what they call »traumatic memory« has been incompletely processed by the brain. In fact an authoritative account by Young (1995) shows why traumatic memory is not a found object but a socially constructed one. There has always been unhappiness and disturbing recollections but not traumatic memory, in the sense that it is defined and deployed today. Young points out that during this century professional definitions of memory have tended to its removal from the exclusive ownership of the person carrying it, handing it over to experts to pronounce on its meaning and significance. Given that war is a public and collective experience leaving memories which can be described as social as much as personal, these biomedicalised and individualised concepts have limited explanatory power (Summerfield 1998: 22). The possibility that the Western trauma discourse, imported into communities socio-culturally devitalised by war, might impair their struggle to reconstitute a shared sense of reality, morality and dignity merits serious consideration (Summerfield 1998: 31).

Much of the discourse has resolved around the concept of Post Traumatic Stress Disorder (PTSD) and research show that this diagnose captures the fundamental psychological disturbances after an extreme trauma event. But there is a growing concern that this models developed in Western psychiatry and in the wake of the war in Vietnam should not be exported uncritically (Bracken & Petty 1998).

Consultants to WHO, UNICEF, ECTF etc. claims that there was an epidemic of »posttraumatic stress« to be treated, and also that early intervention could prevent mental disorders.

Trauma programmes costing millions of dollars have been imported into Bosnia, Rwanda, the Balkans and other war zones on the back of extravagant claims about »post-traumatic stress« in exposed populations; often portrayed as a »hidden« epidemic, meaning that experts are required to diagnose and deal with it. Post Traumatic Stress Disorder, and the checklists used to diagnose it, are held to be universally valid, as are the mental health technologies brought to address it.

It is not empirically proved that recollections of earlier experiences re-emerge in the present in the form of pathological symptoms. The treatment of choice is therefore not always an emotional relieving of the repressed memories. Furthermore the PTSD-diagnosis is culture sensitive and people react differently dependant on the cultural context of expressing traumatic experiences.

An increasing body of literature from medical anthropologists (Gaines 1992, Bracken et al. 1995) indicates that not only are differences in response more numerous than similarities, but that the features of PTSD identified in different cultural settings around the world do not mean the same thing to the people in each setting. These findings have given rise to doubts among medical anthropologists regarding the pertinence of diagnoses such as PTSD to non-Western cultures (Gaines 1992, Kleinman 1987).

For example, many refugees have shown to be extremely productive economically in spite of high levels of trauma and despite being depressed. This combination of high trauma with high symptoms and high functioning have been found to be similarly valid in a recent survey of Bosnian refugees (Mollica et al. 1999).

Examples are legion: Cambodians clearly see »trauma« as a private matter and do not share these imported ideas about what they should do about it (Boyden and Gibbs 1996). Mozambican refugees describe forgetting as their normative means of coping with past difficulties; Ethiopians call this »active forgetting«.

Staying silent is a pragmatic decision for many. And if the professional asks them to tell their stories one can confuse human right testimony with treatment. Broken social world, poverty and lack of rights; but it seems easier to obtain funding from Western donors if this was portrayed as trauma whose antidote was counselling.

War is a collective experience and perhaps its primary impact on victims – Western and non-Western – is through their witnessing the destruction of a social world embodying their history, identity and living values and roles. This is not a private injury, being carried by a private individual.

The »trauma« that can be meaningfully addressed by western counselling or other talk therapy is absurdly simplistic. Work through and psychological debriefing might create re-traumatisation. We need definitions

of »health« and »mental health« which are indigenous and socialised, not merely »technical-medical«.

Social orientated reactions and collective memory

The mental symptoms of trauma do exceed the traditional PTSD symptoms and do include social orientated reactions which are contradictory to reconciliation. From a more psychosocial perspective trauma could be considered as inhumanisation as e.g. »Impoverishment of the human capabilities such as capability to think brightly, to communicate truth, sensibility for suffering of the others. Behaviour changes in favour to ideological rigidity, evasive scepticism, paranoiac defence, hatred and desire for revenge. Insecurity facing one's own destiny, lack of sense in making things and a strong need to belong to a group are spread feelings«. This can destroy social relationships as e.g. »Human character of the enemy has been denied and consequently the enemy has been refused as an interlocutor. Social polarisation, institutionalised lies and militarisation of social life characterise war situation. Polarisation promotes psychosocial disorders. War life causes a schizophrenic attitude between the subjective and the real life because it is impossible to confirm the personal knowledge and experience in the reality, except in particular small groups. Lies have become a life style. Militarisation of social life can promote militarisation of mind. For people growing in this context, contempt for human life, the law of the strongest as social criterion and the corruption as life style are accepted as natural, creating thus a vicious circle«. Martin-Barro, 1988 ref. From Manenti 1998: 14)

Personal account from Kosovo

The war is an industry, but the humanitarian work is too – and it is a huge industry. I worked as a mental health officer in Pristina, Kosovo for four months. When I started in June 1999, the WHO office was placed in a little bungalow with about 15 people and three Landrovers. When I ended, we had moved to a bigger office building with about 90 employees and 21 cars. About 280 NGO's were working in Kosovo, 65 within the field of Mental Health. None of the humanitarian activities were regulated of the intermedium State-government United Nation Mission in Kosovo, UNMIK. Every thing was possible. NGO got into Kosovo as tourists and started to work. Some did very good work, some bad and destructive.

The Military forces had been in the Balkan for many months before the mental health worked started, some of them for years. They were named

the »black vultures«. 55.000 soldiers had come to Kosovo for the war. After the war they were not sent back of several reasons. Some of the military equipment is so heavy and difficult to move. »When we first have arrived, we will never go home« – as the soldiers said. They stayed in the Balkan region, because they might be needed in the future, but when you asked for the rationale of the dimension of 55.000 soldiers in Kosovo you could not get an answer. The internal conflict between the Serbs and Albanian could not alone justify their large-scaled presence.

The NGO's and the large international humanitarian organizations were called the »white vultures« because they were in white cars, following the »black vultures« in their black military equipment and cars. When the Albanian flew to Macedonia and Albania, the NGO's followed them and when the refugees returned to Kosovo the NGO's turned around and followed them back. Some of the NGO's said that they were present in the region, not only because of the acute need for assistance, but because of future tasks. »When Milosoviz is falling, we have to move to Serbia and be present there«. Some of the NGO's did not have a perspective for more than three – four months, because of the unstable situation, they might be needed in other places in the nearby future. Some of the Albanians said to me: »Strange – we are the only ones who support Milosoviz. The longer he will stay in power, the longer you will stay here in Kosovo«.

Conclusion. The humanitarian help does have resemblance to an industry, which do not always in its proportions have a professional basis.

The Rwanda-case is illustrative of how the local government reacted against the »white vultures«. There were present around 150 NGO's in Rwanda during the crisis. The local government asked for an agency report from everybody within 36 hours. Every NGO had to fill out what they were doing, purpose, methods, funding, time perspective, local counterparts etc. After a week the government threw out more than the half of them. That experience made most of the NGO's afraid of a repetition of this Rwanda case in Kosovo.

Two cases illustrate the difficulties of doing psychosocial work when the local involvement didn't have top priority.

1. I had an Albanian psychologist working together with me. He had been a translator for a group of psychologists arriving to a village for doing short term interventions in forms of debriefing seminars. The local people welcomed the initiative, but only to the foreigners. Local people are often very kind and friendly to foreigners. But to the translator, their compatriot, they whispered in their own language: don't come back with these foreigners any more, we don't need them.

Few mental health workers didn't use time to ask people about their needs, and local authorities were not always involved in the project. Often parallel systems of therapeutic institutions were emphasized, instead of establishing a link to what was already working and what had been

working before the war. Many Kosovars were not interested in psychotherapeutic work. They found it too naïve to believe that psychotherapy could release some of their symptoms of meaninglessness, depression and anxiety. They needed »wintering« of their houses, food and shelter, and economical support to the local government, the school teachers, the doctors etc.

2. There were also examples of very good psychosocial work. Two psychotherapists attended the opening of the mass graves. The opening stimulated of course despair and enormous psychic turbulence. The psychologists told me that the opening of the graves provokes a chaotic situation, adults and children were attending the opening and some went into an almost psychotic state. The psychologists have to change their job to practical ones as, e.g. making a fence around the graves, informing people of what they would see if they wanted to see the bodies, some times advising that perhaps it was better to just have some of the dead relative's clothes to see. They had to take care of the children for the following days, making food for the families etc. Psychotherapy changed into a very practical work for the two psychologists – and they made a tremendous job.

Learning in practice

My job of being a WHO mental health coordinator turned out to be a process of how to learn the NGO's to relate to the Kosovar's need. My purpose was not to learn the Kosovars to survive the war by helping them with their so-called mental health problems. My focus was on the relationship between the consultants and the local people, and especially on the cultural, political luggage the NGO's carried with them to Kosovo; to establish situations where the NGO's were professional acculturated, and got rid of some of their trauma stuff.

As a reflective practitioner I established Schön's »societal conversations« between the locals and the helpers. Concretely: I arranged meetings between the local Kosovars and the NGO's with the agenda of »agency reports«, and »discussions of guidelines« on the basis of input from me. One of my main tasks, was to give informations of the local context to the NGO's. One of the biggest mistakes was not to be in the field and to know people before you started your work. Lots of the NGO's came with experiences from the nearby region and have developed models for psychosocial support which they without reflections transferred to Kosovo. »We know from Sarajevo that this work is effective and we want to implement it in Kosovo. We have already been one week in the local villages and can start tomorrow«.

WHO liked this implementation attitude and gave low priority to investigation and preparation. When I after one month declared that we did not know enough about the local resources, and advocated for a need-assess-

ment study, nobody in WHO took that serious. Fortunately I convinced DANIDA about the importance of being in the field and doing a profound interviewing. They donated half a million dkr. to an assessment study, mainly because the local counterparts found it very important. But WHO never implemented the project; they were for actions and implementations, not for investigations and critical reflections of the NGO's work.

Recommendations for strengthening the collective memory: Decentralised cooperations

My scepticism to institutional learning gave me interest for a special form of reciprocal interchange of knowledge and information; a kind of reciprocal supervision, called Decentralized Cooperations (Manenti 1999).

Many institutions use the concept of reconciliation, but the actual approach is surprisingly little developed in methodology. When I was present in Kosovo in 1999, UNHCR did have a working group specialised in protection of ethnic minorities in Kosovo, but the activities had too low a priority compared to the importance of the subject. Especially within the framework of mental health different workshops proposal had asked for economical support. But their use of concepts and interventions were vague and naïve. Even the subject is considered important no professional specialist with experience in the reconciliation area was present in Kosovo.

International agencies, particularly inter-governmental ones such as the UN and EU, are limited in their ability to strengthen civil-society and promote democratic process at the appropriate levels. These limitations are financial, structural, legal and operational. In countries where democracy is fledgling or superficial, Decentralised Cooperation is an innovative tool for community empowerment. It can promote bottom-up initiatives and create a »culture of exchange« which enhances well being at both ends of local partnership.

In the past there were several experiences of DC mainly related to the twinned cities. The term »twinned cities« dates back to 1952. The »twinned phenomenon« appeared during the post-war years, initially based on political values as it helped in altering mentalities and was committed to bringing France and Germany together.

DC reflect the fact that genuine development involves actors beyond the mere government sector; the increasing place of »civil society«.

»The war had destroyed houses, facilities, factories and other infrastructures. The most visible damage was to things, but the most profound damage was to human relations. Rebuilding infrastructures without rebuilding the possibility of civil, democratic coexistence at the same time was to side-step the real issues.... Suffering from top-heaviness, central-

ism, sectorialism, authoritarianism and a charity mentality, international cooperation frequently imposes its own pre-established solutions, which fail to take into account demands for peace and democracy. All the problems mentioned above derive from a failure to consult the people involved« (Maneti 1999: 15).

29 Italian local committees representing 164 municipalities, 10 provincial administrations, 7 regions and 120 NGO's – goods, services, infrastructures, capacity building and new human relations have been the concrete results of this experience in 22 Bosnian towns. DC is a relatively new and not altogether becoming term. It implies, correctly, that past development efforts have too narrowly operated in the context of centralised intergovernmental cooperation. The concept of an »exclusive club« still largely prevails, but international cooperation in a decentralised mode recognises that a »people's sector« has a growing place in development and solidarity efforts.

In this context the cultural psychologists among other professionals are working as a technical secretariat of the project, providing guidance, technical standards, and analysis of the overall project. Committees were established in 29 Italian local committees, which have been linked with 22 Bosnian communities.

The many partners of the DC project followed a homogeneous methodology. The main aspects could offer recommendations for the cultural psychologist combating state organized violence:

The institutional learning in chaos:

- Identification of and systematic involvement of all potential organised local partners for human development.
- Organization of technical discussions and exchanges between the linked communities to identify areas of common interest in which decentralised co-operation could provide a qualitative contribution to the social development of the local partners.
- The promotion and constitution of municipal working groups which include representative of local authorities, public service institutions and civil society organisations as the counterpart of the linked Italian committee for all activities of DC.
- Participatory methods for identifying needs, resources and priorities for project activities such as the implementation of public workshops, development of community needs and resource maps etc.
- Prioritisation of those activities which foster inter-ethnic dialogue, respond to the needs of the most vulnerable groups, contribute to the development of inter-sectoral and holistic solutions to the community's problems.

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