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Traumatized Societies and Psychological Care: Expanding the Concept of Preventive Medicine

Vamık D. Volkan

Vamik D. Volkan, M.D., is Director of the Center for the Study of Mind and Human Interaction and Professor of Psychiatry at the University of Virginia. He is a Training and Supervising Analyst at the Washington Psychoanalytic Institute. *Earlier versions of this paper were presented at the Eighth International Conference on Health and Environment at the United Nations in New York, April 23, 1999 and at a conference entitled "Crossing the Border" sponsored by the Dutch Adolescent Psychotherapy Organization in Amsterdam, May 18, 2000.*

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When a massive disaster occurs, those who are affected may experience its psychological impact in several ways. First, many individuals will suffer from various forms of post-traumatic stress disorder (PTSD). Second, new social processes and shared behaviors may appear throughout the affected community/ies, initiated by changes in the shared psychological states of the

affected persons. And, third, traumatized persons may, mostly unconsciously, oblige their progeny to resolve the directly traumatized generation's own unfinished psychological tasks related to the shared trauma, such as mourning various losses. This paper focuses on the latter two expressions of the psychological impact of disaster. In particular, it addresses the impact of trauma resulting from conflict between large groups. In this context, a large group consists of thousands or millions of people, most of whom will never meet one another, who share a sense of national, religious, or ethnic sameness —in spite of family and professional subgroupings, societal status, and gender divisions—while also sharing certain characteristics with neighboring or enemy groups (Volkan, 1999a, 1999b).

Types of disasters

Shared catastrophes are of various types. Some are from natural causes, such as tropical storms, floods, volcanic eruptions, forest fires, or earthquakes. Some are accidental man-made disasters, like the 1986 Chernobyl accident that spewed tons of radioactive dust into the atmosphere. Sometimes, the death of a leader, or of a person who functions as a "transference figure" for many members of the society, provokes individualized as well as societal responses— as did the assassinations of John F. Kennedy in the United States (Wolfenstein and Kliman, 1965) and Yitzhak Rabin in Israel (Erlich, 1998; Raviv, et al. 2000), or the deaths of the American astronauts and teacher Christa McAuliffe in the 1986 space shuttle Challenger explosion (Volkan, 1997). Other shared experiences of disaster are due to the deliberate actions of an enemy group, as in ethnic, national, or religious conflicts. Such intentional catastrophes themselves range from terrorist attacks to genocide, and from the traumatized group actively fighting its enemy to the traumatized group rendered passive and helpless.

A recent study by Goenjian, et al. (2000) compared Armenians directly affected by the 1988 Armenian earthquake with Armenians traumatized as a result of Armenian-Azerbaijan ethnic enmities during the same year. It concluded that,

after 18 months and again after 54 months, there were no significant differences in individual "PTSD severity, profile, or course . . . between subjects exposed to severe earthquake trauma versus those exposed to severe violence" (p. 911). Such statistical studies measuring observable manifestations of a trauma's lasting effects (anxiety, depression, or other signs of PTSD) are misleading, however, insofar as they do not tell us much about individual minds or hidden, internal psychological processes; apparent symptomatic uniformity may hide significant qualitative differences. Further, such studies do not tell us about societal processes that may result from catastrophes and their long-term (transgenerational) effects. For instance, the fact that many injured Armenians refused to accept blood donated by Azerbaijanis after the earthquake indicates that the tragedy had in fact enhanced ethnic sentiments, including resistance to "mixing blood" with the enemy.

Even though they may cause societal grief, anxiety, and change as well as massive environmental destruction, natural or accidental disasters should generally be differentiated from those in which the catastrophe is due to ethnic or other large-group conflicts. When nature shows its fury and people suffer, victims tend ultimately to accept the event as fate or as the will of God (Lifton and Olson, 1976). After man-made accidental disasters, survivors may blame a small number of individuals or governmental organizations for their carelessness; even then, though, there are no "others" who have *intentionally* sought to hurt the victims. When a trauma results from war or other ethnic, national, or religious conflict, however, there is an identifiable enemy group who has deliberately inflicted pain, suffering, and helplessness on its victims. Such trauma affects large-group (i.e., ethnic, national, or religious) identity issues in ways entirely different from the effects of natural or accidental disasters.

A closer look suggests that it is sometimes difficult to discriminate between different types of disasters. For instance, the massive August 1999 earthquake in Turkey which killed an estimated 20,000 people was obviously a natural

disaster. But it is also an example of a man-made accidental catastrophe: many of the structures that collapsed during the earthquake had not been built according to appropriate standards. Further, it became known after the quake that builders had bribed certain local authorities in order to construct cheaper, unsafe buildings.

Incidentally, among the most interesting effects of that earthquake was that the disaster stimulated changes in heretofore durable ethnic sentiments. After the earthquake, rescue workers from many nations rushed to Turkey to help—among them Greeks. By publishing pictures and stories of Greek rescue workers, Turkish newspapers helped to "humanize" the Greeks as a group, who for decades had generally been perceived as an "enemy." Indeed, only a few years before the quake, Turkey and Greece had almost gone to war in a dispute over some rocks (Kardak/Imia) near the Turkish coast (Volkan, 1997). The Turkish disaster and the earthquake in Greece the following month actually initiated a new relationship between the two nations—what is now referred to as "earthquake diplomacy" in many diplomatic circles.

A closer look at this softening of the relationship between Turkey and Greece after the earthquakes shows that it is motivated by deep, mostly unnoticed, psychological dynamics. The shared aggressive fantasies that go along with enmity or opposition have not gone away, rather they are covered over by an apparent shared reaction formation—at the large-group level, the generosity provoked by the death of thousands of members of the "enemy" group is actually at root a defense mechanism. This seemingly negative unconscious motivation does not take away from the reality of this new closeness, however. The crucial issue is whether this closeness can be sublimated. Some recent events indicate that the brotherly feelings engendered by the earthquakes may be threatened, but only time will tell to what extent this "togetherness" can be institutionalized. (For more details on what I call the "accordion phenomenon," see Volkan, 1999d.)

Although massive disasters like the Turkish earthquake may sometimes fall into several categories at once, it remains useful to differentiate between them because those that are due to ethnic, national, or religious conflicts—including wars and war-like situations—are the only ones that can trigger a particular large-group identity process. This process is perhaps most easily imagined as a cycle: Disasters deliberately caused by other groups lead to massive medical/psychological problems. When the affected group cannot mourn its losses or reverse its feelings of helplessness and humiliation, it obligates subsequent generation(s) to complete these unfinished psychological processes. These transgenerationally-transmitted psychological tasks in turn shape future political/military ideological development and/or decision-making. Under certain conditions, an ideology of entitlement to revenge develops, initiating and/or contributing to new societal traumas: the circle is, sadly, completed. Diplomatic efforts, political revolutions, and changes in the identity of the large group may all contribute to interrupting this sequence; later in this paper, I will suggest a special role for mental health workers in breaking the cycle of the traumatized—and traumatizing—society.

Societal processes after disasters caused by "others"

All types of massive disaster have psychological repercussions beyond individual PTSD. Indeed, the fact that natural or man-made disasters evoke societal responses has long been known. If the "tissue" of the community (Erikson, 1975) is not broken, however, the society eventually recovers in what Williams and Parks (1975) refer to as a process of "biosocial regeneration" (p. 304). For example, for five years following the deaths of 116 children and 28 adults in an avalanche of coal slurry in the Welsh village of Aberfan, there was a significant increase in the birthrate among women who had not themselves lost a child.

The impact of some accidental man-made disasters is much wider. Again, the nuclear accident at Chernobyl, with at least 8,000 deaths (including 31 killed instantly), provides a representative example. Anxiety about radiation contamination lasted many years, and with good reason. But these fears

exercised a considerable impact on the social fabric of communities in and around Chernobyl. Thousands in neighboring Belarus, for example, considered themselves contaminated with radiation and did not wish to have children, fearing birth defects. Thus the existing norms for finding a mate, marrying, and planning a family were significantly disrupted. Those who did have children often remained continually anxious that something "bad" would appear in their children's health. Here, instead of an adaptive biosocial regeneration, society reacted with what might be termed a "biosocial degeneration."

Biosocial regeneration and degeneration are also observable after disasters due to ethnic or other large-group hostilities. A somewhat *indirect* biosocial regeneration occurred among Cypriot Turks during the six-year period (1963-1968) in which they were forced by Cypriot Greeks to live in isolated enclaves under subhuman conditions. Though they were massively traumatized, their "backbone" was not broken because of the hope that the motherland, Turkey, would come to their aid. Instead of bearing increased numbers of children like the inhabitants of Aberfan, they raised hundreds and hundreds of parakeets in cages (parakeets are not native birds in Cyprus)—representing the "imprisoned" Cypriot Turks. As long as the birds sang and reproduced, the Cypriot Turks' anxiety remained under control (Volkan, 1979). The art and literature stemming from the Hiroshima tragedy (Lifton, 1968) might also be considered a form of symbolic biosocial regeneration. In the case of Hiroshima, however, the society also exhibited biosocial degeneration and showed "death imprints" for decades after the catastrophe; the society's "backbone" was in fact broken, and biosocial regeneration could only be limited and sporadic.

What primarily differentiates catastrophes due to ethnic conflict from natural or man-made disasters is that, in the former, societal responses can last in *particular, uniquely damaging* ways for generations: the mental representation of the disastrous historical event may develop into a "chosen trauma" for the group (Volkan, 1997, 1999a, 1999b). The "memories," perceptions, expectations, wishes, fears, and other emotions related to shared images of

the historical catastrophe and the defenses against them—in other words, the *mental representation* of the shared event—may become an important identity marker of the affected large-group. Years, even centuries, later, when the large-group faces new conflicts with new enemies, it reactivates its chosen trauma in order to consolidate and enhance the threatened large-group identity. The mental representation of the past disaster becomes condensed with the issues surrounding current conflicts, magnifying enemy images and distorting realistic considerations in peace negotiation processes. I will return to these mechanisms of transgenerational transmission and reactivation of chosen trauma later in this paper.

Initially, when a large group's conflict with a neighboring group becomes inflamed, the bonding between members belonging to the same group intensifies. There is a shift in members' investment in their large-group identity; under stressful conditions, large-group identity may supercede individual identity. This movement exaggerates the usual rituals differentiating one group from the other. As the two groups enter "hot" conflict, the relationships between people in each group become governed by two obligatory principles: 1) keeping the large-group identity separate from the identity of the enemy; 2) maintaining a psychological border between the two large groups at any cost (for details see, Volkan, 1988, 1997, 1999c). When large groups are not the "same," each can project more effectively its unwanted aspects onto the enemy, thereby "dehumanizing" (Bernard, Ottonberg and Redl, 1973) that enemy to varying degrees. After the acute phase of the catastrophe ends, however, these two principles may remain operational for years or decades to come. Anything that disturbs them brings massive anxiety, and groups may feel entitled to do anything to preserve the principles of absolute differentiation—which, in turn, protects their large-group identity. Thus hostile interactions are perpetuated. When one group victimizes another, those who are traumatized do not typically turn to "fate" or "God" (Lifton and Olson, 1976) to understand and assimilate the effects of the tragedy, as in a natural disaster. Instead, they

may experience an increased sense of rage and entitlement to revenge. If circumstances do not allow them to express their rage, it may turn into a "helpless rage"—a sense of victimization that links members of the group and enhances their sense of "we-ness." We see the tragic results of this cycle across the globe.

Diagnosing societal processes after large-group hostilities

The methodology for diagnosing societal shifts resulting from a population's shared psychological changes after large-group hostilities is relatively new; I first began developing it during work in Northern Cyprus after the Turkish Army divided the island of Cyprus into *de facto* Northern/Turkish and Southern/Greek sectors in 1974 (Volkan, 1979). Diagnostic work carried out by members of the Center for the Study of Mind and Human Interaction (CSMHI) in Kuwait three years after that country's liberation from Iraqi occupation provides a more recent and refined example of the methodology (see the article by Thomson in this issue, as well as Howell, 1993, 1995; Saathoff, 1995, 1996; Volkan, 1997, 1999a).

In 1993, a CSMHI team made three diagnostic visits to Kuwait under the directorship of Ambassador W. Nathaniel Howell (Ret.), who, as US ambassador to Kuwait during the Iraqi invasion of 1990, kept the Embassy open for seven months during the occupation of Kuwait City. Ambassador Howell and other CSMHI faculty members interviewed more than 150 people from diverse social backgrounds and age groups to learn how the mental representation of the shared disaster echoed in the subjects' internal worlds. The technique of these interviews was based on psychoanalytic clinical diagnostic interviews, in which the analyst "hears" the subject's internal conflicts, defenses, and adaptations. As the subject reports fantasies and dreams, this material adds to the interviewer's understanding of his or her internal world. As can easily be imagined, we found that many Kuwaitis suffered from undiagnosed individual PTSD. Nevertheless, our emphasis in these interviews was not on individual diagnosis, but on discovering shifts in societal conventions and processes.

After interview data were collected, we looked for common themes in the interviews indicating shared perceptions, expectations, and defenses against conflicts created by the traumatic event. These "common themes" may not register in the public consciousness as represented in news, cultural production, etc., but come to light when we observe them in many interviewees. We learned, for example, that young Kuwaiti men's perceptions of Iraqi rapes of Kuwaiti women during the occupation had become generalized, meaning that on some level, they perceived all Kuwaiti women to be tainted. We found, as well, that many young men who were engaged to be married now wanted to postpone their marriages, and that those who were not yet engaged wanted to put off seriously seeking a mate. Because women who have been raped are traditionally devalued in Kuwaiti culture, the generalization of perception was threatening conventions about the age of marriage. While this shift did not pose an actual danger, it did create a measure of societal anxiety.

We found even more direct expressions of societal "mal-adaptation" in post-liberation Kuwait. During the invasion and occupation, many Kuwaiti fathers were humiliated in front of their children by Iraqi soldiers, who sometimes spat on them, beat them, or otherwise rendered them helpless before their children's eyes. In cases where humiliation or torture had occurred away from their children's view, the fathers often wanted to hide what had happened to them. Without necessarily being aware of it, fathers began to distance themselves from certain crucial emotional interactions with their children, especially with their sons, in order to hide or to deny their sense of shame. Most children and adolescents, though, "knew" what had happened to their fathers, whether they had personally witnessed these events or not.

Many school buildings in Kuwait City were used as torture chambers during the Iraqi occupation. When I visited Kuwait City during this project, however, it was hard to believe from looking at schools and other buildings that catastrophe had struck there only three years earlier. Except for a few

buildings with bullet holes that were intentionally left as “memorials” and the highway heading north toward Iraq still lined with destroyed military vehicles, the city appeared completely renovated. Adults did not speak to children about what had happened in the schools during the invasion, but the children knew; and, when they returned to their renovated schools, that “secret” quite naturally caused them psychological problems. The very young—without, of course, knowing why—began to identify with Saddam Hussein instead of with their own fathers. In one telling instance, at an elementary school play staging the story of the Iraqi invasion, the children applauded most vociferously for the youngster who played the role of Saddam Hussein (Saathoff, 1996). “Identification with the aggressor” is the psychoanalytic term for a period in which a child identifies himself or herself with the parent of the same sex with whom the child has been involved in a competition for the affection of the parent of the opposite sex (A. Freud, 1936). In childhood, this process results in a child’s emotional growth. A little boy, for example, through identification with his father, whom he perceives as an “aggressor,” makes a kind of entrance into manhood himself. In other situations, however, like those of many Kuwaiti elementary school children, identification with the aggressor—in this case, Saddam Hussein—can obviously create problems.

The reiteration of the “distant father” scenario in Kuwaiti families thus set in motion new processes across Kuwaiti society. Many male children, who needed to identify with their fathers on the way to developing their own manhood, responded poorly to the distance between themselves and their fathers—resulting, for example, in gang formations among teenagers. Frustrated by the distant and humiliated fathers (and mothers) who would not talk to their sons about the traumas of the invasion, they linked themselves together and expressed their frustrations in gangs. Of course, some degree of “gang” formation is normal in the adolescent passage, as youngsters loosen their internal ties to the images of important persons of their childhood and expand their social and internal lives through investment in “new” object images as

well as in members of their peer group. In the ordinary course of events, however, this "second individuation" (Blos, 1979) maintains an internal continuity with the youngster's childhood investments. For example, the "new" investment in the image of a movie star is unconsciously connected with the "old" investment in the image of the oedipal mother; or, a "new" investment in a friend remains somewhat connected to the "old" image of a sibling or other relative. Humiliated and helpless parent-images necessarily complicated the unconscious relationship between the Kuwaiti youngsters' "new" and "old" investments. Indeed, as we have found in other situations as well, when many parents are affected by a catastrophe inflicted by "others," the adolescent gangs that form after the acute phase of the shared trauma tend to be more pathological. In Kuwait, the new gangs were heavily involved in car theft—a new social process involving the emergence of a crime that essentially had not existed in pre-invasion Kuwait.

The CSMHI team made some suggestions to Kuwaiti authorities based on this research. We proposed a number of political and educational strategies to help the society mourn its losses and changes and to speak openly about the helplessness and humiliation of the occupation in a way that would heal splits between generations as well as between subgroups within Kuwaiti society—such as between those who fought against the Iraqis directly and those who escaped from Kuwait and returned after the invasion was over. When we tactfully presented our findings about children and adolescents to the authorities, however, no action was taken.

Since we now have a technique for evaluating post-traumatic societies (for details, see: Volkan, 1999d), this is an arena in which psychodynamic insights can be useful for non-governmental organizations (NGOs) and the mental health workers associated with them. NGOs that deal with traumatized societies after ethnic or other large-group conflicts need to recognize the shared psychological problems and maladaptive societal changes that may lead to future conflict because of transgenerational transmission.

Transgenerational transmissions

During recent decades, the mental health community has learned much about the transgenerational transmission of shared trauma and its relation to the mental health of future generations. This development owes a great deal to studies of the second and third generations of Holocaust survivors and others directly traumatized under the Third Reich (since there are so many studies on this topic, I will mention only two with which I am extremely familiar: Kestenberg and Brenner, 1996; Volkan, Ast, and Greer, in press). Nevertheless, this mental health issue has not received sufficient consideration from those official international organizations and NGOs who deal with the psychological well-being of refugees, internally displaced individuals, and others who have experienced the horrors of war or war-like conditions. For example, the official joint manual of the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Refugees (UNHCR)(1996) on the mental health of refugees mentions only crisis intervention methods, relaxation techniques, alcohol and drug problems, and professional conduct toward rape victims. Of course, after a disaster, the crisis situation takes precedence over other considerations, but, when the crisis is over, crucial psychological processes continue in full force. The WHO/UNHCR report does not refer at all to the serious issues of societal response and transgenerational transmission following ethnic, national, and religious conflicts. And my own professional experience with the WHO and UNHCR at various troubled locations around the world suggests that these organizations have not yet seriously considered these issues and do not yet plan to develop strategies for preventive efforts to break this cycle of trauma and transmission.

If we want to understand the tenacity of large-group conflict, we must first understand the mechanisms of transgenerational transmission. One of the best-known examples of a relatively simple form of transgenerational transmission comes from Anna Freud and Dorothy Burlingham's (1945) observations of women and children during the Nazi attacks on London. Freud and Burlingham

noted that infants under three did not become anxious during the bombings unless their mothers were afraid. There is, as later studies have established, a fluidity between a child's "psychic borders" and those of his or her mother and other caretakers (see, for example, Mahler, 1968), and the child-mother/caretaker experiences generally function as a kind of "incubator" for the child's developing mind. Besides growth-initiating elements, however, the caretaker from the older generation can also transmit undesirable psychological elements to the child. The same fluidity also occurs in drastic ways among adults under certain conditions of regression, such as after massive shared catastrophes—even after the crisis situation ends and life as refugees, for example, begins.

In Tbilisi, Georgia, I examined a Georgian woman from Abkhazia and her 16-year-old daughter who had been refugees for over four years. The two were living with other family members under miserable conditions in a refugee camp near Tbilisi. Every night, the mother went to bed worrying about how to feed her three teenaged children the next day. She never spoke to her only daughter about her concerns, but the girl sensed her mother's worry and unconsciously developed a behavior to respond to and to alleviate her mother's pain. The daughter refused to exercise, became somewhat obese, and continuously wore a frozen smile on her face. As our team interviewed both of them, we learned that the daughter, through her bodily symptoms, was trying to send her mother this message: "Mother, don't worry about finding food for your children. See, I am already overfed and happy!"

But there are many forms of transgenerational transmission. Besides anxiety, depression, elation, or worries such as those the Georgian woman from Abkhazia presented, there are various psychological tasks that one person may "assign" to another. It is this transgenerational conveyance of long-lasting "tasks" that perpetuates the cycle of societal trauma described above. The well-known phenomenon of the "replacement child" (Poznanski, 1972; Cain and Cain, 1964) illustrates this form of transmission. A child dies; soon after,

the mother becomes pregnant again, and the second child lives. The mother "deposits" (Volkan, 1987) her image of the dead child—including her affective relationship with him or her—into the developing identity of her second child. The second child now has the task of keeping this "deposited" identity within himself or herself, and there are different ways for the child to respond to this task. The child may adapt to being a replacement child by successfully "absorbing" what has been deposited in him or her. Alternately, he or she may develop a "double identity," experiencing what we call a "borderline personality organization." Or, the second child may be doomed to try to live up to the idealized image of the dead sibling within himself or herself, becoming obsessively driven to excel. Similarly, adults who are drastically traumatized may deposit their traumatized self-images into the developing identities of their children. A Holocaust survivor who appears well adjusted may be able to behave "normally" because he has deposited aspects of his traumatized self-images into his children's selves (Brenner, 1999). His children, then, are the ones now responding to the horror of the Holocaust, "freeing" the older victim from his burden. As with replacement children, such children's own responses to becoming carriers of injured parental self-images vary because of each child's individual psychological make-up apart from the deposited images.

After experiencing a group catastrophe inflicted by an enemy group, affected individuals are left with self-images similarly (though not identically) traumatized by the shared event. As these hundreds, thousands, or millions of individuals deposit their similarly traumatized images into their children, the cumulative effects influence the shape and content of the large-group identity. Though each child in the second generation has his or her own individualized personality, all share similar links to the trauma's mental representation and similar unconscious tasks for coping with that representation. The shared task may be to keep the "memory" of the parents' trauma alive, to mourn their losses, to reverse their humiliation, or to take revenge on their behalf. If the next generation cannot effectively fulfill their shared tasks—and this is usually

the case—they will pass these tasks on to the third generation, and so on. Such conditions create a powerful unseen network among hundreds, thousands, or millions of people.

Depending on external conditions, shared tasks may change function from generation to generation (Apprey, 1993; Volkan, 1987, 1997, 1999a, 1999b). For example, in one generation the shared task is to grieve the ancestors' loss and to feel their victimization. In the following generation, the shared task may be to express a sense of revenge for that loss and victimization. Whatever its expression in a given generation, though, keeping alive the mental representation of the ancestors' trauma remains the core task. Further, since the task is shared, each new generation's burden reinforces the large-group identity. As indicated earlier in this paper, I term such mental representations the large group's "chosen trauma." In open or in dormant fashion or in both alternately, a chosen trauma can continue to exist for years or centuries: whenever a new ethnic, national, or religious crisis develops for the large group, its leaders intuitively re-kindle memories of past chosen traumas in order to consolidate the group emotionally and ideologically.

The behavior of Slobodan Miloševi(and his entourage before the Serbs' war with Bosnian Muslims in 1990-1991 and again before the conflict with Kosovar Albanians in 1998 exemplifies this leadership function. By reactivating the Serbs' chosen trauma, the "memory" of the Battle of Kosovo (June 28, 1389), Miloševi(and his supporters created an environment in which whole groups of people with whom Serbs had lived in relative peace as fellow Yugoslavians became "legitimate" targets of Serb violence. As the six-hundredth anniversary of the Battle of Kosovo approached, the remains of Prince Lazar, the Serbian leader captured and killed at the Battle of Kosovo, were exhumed. For a whole year before the atrocities began, the coffin traveled from one Serbian village to another, and at each stop a kind of funeral ceremony took place. This "tour" created a "time collapse." Serbs tended to react as if Lazar had been killed just the day before, rather than six hundred years earlier. Feelings,

perceptions, and anxieties about the past event were condensed into feelings, perceptions, and anxieties surrounding current events, especially economic and political uncertainty in the wake of Soviet communism's decline and collapse. Since Lazar had been killed by Ottoman Muslims, present-day Bosnian Muslims—and later present-day Kosovar Albanians (also Muslims)—came to be seen as an extension of the Ottomans, giving the Serbian people, as a group, the "opportunity" to exact revenge in the present from the group who had humiliated their large group so many centuries before. In this context, many Serbs felt "entitled" to rape and murder Bosnian Muslims and Kosovar Albanians. (For further details of the reactivation of the Serbian chosen trauma and its consequences, see: Volkan 1997, 1999a).

Therapeutic interventions and the need for "psychopolitical dialogues"

When a catastrophe is in its crisis phase, what international organizations such as UNHCR, WHO, the Red Cross, and Red Crescent can do for the people who are affected depends, of course, on the conditions on the ground. It may be dangerous for foreign mental health workers to enter certain zones until a necessary level of safety is assured, which may take some time. Once security has been established and foreign mental health experts arrive on the scene, how they approach traumatized persons is well-documented in the WHO/UNHCR manual (1996) mentioned above.

But security issues, searches for relatives, and military, paramilitary, and propaganda interests sometimes take unnecessary precedence over direct psychological health concerns. When Finnish psychiatrist Henrik Wahlberg, representing the WHO, arrived in Macedonia to assist Kosovar refugees following the NATO bombings in 1998, he found that, since the bombing had stopped, refugees were ready to return to Kosovo *en masse*. They wanted to return to their homes, to find out what had happened to their lost relatives and to houses, farms, and businesses left behind. They gave little or no thought, at this point, to seeking psychiatric help. When the road from Skopje, Macedonia to Pristina, Kosovo had been secured, Dr. Wahlberg visited a mental hospital in

the Kosovo capital that was still manned by Serbian psychiatrists and staff—but there were no patients in residence. When Dr. Wahlberg revisited the hospital the next day, he found that the Serbian doctors and staff had been forcibly replaced by Kosovar Albanian doctors who sat in locked offices, protected by armed guards. But still no one was being treated there.

I believe that NGOs—and those foreign psychiatrists, psychologists, or social workers associated with such organizations—can help indigenous mental health workers in two ways. First, they can train these local caregivers through lectures, seminars, and workshops. In the course of CSMHI's work in traumatized societies such as Northern Cyprus, Kuwait, the former Yugoslavia, and the Republic of Georgia, we have seen evidence that NGOs have been very effective and helpful in providing this intellectual, consultative, and supervisory help to local health care workers. This is no small task indeed, since in a given crisis area there may be only a few previously trained psychiatrists, psychologists or similar professionals—or none at all. We found just such a situation in South Ossetia (within the legal boundaries of the Republic of Georgia), where foreign mental health care workers—some of whom, in fact, belonged to the former enemy ethnic group—had come to help teachers and parents understand the concept of psychological trauma.

Providing intellectual support, however, is *not* enough. I propose that, to be truly helpful, foreign psychiatrists, psychologists, and social workers must consider a second, concurrent approach, one that is often bypassed in war-torn areas: outside experts must, from the first, pay attention to local mental health workers' own psychological needs. Without working out their own internal conflicts concerning ethnic or other large-group conflict, indigenous workers will not be fully able to help their own people, however high the quality of the consultative and supervisory aid they receive from foreign workers.

I met one Bosnian psychiatrist who, having survived the 1993 siege of Sarajevo, found herself "paralyzed" in the work of treating the PTSD population when peace finally arrived. The months-long siege by Bosnian Serbs was a massive

catastrophe in itself. About 11,000 residents of Sarajevo were killed, and an estimated 61,000 were wounded. Everyone, including mental health workers, was traumatized. Three years before I met her, this psychiatrist had begun to experience a symptom that was still with her when our paths crossed: before going to sleep or upon awakening, she would check her legs to see if they were still attached to her body. When I examined the meaning of the symptom with her, we discovered that it was connected to an incident during the siege: she had rushed to the hospital one night, fearing that she might be shot any moment by a stray bullet, and had seen there a young Bosnian man whom she had known before the ethnic troubles began. The young man's legs had been smashed in a bomb explosion, and they had to be amputated, an operation that she witnessed. This incident, for personal psychological reasons, came to symbolize the tragedy of Sarajevo for her. Unconsciously, she identified with this young man. Instead of recalling the tragedy by experiencing appropriate emotions, she was remembering only her own horror of being under enemy attack, day after day. Because of her unconscious fear of experiencing these terrible feelings, she could not fully help her patients experience their emotions in the therapeutic setting or relieve them of maladaptively repressing or denying what had happened to them. A few months after I brought the connection between her symptom and her identification with the young man to her attention, however, her symptoms disappeared.

In bloody ethnic or other large-group conflicts, those who are not directly physically affected are nevertheless psychologically affected by the group's trauma. As mentioned previously, the eruption of large-group conflict strengthens the emotional links among individuals who belong to the same group. Under these circumstances, even a person who was not directly affected tends to experience feelings—ranging from group pride and a sense of revenge-entitlement to group shame and humiliation and helplessness—in common with the other members of the group; these are inherently collective feelings. The

loss of people, land, and prestige affects everyone—including indigenous mental health caretakers—in a victimized large group.

A young Croatian psychiatrist who was not directly traumatized during the Croatian-Serbian war was assigned to work in a hospital in Vukovar, a border city between today's Croatia and Serbia, after peace was established. During the war, the Serbs had sacked Vukovar as residents of Croatian origin fled inland; today, Vukovar is a Croatian city, though most of its residents are of Serbian ethnicity. Thus the young Croatian psychiatrist was proud to be assigned by his Ministry of Health to work in Vukovar, and he thought it his national duty to help to change the emotional atmosphere of the city so that Croatian former residents would want to return. His sense of ethnicity was thus highly intensified, though not in any specifically prejudicial way, when he arrived in Vukovar. His colleagues, who were of Serbian origin, also wanted to demonstrate their good will toward the newcomer, and so addressed him by his first name. Soon, however, working daily with colleagues who spoke to him as if nothing had happened between their ethnic group and his began to infuriate the young Croatian psychiatrist. Further, he believed that one of them had been involved in making an "extermination" list of Croatian hospital patients when Serbian forces were attacking the city; he felt like a traitor for working with this person. Therefore, when treating his PTSD patients in the Vukovar hospital—most of whom were Serbian, and only a small number Croatian—he found himself confounded, to a great extent, in his function as a mental health caretaker. Though not personally traumatized during the conflict, this doctor needed to work through his feelings associated with belonging to the traumatized group in order to further, in his professional work, the task of reconciliation he consciously so much wanted to support.

But it is not enough to help a traumatized large group's mental health professionals to work through personal ethnic sentiments that interfere with constructive, realistic interaction with patients. Besides taking care of persons with individual PTSD and working through their own responses to trauma,

indigenous mental health workers may also play a very important role (when politics permit) in helping their societies to confront the societal effects of shared psychological response to large-group trauma. Indeed, indigenous psychiatrists, psychologists, and social workers may even be able to develop and to enact strategies to interrupt the vicious cycle of transgenerational transmission. CSMHI-sponsored conversations between prominent Estonians and Russians resulted in a variety of concrete actions. After the dialogues, participants became involved in such activities as writing psychologically-informed, tension-reducing articles for local newspapers, revising schoolbooks to change images of the "enemy" group, cultivating realistic public debate, etc. NGOs and associated foreign mental health workers can similarly help indigenous professionals to find psychologically useful and politically tactful strategies to bring their newly-gained insights to the public arena (see Apprey article in this issue and Volkan, 1999d).

At present, the possibilities for engaging indigenous mental health workers in such activities remain mostly theoretical—perhaps, indeed, mostly wishful thinking. Nevertheless, CSMHI has recently participated in a promising experiment in the Republic of Georgia. For more than two years, we have been collaborating with Georgian psychiatrists and psychologists who belong to the Tbilisi-based Foundation for the Development of Human Resources (FDHR) and with South Ossetian teachers/psychologists at the Tskhinvali-based Youth Palace in a project of "preventive medicine" for their traumatized societies.

Soon after the Republic of Georgia regained its independence from the Soviet Union, civil war erupted between Georgians and South Ossetians as the latter group began to take steps towards its own independence. Since the cease-fire in 1992, there has been little further violence between Georgians and South Ossetians, but no political solution has yet emerged. Our program was intended to help indigenous child-care workers to explore their own traumas so that they could be better caregivers and perhaps help to prevent the children from carrying the trauma's influence into adulthood and transmitting it to future

generations. Ninety traumatized South Ossetian children in Tskhinvali (capital of South Ossetia), ranging in age from eight to fifteen, met weekly in small groups of 20 with teachers/caretakers to explore their responses to trauma through a technique resembling play therapy.

The need for the teachers and psychologists to address their own responses to the trauma was particularly evident in a session that CSMHI observed in which the South Ossetian children were asked to draw pictures. One of the children drew a small island in the middle of blue water with a tree on it. On the highest point of the island, a stick figure stood shouting, "Help! Help!" Although this would have been an opening for one of the teachers to ask why the figure was calling for help or otherwise probe what appeared to be an expression of helplessness, no one did so. Another drawing, illustrating a story that the children were inventing, depicted a person who arrives on an island and sees a boatload of other people and wants to fight them. Such a reference to aggression provoked another child to exclaim, "Even though it is hard to make friends after war, we want peace!" and the group moved on to other topics without exploring the subject further. Throughout the session difficult feelings were either ignored or suppressed. Later, in a debriefing after the children had left, one of the instructors admitted that she was afraid to touch on painful topics such as aggression and helplessness. When a CSMHI team member inquired as to what happened to the children's aggressive feelings, the instructor responded "It is too much for the teachers to talk about painful things, so we do not let the children talk about them either."

I later learned the story of this young South Ossetian teacher/psychologist, and how her own experience in the war both motivated and paralyzed her. During the conflict in Tskhinvali, Lia (not her real name) was among 20 children and teenagers sent away from the fighting to safety in Russia as part of a humanitarian aid program sponsored by an international organization. When the organization representatives approached her mother, they said she could only send one of her children. The fact that Lia was chosen by her mother to be

"saved" caused her a type of survival guilt both during the war and long after it. All during her four month "exile," she was acutely aware that her mother had chosen her over her sister, and she fantasized that her mother and sister were both killed in the conflict. Although both mother and sister lived through the war unharmed, Lia's guilt, now internalized, was all consuming and eventually transformed into a feeling that no one would like her. She again "abandoned" her family to attend a university in Russia. Now, returned to Tskhinvali once again and still convinced that she was unlikeable, she was driven to help others, to help the children. Paradoxically though, if the children she was working with talked about their experiences of helplessness and terror (which they needed to do to recover from the trauma), Lia's guilt over having been "chosen" to be spared the dangers of the war became overwhelming. Consequently, she, and other helpers too, could not bear to encourage the children to discuss openly their painful experiences. This outpouring of her story to me was the first time she had unburdened herself of the guilt that plagued her. After that, whenever I went to Tskhinvali, we discussed ways in which she could begin to let go of it, to make peace with her sister and family and become better able to help others deal with such painful feelings.

Despite the teachers' own challenges, the South Ossetian youth program was a success for the children who participated in it. Its impact is reflected in the fact that no youngster who participated in the program fell victim to prostitution or criminality, two of the major new societal processes particularly affecting youth in South Ossetia since the conflict.

Our program went one step further, however: we sought to develop the Georgian and South Ossetian caregivers with whom we were working into "core groups" working to break the cycle of enmity between the two groups from within each community. Using the concept of "psychopolitical dialogue," a technique developed by CSMHI in work with parliamentarians, political leaders, and other influential members of traumatized societies, CSMHI faculty

organized small group meetings in which the caregivers explored their own ethnic sentiments, rituals, and perceptions of the "enemy" and began to differentiate fantasied expectations of themselves and their enemies from realistic ones. Whenever possible, we also brought together mental health workers from the antagonist groups in small groups for a series of similar dialogues. Though I will not detail here the technique (see Apprey, 1996; Volkan, 1997, 1999a, and, in particular, Volkan, 1999d), we believe that such dialogues may succeed in generating psychological and emotional healing between the two groups from within each.

After less than three years, it is difficult to say yet whether we can significantly affect societal processes and potential transgenerational transmissions in Georgia; "preventive medicine" for traumatized societies is by necessity long-term work. Whether this or any experiment will proceed depends on the continued availability of funds as well as on political considerations and "permissions." Unfortunately, the lack of response that our work in Kuwait received from local authorities is not an isolated instance, and this is one of the major obstacles to the sort of "treatment" for traumatized societies that I would like to encourage. But we know too well the costs of not having the courage to re-open large-group psychological wounds in a therapeutic way before they can develop into what I call chosen traumas. Societal responses to a war or war-like situation may not appear for years after the shared trauma, and the connection of present problem to past cause is often lost. Societies are often puzzled by the symptoms that emerge, and may develop incorrect and/or inadequate explanations. Since the actual cause remains unknown, attempts to counter its effects are easily frustrated or may even worsen the situation. Involving indigenous mental health workers as "healers" of maladaptive results of societal changes and transgenerational transmissions theoretically makes a great deal of sense. But the appropriate international organizations must sanction and support the practice for it to

receive the methodological development and scale of field testing it richly deserves.

Summary

While we have amassed a great deal of knowledge about individual PTSD, we need to remember that, after ethnic, national, or religious hostilities, whole societies change too. Though post-conflict societal changes "piggyback" on physical destruction, economic collapse, and political constrictions, the shared psychological causes also need to be thoroughly explored. The mental health professional should be aware that the help he or she can provide needs to go beyond treatment of individual cases of PTSD. Foreign and indigenous mental health professionals alike can seek a role in developing strategies to break the transgenerational transmissions of trauma and their malignant consequences. Besides being "healers" of traumatized individuals, we, as psychiatrists, psychologists, or other mental health workers, can also look for ways to help administer "preventive medicine" to societies recovering from ethnic, national, and religious conflicts.

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