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Creating a Network in a Refugee Camp in Former Yugoslavia

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Collective Post-traumatic Disorders, Residual Resources, and an Extensive Context of Trust

Creating a Network in a Refugee Camp in Former Yugoslavia

Between 1993 and 1996, at the request of Médecins Sans Frontières, Belgium, a “pilot project for network therapy centered on families” was designed for, and developed in, two refugee and displaced persons camps during the war ravaging former Yugoslavia. These two facilities housed approximately a thousand families, most of whom had lost one or more members and were suffering from very serious trauma.

We decided to accompany our intervention with a dual process of evaluation. During the preliminary stage of this evaluation, the coordinator met with some of the families to ask for their help in supplying information concerning their needs and developing the most appropriate interventions. We held “meetings” in which we presented ourselves in terms of our availability and allowed the families to decide how best we could help them and how that help should be organized. The second stage of the evaluation, which was conducted largely by A. Chauvenet,

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a sociologist [1], was based on families' testimony concerning the effects of our work and ultimately served to help us redefine our practice.

The evaluation became an integral part of the therapeutic process: it actively contributed to the creation of trust, which was the foundation of our practice. We were concerned that our intervention not jeopardize bonds already weakened by the trauma these people had suffered; in fact, these bonds turned out to be important therapeutic resources.

From risk to redefinition of practice

We noted early in our evaluation of needs and how best to address them that people seldom asked help for themselves. Parents asked for books for their children; some people asked us to visit another family about whom they were worried; others asked for medication for an ailing grandparent; and so on. What emerged was a prescription based on the contextual therapy of Boszormenyi-Nagy [2], which required us to take into consideration every person, even absent, who could be influenced by the therapy, to make ourselves available not just in terms of trying to alleviate the distress these people were experiencing but also in terms of the resources their distress revealed, particularly the bonds among them that became evident.

We began to wonder about the intentional violence expressed in torture and organized rape. Why did rape constitute such a powerful secret weapon? What could it harm that conventional weapons could not? The answer, we found, was that it attacked and destroyed the bonds between husband and wife, mother and children, women and the collective. And since such violence intentionally destroyed cultural, political, social, and natural bonds, those links had to be precisely the specific site of our intervention. However, we were conscious of the risk of our intervention in this particular area: the risk of perpetuating the trauma and its effects through reviving memories of the experiences.

The singular situation the refugees faced during the war was intensely traumatic, with effects that mutually reinforced each other: the conditions from which they fled, the flight itself, the refugee status, the loss of not just material goods but of affective and symbolic possessions, and expulsion from the public and political arena that entailed deprivation of citizenship. Everything that assigned a person a place in his community and in his history, everything that enabled him to "belong," was either destroyed—explicitly, by "ethnic cleansing," which gave rise to a

desire for revenge—or was lost or blurred in the “nontime” and “nonspace” of the circumstance of being a refugee. To be a refugee meant to relive permanently the tragic events not just in imagination and memory but also in everyday reality.

The overall situation intensely affected everything that underlies trust, on both an individual level and with regard to relational space: “*We no longer know who is who; we can’t trust people anymore,*” we were often told. The refugees’ words expressed their awareness of the shrinking of space and time, of the negation of autonomy and everything that constitutes identity: “*I feel like I’m in prison. I’m free—that’s not what I mean. I feel as if someone had put me here, and I can’t go where I want. I have material problems; I can’t even start to plan for the future. I don’t even know if they’re going to send us somewhere else. I have the feeling that someone else is always deciding my fate. I feel really terrible.*”

Comments such as these led us to realize that the bonds that had been shattered had to be the focus of our therapeutic intervention, that although we risked causing more pain by focusing on what had happened to the refugees, we had to acknowledge the harm that had been done to them and try to diagnose and meet their needs through searching for residual resources and gaining their trust. The fragility of our clients demanded an approach that led us to define and construct our practice as an offer of availability that took into consideration the conflicts of interest inherent in family bonds and the present reality of the refugees’ lives.

A network of trust

We made our availability known through a number of “entry ways” that enabled our encounters to be informal and casual yet avoided any impression of intrusion. Specifically, the waiting room of the community clinic, the kindergarten, and the teenagers’ clubs constituted our “entry ways.” Being open to both local people and refugees and to any form of presentation of distress or pain, these entry ways avoided stigmatization and permitted therapists to express their concern and desire to help and to observe significant ties among people and the potential resources for recovery that those ties represented. Each entry way was part of a larger network that was mobilized to help individuals and families in regaining trust in their fellowmen and restoring shattered bonds.

Important in the therapeutic process activated by the network were residual bonds that served as resources. These were bonds that could,

and often had, resisted efforts to destroy them, that mobilized resources and resistance to traumatic events [3].

By way of illustration, we present the following brief account of a visit by five members from our program to a family that included three generations:

The Alic family, Grozdana and Slobodanka, the maternal grandparents, and two children, Sretan, a boy of 11, and his 7-year-old sister, had been refugees from Mostar for over a year. The parents had invited us as consultants for an on-site visit. Conversation began with a discussion of the physical ailments of the grandparents and a query about whether the psychiatrist could get some medication for the epileptic grandmother. The grandfather had been a farmer and was unable to accept that his grandson would never be able to take over the family farm and develop it. He and his grandson were close, he said. The father, defeated by exile, was preoccupied with trying to supply his family with the bare necessities of life and was seldom home. The adults were living in nostalgia and illness; the children had only sport and school to occupy them.

The problem that concerned the adults, however, was Sretan, who was unstable and nervous, doing poorly in school, and seemed interested only in football. The psychiatrist wondered if the boy's nervousness was caused by the weight of the burden the family was placing on his immature shoulders and asked the grandfather and the boy what they thought should be done for when there was no more earth to cultivate and no more trees to plant. Would Sretan's focusing on his lessons help the family build a future when he could see the future only abstractly and with uncertainty? How could the grandfather recognize the difficulties of his grandson's situation and involve the father? We were only beginning a reactivation of the transgenerational resources when the conversation ended.

Conclusions

Throughout our work, we were preoccupied with a balance between give and take, a fragile balance between acknowledgment of the unfairness of fate and the will to continue to search for and discover healing resources, even where they seemed unpredictable or unlikely. In some ways, our offer of availability characterized the program itself. Our practice was always open to negotiation with both families and professionals; in sum, our "therapy" was created or invented from one encounter to the next, healing bonds being sought and give and take between helpers and helped being essential to the relationship. Most of the consulta-

tions were in the refugees' homes, where traditions of hospitality were observed and furthered the building of trust, e.g., nonacceptance of a cup of coffee could be felt as nonacceptance of friendship. The ultimate goal was, through friendship and concern, to restore some measure of trust in others and reactivate healing bonds in people who had suffered severe trauma and faced an uncertain future.

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