

# Mental Health Programs In Areas Of Armed Conflict: The Médecins Sans Frontières Counselling Centres In Bosnia-Hercegovina

**Kaz de Jong, Rolf J. Kleber & Vesna Puratic<sup>1</sup>**

*M*ental health programmes in complex emergencies are generally accepted as an important component of aid work. However, this is a relatively recent development and there is a lack of theory-based practice and little analysis of previous interventions upon which effective, appropriate and sustainable programmes can be based. This article describes the theoretical framework, objectives, implementation and intervention activities of the mental health programme of Médecins Sans Frontières (MSF) in Bosnia-Hercegovina, 1994-1998. Approximately 10,000 individuals were helped during this time. The aims of the programmes were to provide culturally-appropriate support, assist in coping with extreme stress, counteract helplessness, and reinforce protective factors. Ten counselling centres were established where 70 local counsellors and supervisors worked after a training period of three months. Assistance and interventions provided by the counsellors ranged from mass psycho-education, training, individual outreach activities to crisis intervention and brief psychotherapeutic treatment – psychological structuring, working on (self) control, training self-help techniques, reconnecting the experiences to one's emotions and discussing the personal meaning of traumatic experiences.

*Despite general acceptance that war may lead to serious mental health problems, the provision of*

*help is stilled by disagreement on the cultural relevance and effectiveness of different interventions in emergency mental health programmes. This article, describing the establishment of a training programme and counselling centres during a war, and the continuation of these programmes six years on, provides a strong case in favour of the applicability of these programmes.*

**Key Words:** Emergency care, trauma, counselling, mental health, Bosnia-Hercegovina, war stress

## **Key issues**

Until recently, aid agencies working in complex emergencies largely focused their efforts on physical help, to the neglect of behavioral, mental and social problems. The delivery of mental health care and psycho-social support in complex emergencies began in the conflict settings of former Yugoslavia and Rwanda in 1994, where a number of agencies established programmes focusing primarily on the effects of (post)traumatic stress. These programmes put the psychological consequences of massive man-made violence on the agenda of the international community.

The implementation of mental health programmes in complex emergencies is becoming more and more common. Clinical expertise and research findings from psychology, psychiatry and social science are increasingly applied in war conditions, refugee settings and situations affected by natural disasters. It is now generally accepted that mental health programmes offer a relevant and much needed contribution to the alleviation of the suffering of people in war and disaster stricken areas (e.g. Ajdukovic, 1997).

In line with this quickly growing interest key issues require attention. One of these issues is whether Western conceptual frameworks on psychological stress and mental disorders can be transferred to different areas of the world (Kleber, Figley & Gersons, 1995; Summerfield, 1995). A second issue is the striking scarcity of thorough and theory-based descriptions of concrete mental health programmes in war-stricken areas: no thorough examination of these programmes have been published to date. Consequently the area of mental health interventions in war stricken areas is characterized by many myths, incorrect expectations and invalid criticisms. This lack of theory-based practice led the World Health Organisation to define mental health as one of the six applied research priorities in complex emergencies (WHO, 1998).

In order to develop sound and appropriate support programmes, an examination of the central principles and the concrete activities of mental health interventions in conflict settings is relevant. Such an analysis will bring the academic discussion to a practical level and will contribute to appropriate

support for those suffering from violence.

This article describes the theoretical framework, the objectives, the implementation procedures and the intervention activities of the mental health programme of Médecins Sans Frontières<sup>2</sup> (MSF) in Bosnia-Herzegovina, 1994-1998. The various implications of emergency mental health programmes and their usefulness are addressed in the discussion.

### **War in former Yugoslavia**

Before the war, Yugoslavia was a socialist federation in south-east Europe where diverse social, economic and ethnic groups lived peacefully together. In 1991, war started. The reasons behind the war complicated. Among the main reasons were: economic decline, increasing nationalism, disillusionment with communism and authoritarian leadership (e.g. Malcolm, 1994; Mooren & Kleber, 1999).

The Yugoslavian republic of Bosnia-Herzegovina offered a home to three major ethnic groups (Croats, Serbs and Muslims or Bosnjaks). After the independence wars in Slovenia and Croatia, it officially acknowledged its independence on April 6, 1992. Civil war broke out the next day. During 1992, the Bosnian-Serbs were able to conquer a main part of Bosnia-Herzegovina (Detrez, 1996). At the same time military groups of Bosnian Croats fought with Bosnian Serbs as well as with Muslim units.

For more than three years the capital, Sarajevo, was besieged by the Bosnian-

Serb forces. This city of roughly 350,000 inhabitants (UNCHR, 1993) became target for shell fire from the surrounding mountains. Moreover, small areas of the town were occupied by the Bosnian-Serb Army. From these areas the town was held at gunpoint through sniper fire. Primary resources – food, water, gas and electricity – were manipulated. Short cease-fires were often broken by violations on innocent civilians.

After a mortar attack in February 1994 on the Sarajevo market that left 68 people dead and many more injured, UN troops tried to maintain peace between the different parties in and around the city. After the fall of the Muslim enclaves of Srebrenica and Zepa and another mortar attack on the Sarajevo market in 1995, the pressure for international interference increased and NATO began air strikes. Finally, the peace agreement of Dayton, Ohio officially put an end to the war at the end of 1995.

The 1994 mortar attack in Sarajevo and the resulting uneasy UN armistice were the impetus for increasing the international aid effort. In March 1994, urgent medical needs in Sarajevo were assessed. As expected, war-related needs accounted for a high increase of medical problems. At all levels of the health system medical staff complained about an increasing workload from the number of undiagnosed, non-specific complaints (headaches, stomach problems, generalized body pain etc.). Frustrations about unsuccessful medical interventions were expressed. Large numbers of patients returned regularly to the health centres. Many expressed psychological complaints such as hyperarousal, flashbacks, nightmares, anxiety and

sleeping problems. This added additional stress to the already overburdened health system.

A 1994 UNICEF report concluded that 60% of children in Sarajevo suffered from traumatic-stress related symptoms. Household surveys in Sarajevo conducted by MSF (Jalovicic & Davids, 1993; Van der Kam, 1993) revealed that in 9% of households at least one person needed psychological help that was not available. It has been estimated that more than 700,000 persons in both Bosnia-Herzegovina and Croatia suffered from severe psychic trauma and a further 700,000 suffered from trauma responses that would qualify them for professional help under peace conditions (Jensen and Kosuta, 1995).

This increased demand for care was not met by the (mental) health services. All health facilities had suffered because of the war. Some institutions were destroyed, others were under continuous shell or gunfire: medical professionals were killed, had fled the country or were employed by the army. Furthermore, the pre-war conditions of the mental health system, dating back to the communistic era, showed deficiencies. It was primarily focused on hospital care and psychopharmacological treatment; hardly any modern outpatient mental health care was available. Preventive mental health activities (e.g. psycho-education) and counselling services were scarce.

### **Theoretical framework**

An increase in health care capacity and knowledge was urgently needed. Health authorities and Médecins Sans Frontières jointly agreed to increase primary mental health care capacity with a focus

on traumatic stress. Specific knowledge on the provision of mental health care under war conditions was, however, scarce. Ideas from a perspective of coping with traumatic stress (Kleber & Brom, 1992; Lazarus, 1981) were used as a guiding framework. Furthermore, the programme was developed ad hoc from local knowledge and specific advice from abroad. The intervention model that formed the basis of the programme is described below. It was based on the following four central principles.

*1. Culturally-appropriate support.* Pre-war Sarajevo had a rather cosmopolitan and European cultural climate. It was also traditionally the furthest outpost of the Islamic religion in Europe, and within the population there was a genuine tolerance towards different ethnic groups and religions. All four major religious groups were present – Islamic, Orthodox, Christian and Jewish. Most inhabitants were only vaguely aware of their ethnic background. The cosmopolitan feeling created through the diversity of people was for a long time Sarajevo's pride. Though both envied and regarded as arrogant by other parts of Bosnia, Sarajevo was a symbol of tolerance. With the war came loss of cultural identity, the humiliation of being controlled from outside and the dependency of a divided international community undermined the self esteem of the inhabitants. The culturally tight networks of families and friends broke down as the exodus of original town inhabitants and the influx of rural newcomers drastically changed the community of Sarajevo (UNHCR, 1993). The social disintegration contributed to the high levels of chronic and traumatic stress caused by the daily violence, the many losses, and the

shortage of basic resources.

It was essential that the mental health programme both increased individual awareness against learned helplessness and stimulated cultural self help and protective mechanisms (e.g. De Vries, 1996). Crucial within the mental health programme were, therefore, not only an appeal on individual responsibility and an ongoing awareness against learned helplessness, but also the stimulation of cultural self help and community protective mechanisms (e.g. De Vries, 1996).

*2. A perspective of coping with extreme stress.* People in war are confronted with many severe experiences of helplessness and disruption. Individuals have to adjust to a series of circumstances that are beyond their control and understanding. Material belongings are destroyed, friends and family are lost, fundamental assumptions of control and certainty, as well as basic beliefs in the future and in the benevolence of other people are shattered (Janoff-Bulman, 1992; Kleber & Brom, 1992), often beyond repair. War is not a singular traumatic event but a whole sequence of drastic events and prolonged hardships. It is a combination of so-called type I and type II traumas (Terr, 1991).

Research (e.g. Bramsen, 1996) has shown that nearly all war victims experience intrusive recollections, recurrent nightmares, and sudden feelings of reliving the event. These responses are combined with increased arousal, avoidances of stimuli associated with the trauma, and numbing. Through the oscillation between intrusions and avoidances the integration of the traumatic experience is realized, as established by cognitive processing models (e.g. Creamer, 1995). Physical symptoms like headaches, stomach pains and back pains are often part

of this process, and frequently result in visits to the health service.

Post-traumatic stress disorder (PTSD) is frequently used in connection to traumatic events. The concept is well-fitted to describe the serious and prolonged disturbances of individuals confronted with major life events. The distinctive criteria of PTSD (DSM-IV; APA, 1994) are (1) an extreme stressor, (2) intrusive and recurrent symptoms, (3) avoidance and numbing symptoms, (4) symptoms of hyperarousal, and (5) that symptoms of criteria 2, 3, and 4 should be present at least one month. The concept is also included in the International Classification of Diseases (ICD-10) of the World Health Organization (1992). PTSD is strongly associated with dissociation and somatization (McFarlane, Atchinson, Rafalowicz & Papay, 1994; Van der Kolk et al., 1996).

However, an analysis of human responses to extreme and catastrophic experiences solely in terms of PTSD has serious shortcomings. First, not all disorders after traumatic events can be described in terms of PTSD – it is not the only possible disorder after traumatic events, even according to the DSM system. Co-morbidity has been found to be more prominent in trauma patients than was originally assumed (Kleber, 1997). Secondly, and more important, it has been found that many people do not develop mental disorders at all (Kleber & Brom, 1992). Although nearly all people confronted with war will suffer from various negative responses (such as nightmares, fears, startling reactions and despair), it does not mean that they all will develop mental disorders. An emphasis on PTSD overlooks the normal

and healthy ways of adapting to extreme stress. As cognitive theories (e.g. Horowitz, 1986) have explained, the general processes to integrate the traumatic experience should be, in principle, regarded as normal responses. The mental health programme described in this article was, therefore, not specifically focused on psychopathology.

*3. Counteracting helplessness.* Adaptation to traumatic stress is not an isolated process (Lazarus, 1981). Many factors influence this process in positive (protective factors) or negative (risk factors) ways. It is the interaction between these factors that determines, together with the traumatic situation itself, the overall outcome of the coping process (McFarlane & Yehuda, 1996). In the case of the inhabitants of Sarajevo, risk factors were omnipresent.

Adaptation to stress is facilitated when the individual believes he or she is in control during and after the event (Kleber & Brom, 1992). An impression of mastery, whether subjective or not, is important (Thompson, 1991). Trapped in a city without the possibility of creating a meaningful daily activity caused feelings of helplessness and frustrations. Daily confrontation with direct or indirect (witnessing, noises, stories, etc.) violence and its consequences (death, graveyards in the city, destroyed buildings) created a situation of chronic stress. The longer the siege lasted, the more people became exhausted. Both mental and physical resources became depleted. The citizens often compared the circumstances in Sarajevo with a large concentration camp governed from the surrounding hills. The citizens felt isolated and abandoned by the outside world. Food and other humanitarian aid could not compensate for

the disbelief that the civilized, international community did not react stronger to the siege of Sarajevo and ethnic cleansing of Bosnian citizens.

The mental health programme was, therefore, concentrated on the enhancement of control for the inhabitants of Sarajevo and to counteract patterns of learned helplessness (Peterson & Seligman, 1983).

*4. Reinforcement of protective factors.* The resilience of people, even in the horrendous war circumstances in a shattered and demolished country, should not be underestimated. The personal strengths and social resources of people should have a place in mental health programmes.

Social cohesion was under severe pressure in Sarajevo during war. Old social networks disappeared but were not replaced, due to large differences between urban and rural population. The ongoing lack of safety further hampered social interactions. Restoring social networks and stimulating social support can facilitate coping with traumatic stress. Social networks (Eitinger, 1964; Rachman, 1978) and social support (Davidson, 1984; Maddison & Walker, 1967) play a positive role in health and adjustment (Sarason & Sarason, 1985) even to the extent of reducing mortality associated with stress (Berkman & Syme, 1979). Activities were organized to support the vulnerable, to protect the weak, to create a pleasant atmosphere (e.g. winter festivals) and to preserve dignity. The mental health programme encouraged the resilience of war-stricken individuals and groups, regardless of ethnicity, religion or political background, and raised a voice for these people through

communication with others, contact with the media and various forms of advice and support.

## Objectives

The overall objective of the programme was to provide support for those suffering from war-related mental health difficulties and to prevent severe psychopathology through the establishment of primary mental health services. The theoretical framework described above formed the basis for these programmes.

Selecting and training local counsellors to help their own people ensured the cultural relevance of the programme. The services had to be easily accessible to everyone in the general population in need (excluding, for instance, psychiatric patients who were referred to health centres or hospitals). Counselling centres were established in Sarajevo and cities in central Bosnia. To increase output and assure future sustainability these centres were integrated in to the existing health care system. The establishment of community based primary mental health care conformed with existing government plans to reform the health care system from hospital based care into primary health care. Co-operation with the health authorities helped promote and encourage the acceptance of the centres. Furthermore, to assist the general population in their normal coping process after extreme stressors psycho-education was organized on individual, group and community level. Lastly, the protective factors were reinforced through various health care interventions: crisis intervention, brief counselling therapy, individual and community outreach.

## **Implementation**

Following an initial assessment, the MSF mental health programme began in March 1994. At that time Sarajevo was besieged for two years. Many people were at risk of developing war-stress related disturbances and a substantial group of citizens already suffered from some kind of mental difficulties.

*1. Selection of counsellors.* Trained counsellors should provide primary mental health care to traumatized people. Bosnian people of various professional (teachers, nurses, social workers) and academic (psychiatrists, clinical psychologists, general practitioner) fields were selected to attend the training course in Sarajevo. The selection of counsellors was based on educational background, experience and availability. Ethnicity was not a selection criterion.

*2. In-depth training.* Training was considered crucial in the project. Since 1994, three intensive courses have been given: two during the siege in Sarajevo (1994, 1995) and one in central Bosnia (1996). Each training course lasted three months. In total 100 persons were trained. Of these, seventy were employed by MSF in the counselling centres. The rest were trained at the request of other organisations.

The organisation of the course during the siege was extremely difficult. Movement both in and out of the city was dangerous due to the hazardous travel circumstances and the presence of snipers. All course material had to be transported in by MSF staff, consultants and trainers. Original plans to involve only local staff were frustrated by the 'brain-drain' as people left the city, coupled with the general absence of knowledge on

traumatic stress. Eleven Dutch experts in psychotrauma, general psychiatry and clinical psychology volunteered to provide the training in Sarajevo<sup>3</sup>.

Since knowledge had to be applicable, the method of 'learning by doing' was used during the training (Pretty, Guijt, Scoones & Thompson, 1995; Weinstein, 1995). This method was in contrast with the existing culture of giving lectures and it took time for participants to get used to this form of learning. The curriculum was organized along an explicit framework; topics were related to stress and coping psychology, traumatic stress studies, psychopathology, social psychiatry, counselling skills and specific subjects (e.g. family dynamics). Skills like listening, interviewing, confronting and structuring were considered to be highly relevant. During the training both trauma experts and participants adapted intervention techniques to the local culture.

The three-month training course was full-time for those not specialized in mental health. Psychiatrists, clinical psychologists and general practitioners attended the course three afternoons a week. The mornings were used for teaching and training, the afternoons for group sessions (often of a therapeutic nature at the beginning) and practical work. A training period within a counselling centre was not possible after the first training course. The two following training courses included a practical period of three months<sup>4</sup> for participants within existing centres.

All participants who completed both the training course and the practical period received an international certificate signed by national and international

health authorities<sup>5</sup>. The certificate was recognised by the local authorities as a sign of quality training. An external evaluation found the curriculum and execution of the course to be effective and appropriate (Etherington, 1996).

To continue the educational process, weekly group meetings were organized after the training course. During these meetings staff presented cases, discussed organizational issues, practised counselling techniques and used debriefing techniques to prevent secondary traumatization resulting from their daily work. Training on the job was provided by local consultants, professional co-ordinators, MSF co-ordinators and expert trainers.

*3. Establishment of counselling centres.* After the first training course (1994) five counselling centres were established in different parts of Sarajevo. In 1995, a sixth was opened. Counselling centres were established in or near existing health centres around the city. After the Dayton peace agreement one centre was moved to a health centre located in former Bosnian-Serbian territory in Sarajevo (Vogosca). It primarily received Muslim refugees from the Bosnian-Serb republic. At the request of the authorities the project was extended to Central Bosnia at the beginning of 1996. In this area, populated by Muslims and Bosnian-Croats, four counselling centres (in the cities of Zenica, Travnik and Vitez) including four mobile teams were established. Although the co-operation between Bosnian-Muslims and Bosnian-Croats was recent and not always self-evident, employees showed great willingness to overcome their past differences and to participate.

Co-operation with the health authorities was crucial; they supported the programme by giving advice, providing space, referring patients and enrolling their staff in the training programme.

*4. Local capacity building.* In the MSF counselling centres multidisciplinary teams were formed, bringing together specialists such as general practitioners, clinical psychologists, psychiatrists, and professionals such as social workers, psycho-pedagogues (teachers with a background in educational psychology) and psychiatric nurses.

Many specialists, professionals and (para-)medical workers had left Sarajevo. Employing remaining specialists for our programme could therefore have undermined the regular health system. After discussion with the health authorities it was decided to employ specialists working in the health system only after working hours. Since specialists in Sarajevo work in 24-hour shifts, it was possible to staff all centres with sufficient specialist supervision.

Each centre was staffed with one supervisor, one consultant (academic specialist), one team leader and three counsellors. Each centre was an independent, functional unit responsible for implementing the activities and tailoring them to the needs of the community. Supervisors were responsible for the overall professional quality and daily affairs. Team leaders were in charge in the absence of the supervisor. Consultants supervised and trained the counsellors. A director bore overall responsibility for all the centres. A separate professional coordinator was in charge of controlling the quality of the work, supervising the teams, and sup-



porting counsellors suffering from secondary traumatisation.

The input from foreign experts was kept to a minimum to stimulate local management. MSF played a coaching and supportive role. This strategy was chosen to increase self-esteem – building something new, running their own business, initiating new activities to help their own people, being responsible for the daily affairs and the quality of their services. These endeavours would serve as a model for other citizens and authorities. Despite the existing circumstances and the experiences with the communistic system which did not promote self-management, the principles of a ‘learning organisation’, such as openness, team learning and focus on increasing capacity (Senge, 1990; Swieringa & Wierdsma, 1992), were applied in training, daily management and activities within the centres. To facilitate the local ownership of the programme and the process of self-management decisions, both the local management team and the counsellors were encouraged to take their own decisions, to bear responsibility for mistakes made and to create solutions.

Daily project management was handed over to the national staff in May 1995. MSF stayed to provide coaching by experts, management support, and financial and logistical continuity. This input became more distant over time. In early 1998, the centres were handed over to the developmental aid agency HealthNet International.

*5. Helping the helpers.* Most counsellors had encountered traumatic events themselves during war. Their work also predisposed them to secondary traumatisation (Figley, 1995). During the training course this issue was addressed through small

therapeutic groups in which participants debriefed each other, shared experiences and emotions, gave support and attempted to integrate their traumatic experiences. All members of the group experienced themselves what they were going to ask of their clients. The mix of being client, member of a group and helper was beneficial. After three months the group spirit among all participants was strong. These groups continued as part of the weekly group meetings.

The professional co-ordinator was assigned to give support or organise help for the helpers. Ongoing education (workshops) and team building activities proved to be effective in the battle against vicarious traumatisation.

## **Interventions and activities**

A community based mental health programme should direct its activities at several levels: the individual, the community and vulnerable groups. The forms of assistance provided by the centres were manifold. They ranged from psycho-education and media sessions to crisis intervention and brief treatment. In the period between Autumn 1994 and January 1998 approximately 10,000 individuals were helped.

*1. Psycho-education of specific groups.* Psycho-education is an effective tool to alleviate (post) traumatic stress responses in large numbers of the population and to support the normal coping process (Brom & Kleber, 1989; Herman, 1992; Mitchell & Dyregrov, 1993). The centres organized psycho-education sessions and psychosocial activities for vulnerable groups (school children, refugees, elderly, etc.). Ten sessions of basic psycho-education were offered, specific context-

related issues were raised and basic psychosocial needs were addressed. The availability of information on war stress provided an incentive for people to come, express their worries, share their feelings and give each other support.

*2. Psycho-education of the general public.* The aim of psycho-education was to create an environment in which individual acknowledgement of war-related emotional problems was facilitated. To reach the large group of people suffering from war-related stress in the besieged cities mass media were used. Radio Bosnia i Hercegovina (radio BiH) allowed MSF counsellors to broadcast a programme one hour a week. Radio BiH was received all over Bosnia (including Bosnian-Serb and Bosnian-Croat areas). The radio programme was broadcast from January 1995 until January 1998. A subsequent survey showed that it was wellknown among the population of Sarajevo.

The radio programmes explained the notion of traumatic stress, the normality of the responses, the various reactions, the principle of self-help, the provision of support to others and the possibilities for professional help. To stimulate curiosity and increase direct support the broadcast was formatted as a live, call-in programme linked to themes for specific groups (e.g. internally displaced persons, widows, elderly, orphans, ex-soldiers, workers in factories etc.). These specific vulnerable groups of people suffering from traumatic stress are easily forgotten and marginalized (Op den Velde et al., 1993; Scurfield, 1993). Advocacy, acknowledgement of suffering and raising awareness for those not able to speak for themselves were important components of the radio programme .

*3. Training for specific groups.* The concepts of traumatic stress were not well known among health staff in Sarajevo. Therefore, training programmes were designed for the recognition of traumatic stress, symptoms and disturbances, ways of helping, and possibilities for referral. Training was given to nurses in health centres and hospitals, professionals and specialists working in emergency rooms and first aid services, and general practitioners. Police officers, fire fighters, the staff of orphanages, and teachers were also trained.

*4. Individual outreach.* Intervention programmes for victimized people are often of an active or 'outreach' nature. Many studies into victim support (for example, Maguire & Corbett, 1987; Van der Ploeg & Kleijn, 1989) have shown that this kind of health care is useful. Risk groups are better reached in this way. Disturbances have been found to arise especially among victims who would rather avoid (professional) assistance (Weisaeth, 1989). An outreach approach aims to avoid an association between assistance and personal weakness.

The mental health programme provided support in various forms: companionship with people in similar circumstances, emotional (e.g. talking, activities, remarks), cognitive (e.g. advice, information), outspoken acknowledgement of what has been suffered, and the development of ceremonies and memorial rituals. The socially withdrawn, the depressed, and the elderly were supported through basic social support and counselling. The establishing of links to the surrounding social network was a high priority in creating sustainable support. These outreach activities also provided

a model for as a sense of togetherness, compassion and emotional support to others in the neighbourhood.

*5. Crisis intervention.* Immediate assistance was available through crisis intervention. This brief intervention consisted of a basic intake procedure, combined with emotional support and some psychological structuring of the event as well as psycho-education. This lasted for a maximum of three sessions. When help was needed for a longer time the formal intake procedure was followed.

*6. Treatment.* After the formal intake procedure (including assessment of complaints and registration) clients were offered counselling treatment for a limited period. A central element was to facilitate the expression of thoughts and feelings with regard to war experiences. Telling the story of the event helps victims to integrate the experience into their own life (Herman, 1992). Narrative approaches ('talking cure') and other forms of expression, such as drawing, play and more collective activities (ceremonies and rituals) can facilitate the integration. Treatment was based on principles derived from brief trauma-focused therapy (Brom, Kleber & Defares, 1989; Foa, Hearst-Ikeda & Perry, 1995). The basic components of treatment were: psycho-education (including family members), psychological structuring of experiences, working on control, reconnecting experiences to emotions, working on integration and future perspective, and self-help techniques. Examples of intervention techniques included: relaxation, guided meditation, guided communication, systematic desensitisation, and behaviour prescription. To increase self-help and understanding and to create a safe

environment for the client the social system surrounding the client (e.g. spouse, family members) was (if possible) also part of the intervention.

Both individual and group treatments were offered. Group interventions were preferred, especially for the secondary benefits of sharing and providing mutual support (Grinker & Spiegel, 1945; Walker, 1981). Treatment of mildly traumatized people lasted approximately 10-15 sessions. The period of treatment was kept short for several reasons. The number of people in need was estimated to be substantial (Jalovcic & Davids, 1993; Unicef, 1994), so offering long-term treatment would reduce the overall number of beneficiaries. Moreover, it has been found that brief therapy focusing on trauma-related disorders (such as (P/TSD) is effective (Marmar, Foy, Kagan & Pynoos, 1993). There was also a practical reason: the professional level of the staff limited the number of treatment sessions to 10-15; most did not have sufficient experience to deal with the transference and counter-transference established during long lasting, intensive psychotherapy. For similar reasons psychotropic drugs were not prescribed in the centres, in spite of the fact that the use and prescription of tranquillisers was widespread in Sarajevo.

Therapist and co-therapist did the intake and follow-up together. The objective of the intake was to receive client data and get the perspective of the client on the problem. To motivate the client information gathering during intake was combined with giving emotional support or practical advice. The team discussed, after the intake procedure, the client's case. The consultant supervised the difficult cases. Clients were registered after each

session. The decision to end treatment was evaluated by the team.

## Discussion

Emergency mental health care is a new area in which many key scientific as well as clinical questions remain. It is not a self-evident intervention and there are several significant issues related to its application. In the last section of this article we discuss the implications of the implementation of a comprehensive counselling programme in a war-stricken area.

The choice to implement a mental health programme during a war such as the conflict in former Yugoslavia is relevant when terror and violence are found to be devastating for both communities and individuals. Ideally, such a programme should already be applied during the ongoing hostilities (see also Ajdukovic, 1997; Butollo, 1996). Moreover, it should not be based on a limited perspective of trauma recovery, nor on rigid concepts of symptom reduction, as we have explained in our theoretical framework.

Experimental research in psychology has shown that some form of disclosure (e.g. talking about the experience) is helpful, mentally as well as physically (Pennebaker, 1995). During war a mental health programme may prove to be instrumental in improving individual coping mechanisms and thus indirectly increase the capacity to survive.

On a community level such a programme bears the implicit message of worthiness. We observed in our program that the individual counsellors created through their work a new meaning for

themselves and others in their vulnerable existence. On many occasions the local counsellors declared that helping their own people increased feelings of worthiness and triggered self-esteem. The counsellors regarded the programme as a tool to regain control and to maintain self-respect during war. To start investing in a post-war health system service amidst a seemingly endless war showed a strong sense of future perspective. Through their work activities and job discipline the counsellors felt a strong ownership of the programme. Often in difficult and dangerous circumstances outreach activities were executed.

From a practical point of view an early start of a programme is an anticipation on the difficult and often disappointing post-war situation in which the population will have to face and integrate the horrors of war and to build a new future. Some people will need professional support for this. A system that is implemented during war is better equipped to meet post-war challenges.

A serious drawback of many emergency (mental) health programs is the lack of reliable information with regard to the effects of the interventions. What is the precise impact of violence on the population? Do the interventions really work? Of course, it is extremely difficult to conduct research in war-stricken areas. There are other priorities and there are ethical arguments – people in need may be offended by being seen as interesting research subjects. Nevertheless, there is a growing need for empirical data for scientific reasons and also for policy making.

The absence of monitoring models appropriate for the Sarajevo situation created a serious challenge. A new system had to be created. From 1995 a thor-

ough monitoring system was implemented to register signs and symptoms of clients of the counselling centres and the effects of the various interventions. Standardised questionnaires, such as the General Health Questionnaire (Goldberg & Hillier, 1979) and the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979) were used, together with other instruments adapted to the programme. The extensive monitoring system and the collection of data was an acknowledgment of the work of the counsellors in the besieged areas of Bosnia. From the start of the programme until early 1998 data on approximately 10,000 people had been collected. Monitoring tools and preliminary results are described elsewhere (Kleber, Kulenovic, Mooren & Jong, 1999; Mooren, Kleber, Ruvic & Kulenovic, 1999).

One of the objectives from the onset was the integration of the programme in the existing health system. Though hesitant in the beginning, the Bosnian authorities became co-operative and supportive. After the transferral of the day-to-day management to local people the counsellors and authorities expressed on many occasions their appreciation for this sign of respect and the stimulation of local ownership. Nevertheless, the formal integration into the post-war health system is a slow process with many uncertainties. Post-war conditions with all the political issues, financial constraints and practical problems have further complicated the speed of integration. To provide long lasting support for the programme and secure mental health care activities within Bosnia-Herzegovina, MSF handed over the mental health project to the development

aid agency HealthNet International. By December 1999 approximately one half of the centres had been integrated into new community-based rehabilitation centres. It is expected that the other half will be closed or transferred to other organizations that provide specific treatment and training of war-related problems. Appropriately, the Bosnian people and authorities will decide whether and how the mental health care programme will be integrated.

In spite of its popularity and accessibility, the concept of posttraumatic stress disorder (PTSD) should be used with care. Many authors and representatives of emergency care agencies in former Yugoslavia have suggested that large groups of people will suffer from war-related PTSD (e.g. Agger, Vuk & Mimica, 1995). However, these predictions were not based on solid research findings.

There is a danger of equating war stress with post-traumatic stress disorder (e.g. Bracken, Giller & Summerfield, 1995, 1997) and for the resulting assumption that most civilians would suffer from this disorder (O'Brien, 1994). Even so, agencies and nongovernmental organisations involved in emergency care in Bosnia have often stressed a PTSD perspective on war-related mental disturbances. This discrepancy is remarkable. It implies at least two rather different conclusions. First, that some scientific authors are armchair theorists are not involved in real and concrete mental health care activities in war-stricken areas – it is rather easy to criticise large emergency care programmes that are, by definition, not extensively prepared, but it is quite difficult to provide a sound alternative. Second, that authorities and agencies do not listen to

critical arguments and only pay attention to seemingly easy explanations. Both arguments are oversimplifications and do not hold true for the programme described in this article.

Trauma is a concept that can appropriately bridge the gap between the individual and the surrounding society (Herman, 1992; Kleber et al., 1995). Trauma threatens the individual's sense of self and the predictability of the world. Basic beliefs in trust, confidence and the connectedness with other people are shattered (Janoff-Bulman, 1992). Helping traumatised people is, in principle, a matter of restoring the bond between the individual and the surrounding society. This perspective in particular has been used in the mental health care activities described in this article.

It is important to avoid imposing psychological and psychiatric concepts that are alien to the culture (e.g. Summerfield, 1995). Such a transfer may ultimately be harmful. Ultimately, however, such cultural sensitivity can lead to doing nothing at all. Broadly speaking, any intervention done by outsiders implicates a meeting and, therefore, confrontation of two different cultural worlds. Within this meeting, participants exchange opinions, views and values. A mutual influence is, *de facto*, always occurring. In this sense almost all humanitarian aid interventions are to a certain extent an imposition of Western principles upon other cultures. It is important to acknowledge this. The consideration of one's own cultural and ethical influence upon others and a pragmatic appreciation of the limitation of this influence in concrete interventions is rational. Within the interventions described here we have attempted to avoid imposing alien psychological and

psychiatric concepts. The large number of people visiting the MSF centres is proof of the relevance of the intervention.

A discussion on the relationship between humanitarian aid providers and recipients should be based on the concept of respect for the prevailing culture and its mental health healing practices and on mutual agreement concerning the problems and ways to address them. However, it is also sensible to set limits. Western humanitarian ethics, based on the concept of 'Do No Harm', should allow that it is sometimes unavoidable to impose foreign concepts. In Bosnia-Herzegovina the predominant approach towards mental health was a very traditional psychiatric one. Adjusting our programme to this culture would have meant treating patients by confining them to hospital beds and contributing to possible future drug dependency. An intervention based on preventive mental health activities and counselling was proposed, explained and accepted after extensive discussion.

## Epilogue

Few would deny that war may lead to serious mental health problems. Nevertheless, the psychological impact of war experiences has been seriously neglected in health care and emergency programmes. The emphasis is on instant medical treatment and assistance. There was, and still is, a compelling need to pay more systematic attention to the psychological needs of people in war-stricken areas (see also De Jong, Ford & Kleber, 1999).

One of the top priorities for mental health or psychosocial programme development is applied research through

careful investigations and evaluations. The starting point, as the World Health Organization (1998) has proposed, is an inventory of existing mental health intervention models. Indeed, the extent of the impact of violence on communities and individuals, and the extent of the effects of special interventions, are crucial questions. Only through operational examinations can these questions be answered. Findings may also clarify cross-cultural variations and consistencies in frequency, symptomatology and coping mechanisms (De Girolamo, 1993).

In our experience mental health programmes are commendable. Though many people in war and disaster stricken areas mobilise coping mechanisms by themselves, some need help. The numbers may vary depending on risk and protective factors. The support of adaptation processes, the provision of treatment to those suffering from severe traumatic stress, and the facilitation of community restoration all carry the implicit message that some one cares. This gesture alone may be healing.

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<sup>2</sup> Médecins Sans Frontières is an independent humanitarian organization dedicated to providing medical support to populations in health crises.

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<sup>4</sup> The level and duration of training depend on the extent of existing knowledge and expertise amongst local staff, the needs of target population and the phase a crisis may have reached. For instance, in other emergency settings such as Macedonia (de Jong et al. 1999), Sierra Leone (de Jong et al. 2000), Tajikistan and Lebanon crash courses were held of varying length ranging from several days to two months.

<sup>5</sup> The Director of the National Public Health Institute Bosnia-Herzegovina, the Director of the Netherlands School for Public health, the Dean of the Medical Faculty, University of Sarajevo, and the Chairman of the Department of Clinical & Health Psychology, Utrecht University, The Netherlands.

<sup>6</sup> Advocacy is not restricted to human rights abuses only. In the Sierra Leone emergency programme staff contributed more directly to the reduction of human suffering through advocacy for basic resources required for making food, clean water and shelter. In Sri Lanka it was possible to prevent further traumatisa-tion through advocacy for rights of minority groups.

<sup>7</sup> Our other interventions in non-western settings such as Lebanon, Sierra Leone, Indonesia, Colombia and Tajikistan taught us to balance our western MSF perspectives with the explanatory models and language used by beneficiaries. It is our experience that national staff are well able to act as cross-cultural translators and negotiators when given the opportunity to do so.

*Kaz de Jong, psychologist, is mental health advisor of Médecins Sans Frontières Holland and was formerly coordinator of their counselling centres in Bosnia-Herzegovina.*

*Rolf Kleber, psychologist, is professor of psychotraumatology at Tilburg and Utrecht Universities, The Netherlands, and head research of the Institute for Psychotrauma.*

*Vesna Puratic was coordinator of the Médecins Sans Frontières mental health project in Sarajevo between 1994 and 1998 and is now working for HealthNet International, Sarajevo.*

*Address of correspondence: Prof.dr. R.J. Kleber, Department of Clinical Psychology, Utrecht University, Heidelberglaan 1, 3584 CS Utrecht, The Netherlands.*