Some Basic Questions by Robert Kerep from Slovenia for his Masters Thesis and Answers by Charles David Tauber, M.D., Head of Mission

1. I am aware that you have been working with many victims of the Balkan Wars since 1995. Where, when, and within which organization did/do you work?

   I worked as Head of Mission with the Stichting Coalition for Work with Psychotrauma and Peace. I am a founder and Board member of the organization. If I include our early days, I/we have been working since late 1993. I came to the Balkans, primarily to eastern Croatia, in June 1995. The organization was registered officially in November 1997 in The Netherlands as a non-profit non-governmental organization ("stichting"). We also are registered as a non-profit organization (501(c)(3)) in the USA and are working on obtaining charity status in the UK. In Croatia and Bosnia-Herzegovina (BiH) we are registered as the branch of a foreign organization.

   We have worked primarily in the eastern two counties of Croatia and, to some extent, in the adjoining areas of Bosnia-Herzegovina, that is, the so-called "Posavina", that is Brčko and adjoining areas. We also have worked a small amount in the Vojvodina province of Serbia.

2. Approximately, with how many victims have you worked, starting from the beginning of your work?

   Probably, since 1995, we've dealt with something over 1000 victims, if not more. In the period that I've been working alone, that is, since 1988, I've dealt with at least 1500 people, if not more.

3. How was the organization of psychosocial support within the national/state system and how was the organization of the international community that was present in these areas?

   In my opinion, both the national/state and the international organization of psychosocial support were dreadful. They were aimed more at goals of political publicity and of the bodies concerned being able to say that they were/are doing something than at actual

Mission to Croatia	***Office in The Netherlands***
M. Držića 12 32000 Vukovar Croatia Tel and Fax: +385-32-441975 Website: www.cwwpp.org E-Mail: cwwppsummer@gmail.com	c/o Kupers Ds. S. Tjadenstraat C81 9663 RD Nieuwe Pekela The Netherlands Tel: +31-597-645790 Fax: +31-597-647029 e-mail: pabbv@telfort.nl

effective healing of the wounds of violence, conflict, and torture. There was little if any work that went deeply into the traumatization and the intra- and post-traumatic stress reactions (PTSR). Please note that we use the terminology PTSR rather than PTSD because we believe that there are a variety of reactions, which include both physical and psychological phenomena that are not covered by the DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) and ICD (International Classification of Disease, issued by the World Health Organization) definitions. Additionally, we wish to take these reactions out of the pathological sphere, as we believe them to be natural reactions to circumstances causing trauma. As far as I can see, the main aim was – and still is – quick fixes that give publicity rather than real, long-term healing. Furthermore, large amounts of psychoactive drugs, very frequently in wild and wonderful (sic) combinations were and are being used. These cause psychological if not physical addictions and decrease functionality and true recovery. Furthermore, there is a great deal of labeling of people, which decreases initiative and discourages people from taking responsibility for their own lives as well as making it impossible for them to enter the world of actual work which, when recovery has reached a certain level, also would have a positive effect on rehabilitation.

4. In which fields was the organization good and in which not? Why so?

   I'm not sure whether you mean the national/state and international organizations or ours or both. I will answer both.

   As mentioned, I have few good words for the national/state and international organizations. Other problems, not mentioned above, were and are those of funding. Much work in mental health and recovery was and is considered "irrelevant" and "peripheral", both being words that we have seen in letters of refusal received by ourselves and other organizations. Also, the funding cycles were and are extremely short – a year or perhaps a little more – which is completely insufficient even to start the work. When I was in one country in West Africa several years ago, the local organizations there told me not to come back unless our programs would last at least 15 years. In our view, even that is a short time.

   With regard to our organization, the good things were our level of expertise and that we had access to at least some national and international specialists. We need(ed) more such experts and more staff in general. Finding competent staff also was and is a problem. This requires additional funding. I also think that our approach, as given in your next few questions, was and is a correct one. I have mentioned funding cycles already as a problem. I also see short-term-ism as a problem. Volunteers and other staff are not prepared to work for the periods required to get a good understanding of the region and the problems and to grasp the generalities and specificities of them and to try out possible solutions.

5. How would you organize the system of psychosocial support to victims of conflicts at the strategic level in post-conflict areas in general? Which elements are relevant to manage this field of work?

   First, the problem of capacity must be tackled. Our answer is that of the use of "barefoot" therapists and peacebuilders. We have developed a program known as Pragmatic Empowerment Training (PET), which is person-centered and includes elements of education, supervision, and therapy. Groups include a minimum of 3 and a maximum of 12 persons. The program consists of sessions of two hours per week for about a year. The content includes basic work with people, inter-personal and group communication, basic psychology and counseling, civil society, and human rights. While we have a curriculum, the actual learning is based on the experience and narratives of the participants. Thus, each group, even groups in the same location and with the same demographics, are highly individual.

   We believe that, in the ideal situation, there should be one or more such groups in every village. We believe that this should have a pyramidal structure, each with supervision of the previous level. At the "lowest" level, there should be self-help groups led by one of the persons trained.

   Also crucial in this methodology is interaction between members of various groups in various locations.

   Such work can be carried out in person, which is ideal, or by electronic means and/or by a combination of both.

   We also feel that a crucial part of any program of psychosocial support is an element of destigmatization of working on psychological issues, particularly among the male population.

   Further, no group may be excluded from any work on political or ethnic grounds. Another problem is the politicization of such work, and this, of course, must be stopped.

   Further, there need to be facilities specifically directed at abused and tortured people that combine physical and psychological methods.

   In addition, professionals need to be trained to recognize and treat the problems of psychological and physical reactions and abuse of various sorts. Unfortunately, such training is given very infrequently.

   I wish again to emphasize the problems of capacity. That certainly has been true here. From what I hear from colleagues in a variety of places, it is even more true elsewhere.

Another crucial element is that of psychological supervision for all staff working with people. The lack of the recognition of the need for this has been a major failure here.

Still another element in any program of work on psychosocial support is that of destigmatization and sensitization to psychological and physical reactions and the need to obtain assistance. Again, this has been a major problem here and, from what I gather from colleagues, also is a problem in many other places in the world. Obviously, this must be culture-specific.

6. How would you motivate and select staff to join and help in the projects?

   First, as indicated in the previous question, people do not need to have previous education at a high level to take part in PET. The main criterion for selection should be involvement and empathy for people.

   In some societies, notably those in the Balkans, finances play a major role. This is sensitive and should not be the only criterion, in my view. Yet, in areas of high unemployment, it can be important. We have had people applying to us who have been unemployed and yet will refuse to work as volunteers, despite possibilities for training and, ultimately, improving their job prospects. Another element in this is that some people see a foreign organization as having huge amounts of funding, which we never have had.

   Also important is attention and recognition of achievement and of high quality work and continual praise and good criticism. We believe that there must be continual encouragement to learn. Some of this can be through certification by various bodies at various levels, financing further education locally, encouraging online education, etc.

7. How would you educate/train/coach them?

   Please see Question 5.

8. How would you conduct diagnostics in this kind of area where you have so many victims of conflicts/wars?

   Diagnostics are difficult. We have seen what in our view is excessive reliance on the DSM and particularly on the ICD. In our view and experience, these numbers and diagnoses frequently are wrong and certainly are inadequate to encompass the reactions of the beneficiaries. Thus, we favor a highly individualistic approach. While we realize that this is time-consuming, we have seen quite a number of serious reactions that have been missed by “official” medicine, psychology, and social work and many many others that have been misdiagnosed. Again, we see a system of barefoot therapists as at least

a partial answer to the problem of the large amount of labor involved.

9. For you and according to your opinion, who were the victims of wars in the Former Yugoslav Region? Bosnians, Serbs, Croats, Roma or Sinti, Slovenian, Albanians…? Why?

   In our experience on the ground, everyone has been a perpetrator and everyone has been a victim. Whether a person is a victim or a perpetrator is a question of location and circumstance. Perhaps the one exception to this is the Roma/Sinti, who, in my opinion, have been victims everywhere.

10. With which victims (nationality/ethnic groups) did you work?

    We have worked with virtually all groups that exist here.

11. Which were the most frequent consequences (disorders, illness, etc.) of conflict detected or seen in victims?

    I shall divide this answer into physical and psychological consequences. I should note that the Croatian Ministry of Defenders also has written several reports on this, which are more or less reliable. What I mean by that is that, certainly, they are politically influenced.

    With regard to physical consequences, we have seen virtually every system of the body affected. Quite frequently, the circulatory system is affected, resulting in coronary and cerebral infarcts and hypertension, at the least. We have seen a fair number of endocrine problems, notably diabetes mellitus and thyroid problems. It can be argued that these are auto-immune problems, as there is good evidence that the immune system of the body is diminished in function by high levels of stress. In the same context, we have seen high levels of cancers of various sorts. Further, we have seen gastrointestinal problems, notably ulcers, Crohn's disease, and ulcerative colitis. There also have been respiratory problems. Also, there are what I would call the "standard" problems of muscle stiffness, etc. The Croatian ministry data indicates a higher level of mortality among war victims, military and civilian.

    With regard to psychological problems, again, we have seen virtually everything possible. One of the ultimate consequences of these are relational problems, which I will deal with later in this section. In terms of the direct psychological problems, we see a great deal of depression, anger and rage, anxiety, frustration, isolation, and reactive psychosis. All of this leads to increased levels of suicide and suicide attempts. One of our clients, who is a leading member of a veterans' organization, estimated that more than 80% of his colleagues had attempted suicide *at least* once, with quite a number having made multiple attempts.

A set of highly significant related problems are the lack of initiative and the lack of taking responsibility for life. It is the exceptional client who does not have these problems.

Still another virtually universal set of problems are those of relations. There is no tradition and little practice of expressing emotions, particularly among the male population. This commonly leads to explosions and a large amount of domestic and civil violence. Whatever the degree of violence, family and friendship relationships are strained in a large number – probably a majority – of our clients.

Still another set of problems that we are seeing is that of trans-generational transmission of trauma. This also results in a large amount of violence in the schools (see below).

Another set of problems in all of this are those that cross the physical-psychological barrier. Notable among these are psycho-sexual problems in both sexes, which contributes to the relational problems cited above.

12. If you had any PTSD or Depression, what kind of diagnostics did you use in these cases?

First, we do not use the term “PTSD”. Rather, we refer to *post-traumatic stress reactions (we emphasize the plural here)*. We do not use diagnostic schedules here, but, rather, work with the symptoms, trying to get at the underlying causes, which, in our experience, are influenced not only by the traumatic events but also internal psychological factors as well as external factors other than the trauma.

13. How did you/do you conduct psychosocial support to the victims? Which forms/techniques of support did you use?

As I indicated above, the job has not been started in this region, in our view.

There are a number of ways in which we conduct such support. I have discussed some of this in previous questions. For more details, please see the “What We Do” section of the website www.cwwpp.org. I apologize that the website still is under construction. However, the “Direct Work with People” section as well as the “Education” section give more details.

The point here is that we
- give direct counseling to people individually and in groups, onsite and online;
- give support through education. The Pragmatic Empowerment Training (PET) trains “barefoot” counselors. In the process of that training (see the Education section of “What We Do” on the website and the answers to previous questions), the methodology is such that there a large amount of psychosocial support takes place.

We emphasize that we do not believe that psychosocial support after violent conflict can

be carried out using short-term “quick fix” methodologies. Rather, the processes involved are long-term and must go deep.

14. Without using existing books and sources, how would you define psychosocial support? My/our definition of psychosocial support would be the use of methodologies such that
    - the person can function to complete his/her desired tasks in life;
    - the root causes of the distress are dealt with such that the person can cope with them;
    - the person develops goals in life in the sense of “profession” (including hobbies and vocations), relationships, and spirituality, in the widest sense of that word. In this, we follow Viktor Frankl.

15. Before coming to post-conflict area and start to work, did you have any special training/education for this work? If yes what? Was it delivered for the competent experts?

    - I trained as a physician at the University of Groningen, The Netherlands;
    - I took a number of certificates at the Dutch institutes for mental health education (RINOs) in psychological trauma and work with migrant mental health;
    - I took a course in conjunction with the Netherlands School of Public Health in forensic medicine.

    I also worked as a member of the Medical Examination Group, which was a joint working group of Amnesty International and the Dutch Association for Medical Polemology (a branch of International Physicians for the Physicians for the Prevention of Nuclear War) in which there was mutual education and supervision of one another.

16. After so many years of your experience, how do you think that an ideal program of psychosocial support to the victims of wars/conflicts should be conducted, such that we could say at the end that we were effective and efficient in general?

    First, as I already have indicated, I believe that the conduct of psychosocial support in the Balkans and in other parts of the world has been everything except effective and efficient. It has been a muddled mess, uncoordinated, short-term, and highly ineffective and inefficient.

    I believe that there should be the following elements in an ideal program of psychosocial support:
    - early intervention, starting as quickly as possible, even while the violence is continuing;
    - building of capacity among professionals;
    - more importantly, the creation of new groups of educated people, that is, middle and “lower” level people, including those with no previous education in these fields. Obviously, such people need to be well trained and well supervised;

- local, national, and international programs of “sensitization” to issues of mental health and destigmatization in people obtaining it;
- recognition and emphasis on the long-term nature of the problems, and that they cannot be solved by quick fixes;
- coordination of work such that all regions, urban and rural, are covered in the programs.

17. What is your opinion about the teachers in the schools and their roles in this way of support?

    The role of teachers in the schools is crucial, in my opinion. First, they need to learn to deal with the direct traumatization of their students. Second, they need to learn to deal with the trans-generational transmission of trauma and negative narratives.

    Also, teachers – and pedagogues and school psychologists – need supervision themselves to deal with their own traumatization and the secondary traumatization they get from their students.

18. What is your opinion about monitoring and evaluation process of your ideal system?

    Monitoring and evaluation is crucial. The danger here is that it will be politically influenced. This is all too often the case.

19. Finally, in your opinion, what do you think is the percentage of the population that remains "normal" after the war in post-conflict areas? Here, the definition of "normal" is the status that a person needs no help at all.

    At one level, this is a fairly simple question to answer. I don’t believe that anyone stays normal under this definition, that is, needing no help at all. This needs clarification. There are people who have better coping styles than others. I think that this is something that can be taught and encouraged on an individual and/or group basis. Also, there are people who pretend that they don’t need help and who are reasonable actors and attempt to portray this to the outside world. The degree to which they succeed is variable and, inevitably, it eventually breaks down. Also, there is a great deal of denial. A further mechanism is pushing the reactions inside. This leads to the translation of the traumatic reaction into physical disease. The Croatian Ministry of “Defenders” recently has published several reports on the diminished life expectancy of veterans. Still another way of lessening the symptoms and appearing “normal” is through dependencies. Such dependencies can be on cigarettes, alcohol, coffee, people, and, of course, on drugs, especially those prescribed by doctors such as benzodiazepines. Such dependencies, and what we/I believe to be medical abuse and bad practice, would open another question and another long chapter.

Another part of this is the formation of support networks. Unfortunately, many people do not form such networks, even within their own families. They hold themselves in and do not express their needs for assistance. This leads to severe domestic problems and, frequently, to violent incidents. It also leads to high levels of separation and divorce. Sometimes, people within the same group stay together in some way, such as cafés where veterans stay together. The degree to which this promotes true healing is variable and questionable.

Our definition of post-traumatic stress reactions and your definition of “normal” thus lead to the conclusion that no one is normal in conflict and post-conflict areas.

As one person in Vukovar put it, “if you’re not crazy in Vukovar, you’re not normal”.