Visiting Slovenian Refugee Camps: A Lesson in Courage
By Mary Beth Williams, Ph.D.

Bosnia and its refugee problem seemed so far away to a private practitioner/school social worker from Virginia, until I visited three Slovenian refugee centers earlier this year.

Velenje Center is a former student dormitory, a brick building about six stories high. One family occupies each small room, with common bathroom and kitchen areas. Outside Hrastnik, a wooden barracks serves as another refugee center. Townspeople tend the lush gardens surrounding the center, but these areas are off limits to the refugees. The third center, an old, dilapidated military barracks crams many cots into huge, cold rooms with high ceilings and chipping paint. The same faces inhabit each building: expressions of passive, quiet desperation — sometimes masked by a darkly tinged humor — and glimpses of underlying caverns of pain, suffering and loss.

In 1992, the refugees came to Slovenia, some 70,000 in 28 camps run by the Slovenian government. Today they number 29,000, mostly children and teenagers. When the camps were created, unemployed persons, with no social work, psychology or organizational development training, were thrust into the positions of center directors and staff. The directors earn low salaries and have no financial or emotional support to help them cope with burnout and compassion fatigue.

The Bosnians who reside in the camps cannot work legally, and thus a black-market economy is their only means to earn extra money. In Ribnica, the widows of Srebrenica knit beautiful sweaters, which they sell to boutiques.

In July 1995, the Bosnian Serbs began to overrun and destroy Srebrenica and surrounding cities. A Newsweek article (Apr. 15, 1996) describes the abandonment of the Bosnians by the Dutch troops and subsequent massacre of at least 8,000 people — perhaps as many as 12,000. Each village in the area tells horror tales of boys as young as 12, men and the elderly being systematically executed and their homes looted and destroyed. The wives, mothers, sisters and children of these victims wait in vain for them to escape and flee to the refugee camps.

Generally, the response of the women refugees, mostly widows, is one of passivity. With no opportunity to work except black-market jobs, and little education (many are illiterate), they have no idea of what the future holds. Most were homemakers. Their homes were either destroyed or ransacked, or are now in Serb-occupied territories. Many want to return to Bosnia. Others wish to stay in Slovenia or emigrate elsewhere. But how? Where? To whom? The elderly ex-

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Taking Trauma Theory to the Streets
By Sandra L. Bloom, M.D.

If you’re old enough to remember 1960s, you may recall an organization called Physicians for Social Responsibility (PSR). Founded in 1961 as a physician-based antinuclear group, PSR grew to encompass an international scope and was awarded the Nobel Peace Prize in 1985. When the Cold War ended, so too did large-scale concern about nuclear weapons, and PSR membership declined.

I was invited to join PSR in 1993 as our local chapter in Philadelphia was reorganizing to focus on urban anti-violence programming. I am now president of the Philadelphia chapter. Most of the work, however, is done by three dedicated staff members — one physician and two social workers who have embraced trauma theory and work towards implementing several projects with that knowledge as a foundation. Although our name suggests that the membership is comprised of physicians, in actuality, various health-care professionals offer their services, and we have successfully built important local coalitions.

Trauma theory provides us with a coherent framework around which we have developed several programs that are beginning to have a positive impact on our community.

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We began by convening a psychosocial task force to gather materials that would serve as a basis for a speakers’ bureau, a public education format long used by PSR for its anti-nuclear campaign. Psychologist Michael Reichert and I wrote “Bearing Witness: Trauma and Social Responsibility,” a manual that can be used by members of PSR, policy makers, social service providers, criminal justice workers and anyone else looking for a relatively nontechnical framework for understanding the effects of overwhelming stress.

In this monograph we supply some epidemiological data about violence and then explore forces in the society that increase the likelihood that violence will occur, like corporal punishment, sexism, gender roles, poverty, racism and social stress. We look at how our society actively supports violence through firearms, substance abuse, pornography and the media, and then review the ways we socially respond to violence through our attitudes towards crime and punishment, our failure to protect and a mindset that leaves us alienated from our own feelings. We then review some protective factors that increase the potential for resilience. We present a summary of trauma theory and in the last section we make suggestions for social reorganization. These include emergency measures that may be necessary to provide more social safety and longer-term changes that may be necessary if we are to change as a whole society. We hope to have the monograph published later this year.

Using these ideas as a basis, our executive director pulled together a coalition of more than 35 community and medical organizations to form the Philadelphia Family Violence Working Group. In 1994, the William Penn Foundation offered a three-year grant to this working group to provide domestic violence training as well as other violence prevention programs to 12 community health centers.

This program is called the RADAR Training Model and each training begins with a presentation on the basics of trauma theory. A videotape was produced focusing on trauma theory and the tape has been made available to local and national service organizations interested in violence prevention. The RADAR model is one of 10 domestic violence programs chosen from around the country to be featured in a “State of the Art Health Care Response Manual” due for publication this year.

We have also been asked to provide the RADAR training to several local HMO providers and recently convened a session that was attended by a capacity audience of more than 300 area medical students. In June we will be expanding our training to include a child abuse module. We are also beginning to develop a program to address the prominent issue of secondary traumatic stress that appears to a significant liability for clinicians practicing in high-risk, high-demand urban environments.

In collaboration with two community health centers and three foundations, we started the “Peaceful Posse” program at two Philadelphia public housing developments. Led by a clinician familiar with the community, the Peaceful Posse is an intervention for preadolescent boys aimed at generating attitudes, knowledge and behavior that will alter patterns of violence. We are adding a component to this project that will include the boys’ primary caregivers in the program.

For the past several years, PSR has also been involved in a program called the Health Academy Service Project which provides a multi-institutional mentoring program between area medical students and at an inner city high school. Our task force on firearm violence is in the process of planning a program to implement recommendations made by the American Medical Association, the American Academy of Pediatrics, and the American College of Physicians aimed at reducing gun violence. We are also joining with the Philadelphia Society for Services to Children to organize the 1996-1997 Children’s Peace Rally. We have also begun to develop collaborations with various regional organizations, including Operation Peace, the Standing Committee on Public Affairs of the Philadelphia County Medical Society, the Health Committee of the Board of Education of the School District of Philadelphia, the Health Organization Committee of the Cultural Environment Movement, and the Domestic Violence Coalition.

I feel that our knowledge about the effects of trauma provides a much needed model for understanding the short and long-term effects of violence that is the plague of our cities. It is extraordinarily gratifying to take this knowledge to the streets and watch an audience of in-the-trenches workers light up with the recognition that someone is speaking a language they understand and that relates directly to their immediate experience.

The cross-fertilization between researchers, clinicians, administrators and activists that is such a vital part of ISTSS membership is what has allowed this to happen, and I hope this will inspire other members to “take it to the streets” in their own towns and cities. The pay may not be much but the rewards are immense. It is, after all, an investment in our future.