DOCUMENT RESUME

ED 458 499 CG 031 390

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TITLE Prevention and Intervention of Ethnopolitical Conflict.
PUB DATE 2001-08-00
NOTE 37p.; Paper presented at the Annual Meeting of the American Psychological Association (109th, San Francisco, CA, August 24-28, 2001).
PUB TYPE Opinion Papers (120) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Clinical Psychology; Conflict Resolution; Cooperation; Counseling; Counseling Theories; *Counselor Role; *Cultural Pluralism; Ethnicity; *Ethnology; *International Relations; Models; *Peace; *Prosocial Behavior; Sociocultural Patterns

ABSTRACT

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Prevention and Intervention of Ethnopolitical Conflict

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Abstract

The field of psychology has offered a number of theories to explain the phenomenon of ethnopolitical conflict. Some psychologists have taken aspects of these theories from the research laboratory and have begun to develop and implement strategies for clinical application. In this regard, this paper suggests three distinctive roles for clinical psychologists, at three stages of ethno-political conflict, providing a continuity of care model that employs an adaptation of Ivan Boszormenyi-Nagy's Contextual Family Therapy approach as an overarching model for ethical intervention. The applicability of the contextual approach lies in its focus on addressing each stage of conflict through constructive dialogue and due consideration. Under the umbrella of this approach the author suggests that clinical psychologists, through careful coordination of their roles as policy liaison specialists, community consultants, and direct service providers, can take an active role as members of multidisciplinary teams in making a valuable contribution in the pursuit of peace and the prevention and mediation of ethnopolitical conflict.

Prevention and Intervention of Ethnopolitical Conflict

In the Preamble of the United Nations Charter are the words "Since wars begin in the minds of men it is in the minds of men that the defenses of peace must be constructed" (as cited in Allport, 1950; Mayor 1995). Volkan (1990) argues that psychoanalysts and psychologists with a knowledge of depth psychology can be useful in creating the healing atmosphere that is necessary for the management and/or resolution of conflicts; especially "of the chronic type of conflict, in which the psychological pull of ethnic and national rituals becomes most stubborn and is an impediment to the peace process" (p.221).

Pear (1950) suggests, "that all causes of war are ultimately mental, since if not experienced by someone, they do not exist." The unfortunate reality of many of the world's violent conflicts is that not only do they reflect the breakdown of civil society, but they often generate untold suffering and devastation to unarmed or poorly armed civilians (Cairns & Darby, 1998; Comas-Diaz, Lykes, & Alacron, 1998; Rouhana & Bar-Tal, 1998; Puhar, 1993; Emminghaus, Kimmel, & Stewart, 1997; Ross, 1997; Dutter, 1987; Staub, 1989, 1996).

Traditionally, the role of clinical psychology has been to conduct research into the etiology of psychopathology, and to provide diagnostic assessment and treatment of psychological disturbances. As clinical psychology has developed professionally as an applied science, it has contributed greatly to our understanding of human behavior. A unique characteristic of clinical psychology is, that unlike professionals in the fields of public policy and diplomacy, clinical psychologists routinely practice as members of multidisciplinary treatment teams. By working collaboratively with other professionals

the clinical psychologist is able to afford the patient a "continuity of care". It is the belief of the current author that one area in which the current field of international diplomacy has fallen short is in the provision of a continuity of care in regions that are experiencing what appears to be intractable ethno-political conflict. There may be many reasons for this, e.g., economic constraints, domestic and global political considerations, or other potential "market based" concerns. However, as the international community is learning in the Balkans, providing peacekeepers and promises of economic assistance alone are not sufficient to manage the psychological pull of ethnic and national rituals that can impede the process of peace.

Saunders (1994), in commenting on former UN Secretary General Boutros Boutros-Ghali's 1992 "Agenda for Peace" suggested that "If we are to focus on either the prevention of violent conflict or the building of constructive relationships in a postconflict environment, a political...approach to conflict is essential." He defined the word political as "what happens when people in a community organize themselves to deal with their problems." Saunders (1994) states that the focus, if we intend to prevent violent conflict and build constructive relationships, should be on the "politics of changing relationships." Pfaff (1996) has suggested that the flexibility of social networks and of interpersonal loyalties that they command can help account for the often-rapid emergence of protest actions, even in an authoritarian system. Evidently, a key to understanding and preventing conflict is in the understanding of relational dynamics, which obviously includes past (historical accounts), ongoing conflict, and past and current attempts at conflict resolution. An understanding of relational dynamics is an important component in the mediation and prevention of armed conflict, as well as a

crucial component for the development of ethical and dialogically oriented initiatives for reconstructing post-conflict societies.

This purpose of this paper is to suggest three distinctive roles for clinical psychologists, at three stages of ethno-political conflict, providing a continuity of care model that employs Boszormenyi-Nagy's Contextual Family Therapy approach (Boszormenyi-Nagy & Sparks, 1971; Boszormenyi-Nagy & Krasner, 1980, 1986; Boszormenyi-Nagy, 1985; Goldenthal, 1996) as an overarching model for ethical intervention.

The first role proposed, policy liaison specialist (Tetlock & McGuire, 1986), functions at the level of national and international leadership. The role involves conflict potential analysis, consultation on issues of public policy formulation and implementation, and conflict mediation and resolution strategy development. The second role, community consultant, building upon the role of policy liaison, involves the implementation of specific policies at the national and local level through collaboration with religious, educational, local governing bodies, and other societal and community based institutions. These strategies include educating for peace, the creation of ethical community support programs, and establishing training and educating indigenous educators, mental health, and social service professionals. Additionally, the community consultant may consult with public and private media in an effort to eliminate discriminatory practices or provocative material from making its way into mainstream media sources and to encourage the development of programming designed to facilitate and encourage multi-ethnic community reconciliation, reconstruction, cohesiveness, and cooperation. The third role is that of direct service provider. This role encompasses the

traditional role of clinical psychology, and suggests an orientation toward treatment that attempts to address the socio-political, as well as the psychological dimensions contributing to difficulty in post-conflict adjustment and associated psychopathology frequently prevalent in the treatment of survivors of violent ethno-political conflict.

The Contextual Model

The Contextual approach is organized around four overlapping relational dimensions: Dimension I- Objectifiable Facts or History; Dimension II- Psychology; Dimension III- Systems of Transactional Patterns or Relational Dynamics; and Dimension IV- Ethical Relating. The Contextual ordering of relational dimensions is a useful construct for understanding the factors influencing the movement of disputant groups from the pre-conflict stage of nonviolent civil protest and of diplomatically dissenting voices to the stage of open armed conflict.

Carl Jung (1933) once stated in a discussion on neurosis that "The causes of a neurosis lie in the present as well as in the past; and only a still existing cause can keep a neurosis active. A man is not tubercular because he was infected twenty-five years ago with bacilli, but because foci of infection are still active today. The questions when and how the infections took place are even quite irrelevant to his present condition. Even the most accurate knowledge of previous history of the case cannot cure tuberculosis" (p. 233). The last sentence of this quote, taken out of the context of the previous three sentences would seem to support the belief of many in the field of international diplomacy and conflict resolution. Symptom reduction occurs by paying attention to present circumstances, situations, and events. While this argument may on the face have merit, it is the contention of this author that whether one is discussing tuberculosis,

neurosis, or ethno-political conflict, deciding the best course of treatment or intervention begins first by taking a detailed history, noting the etiology of symptoms. The history generally comprises information regarding when the symptoms first began to occur, their progression, and their duration. With this understanding the physician may prescribe an analgesic remedy to relieve the patient's suffering which may do little to address the underlying causes of the sufferer's ailment or disease, but does provide the sufferer a degree of relief. As in the case of the flu or the common cold, the medication permits the ailment to run its course unaffected and unimpeded. Effective treatment interventions developed for disease eradication rather than merely symptom reduction must derive from a complete understanding of the course and progression of a particular disorder. In this case the goal is not symptom relief but disease eradication.

In the case of human relationships, Boszormenyi-Nagy (1986) states, "Unlike the etiology of a disease like cancer, for example, the underlying substrate of this pathology is not a scientifically known cause. It is a breakdown of relational resources" (p.205). While knowledge of the history in and of itself may do little to bring about resolution or immediate symptom relief, history may be crucial in understanding in what manner relational resources have broken down (Boszormenyi-Nagy & Sparks, 1973; Framo, 1976; Bowen, 1978; Carter & McGoldrick, 1980; Paul & Grosser, 1965; Rolland, 1989). History may also be useful in understanding what interventions have been tried in the past, how and why the interventions failed, which aspects of past interventions were successful, and what direction treatment should take in the present and future.

A good starting point for the prevention and intervention of the social-pathology herein referred to as ethno-political conflict are the injunctives from Jung (1933) and

Boszormenyi-Nagy (1986) that the cause of present conflicts often does indeed "lie in the present as well as in the past," and that nonviolent conflicts often do escalate into violent conflicts as a result of "a breakdown in relational resources." Contextual theory provides a framework for investigating these important issues.

Dimension I of the order of relational dimensions provides a historical and cultural background through which one may begin to understand the historical legacies underlying the specific relational context of the disputant parties. Through Dimension I, one may notice multiple historical and mythical accounts of injustice and brutality carried out by one group against the other. These accounts reveal a multigenerational cycle of violence, animosity, and mistrust that continues to the present day. These accounts of chosen glories and chosen traumas (Volkan, 1990, 1991) have been passed on from one generation to the next with the understood injunction that to be loyal to one's ethnic group one must remember (Rogers, 1990; Simon & Eppert, 1997). But in addition to reminding one of one's origin and history, they have served to promote not only the remembrance of the nation's accounts of glory and defeat, but also to perpetuate the legacy of a revolving cycle of violence. The troubled history and present day relationships between the Northern Alliance and the Taliban in Afghanistan, the United States and Iraq and much of the Arabic speaking world, Serbs and Albanians, Palestinians and Israelis, Greeks and Turks, Turks and Kurds, is further complicated by the political opportunism of their respective leadership, who in their competition for economic and political resources perpetuate the legacies of intercommunity distrust, scapegoating, and the escalation of violence (Moses, 1990a; Shah, 1994). An understanding of historical events, political entrepreneurism, and ethnic competition over

limited territorial, political, and economic resources, will influence the interventions that may be suggested by clinical psychologists as they carry out their role as policy liaison specialists, community consultants, or direct service providers, and as members of a multidisciplinary team of diplomats, politicians, academicians, clergy, and other social scientists and other help-givers.

Dimension II further elaborates the relational context of the involved parties by providing information concerning the psychological and ideological factors influenced by the relational history of the disputants. Dimension II involves an investigation of the way that each party in a conflict sees themselves and others. It involves the attributions that each side makes toward the other, and is reinforced by the legacy of chosen trauma and chosen glory narratives. Sometimes these attributions may seem to outsiders to be strange or fanciful.

During the period of the war in Bosnia a writer who frequently appeared on talk shows asserted that the Serbs are "the second Biblical people, chosen by God like the Jews but destined forever to be misunderstood and persecuted" (Coleman, 1993). And on the Serbian state-run television another regular guest assured viewers that "at the moment when final destruction threatens the Serbian nation, a fleet of vampires will arise from the cemeteries to overwhelm its enemies...Serbs should stockpile garlic to be sure that the vampires do not mistakenly attack them" (Coleman, 1993). During the first democratic elections in Albania, Dr. Sali Berisha, the Democrat candidate for President of Albania, told viewers on Albania's national television that they should vote for him because "the Democratic Party is God's party, and God hates communists", a reference to the Albanian Socialist Party (Jay & Hutton, 1991). Sometimes rhetoric replaces reason.

Dimension III can provide a context for the assessment of the relational system dynamics obstructing dialogue between the disputant parties. It may also provide valuable insight for the development of intervention strategies to encourage and support the facilitation of constructive dialogue. A key component in mediation and conflict resolution strategies is determining what relational resources are available to facilitate opportunities for constructive dialogue. In addition to the historical background and psychological factors, part of any valid assessment of relational resources includes ascertaining who holds the power, and how that power was acquired, is exercised, maintained, and expanded.

Once the factors of the region's history, psychology, and systems of transaction, have been analyzed and understood, the next challenge is to develop a strategy that may ultimately lead to Contextual theory's Dimension IV, or what Nagy (1986) calls "the ethic of due consideration," and I refer to as "relational ethics." Ethical relationships occur through the development of constructive dialogue, which is facilitated through the relational stance of multidirected partiality.

Dimension IV provides a context for the ethical acquisition and exercise of the "leadership imperative". This imperative is directed toward the creation of a safe and efficacious environment for restoring ethno-political fairness, for achieving justice, and for the redress of grievances through the active and ongoing process of constructive dialogue. Conflicts of interests are inevitable in all relationships, but especially in economic and politically charged asymmetrical relationships in which one party believes that the party in power has little concern for the interests of its constituents. Ignatieff (1998) quotes Freud as saying that "it is precisely the minor differences, in people who

are otherwise alike, that form the basis of feelings of strangeness and hostility between them" (p.48). Perhaps building on this idea, Boszormenyi-Nagy, et al. (1986) observed that people generally tend to deny the legitimate aspects of the other sides' argument in a disagreement. As a result, in-groups and out-groups are formed. This framing in unipolar terms, e.g., us and them, good and bad, win or lose, victim and victimizer, can promote an atmosphere of fear and uncertainty leading to the dehumanization of one group by another through their portrayal as a savage soulless enemy with immediate malevolent designs that must be guarded against by all means available (Freud 1930, 1931, 1931: Allport, 1950, 1954; Volkan, 1990, Erikson, 1996; Young-Bruehl, 1996). Perhaps this behavior is part of an evolutionary process ingrained in the human animal to aid survival. Unfortunately, a survival defense though it may be, this type of isolation sets up further polarization, reinforces one group's prejudice and scapegoating of the other, promotes distrust and intransigence, and stifles opportunities for constructive dialogue and peaceful resolution of conflict.

One impediment to the facilitation of constructive dialogue is party preparedness. It is often very difficult, both psychologically and politically, for parties who have been polarized by official and unofficial policies, and the escalation of violence, to trust that dialogue will bring about a fair, just, or politically acceptable solution to the conflict. The main strategy of the Contextual approach, multidirected partiality, is important in navigating these obstacles impeding constructive dialogue.

Multidirected partiality involves disputants being directed toward discovering the humanity of the other side and the contributions that one group has made to the wellbeing of the other over time. The multidirected stance is useful and can be supported at all

three stages of conflict: pre-conflict; conflict; and post-conflict. Through the process of multidirected partiality each side of a conflict is encouraged to explore the many complex factors and issues leading each side to take the actions that each has taken that may have led to the escalation of violent conflict, provides each side of the dispute the opportunity to share with the other their experiences of past victimization, their fears, their hopes and dreams of peace, safety, and prosperity for posterity (Volkan, 1990; Saunders, 1994; Kelman, 1979, 1987, 1992, 1997, 1999; Boszormenyi-Nagy, et. el., 1986).

Seeing the other as human, with similar fears, dreams, and expectations for the future begins the process of creating acts of due consideration and the foundation of trustworthiness. The level of trustworthiness and confidence building created through this process then can serve as a resource for the early and later stages of ethno-political reconciliation. Reconciliation begins when one is able to see their antagonists as human beings with fears, hopes, and aspirations similar to their own. Contextual therapy refers to this movement toward reconciliation as part of a rejunctive process. This rejunctive process when individuals or groups who have been cut-off by relational conflict begin to come together for the purpose of working through their differences through ethical engagement and constructive dialogue.

The goal of rejunction is not forgiveness per se, but rather the deconstruction of dehumanizing images of the other as malevolent and evil. Rejunction is not forgiveness for past unfairness, wrongs, or injustices. One would find it quite difficult to forgive Hitler for the war crimes of the 1930's and 40's, Pol Pot for his actions in the 1970's and 80's, or Milosevic for his crimes against humanity in the 1990's. Rejunction is the outcome of finding a meaningful way to re-establish a context in which former enemies

can feel safe and redirect their destructive entitlement into peace promoting activities. Encouraging forgiveness from people who have experienced unimaginable suffering as a result of ethno-political conflict may be unreasonable and unrealistic in the short term.

The chief goal of this approach is to get disputant parties to learn how to engage responsibly and ethically. By engaging the other in a manner that assumes ethical responsibility, one can create an environment of trust in which others may feel safe and able respond in reciprocal fashion. In diplomacy terms this is called confidence building. Ethical engagements are not always based in equality, but rather are based in equitability. That is, Contextual theory recognizes that there are situations in which relationships are asymmetrical because of unequal distribution of power and resources. In asymmetrical relationships there is also a greater responsibility on those at higher levels of power and influence to provide due concern, through the equitable distribution of available and appropriate resources, and to address the needs of their subordinates in a fair and ethical manner. When the dominant leadership fails to meet the obligations of their leadership, the people begin to manifest symptoms of destructive entitlement. These symptoms may begin in the form of non-violent protest, but left unaddressed can quickly escalate to so-called terrorist acts, and then on to all out violent confrontation (Moses, 1990).

Staub (1989, 1993, 1996), Kelman (1979, 1987, 1992, 1997, 1999), Leuba (1942), Peck (1990), Skinner (1985), and Allport (1950, 1954) have stressed the need to begin the reconciliation process at the earliest opportunity through educational programs and inter-group contact. They have also suggested that inter-group contact may be facilitated at a non-governmental level. In a way, this is a bottom-up process. I would suggest that change may be facilitated from a bottom-up process, but it may well require top-down

support. It is not entirely unlikely that a number of indigenous direct service providers, particularly those with previous professional training, by the nature of their education and prestige, may well find themselves in positions of political influence as their communities move in the direction of institutional reconstruction. Ethical policies mandate the provision of treatment and other available needed resources without regard for ethnicity or political affiliation. The foundation for trust and reciprocal due consideration begins with the first ethical and trustworthy inter-ethnic or political group contact.

The purpose of this paper is to present three potential roles for clinical psychologists as members of multidisciplinary teams interested in the prevention and intervention in ethno-political conflict, and to present Boszormenyi-Nagy's Contextual model as an overarching structure for the understanding of relational dynamics and the organization of the three roles herein purposed. For the clinical psychologist this proposal is an expansion of clinical practice reaching far outside of the hospital and outpatient clinic.

Clinical Psychologist as Policy Liaison Specialist

The first distinctive role for clinical psychologists is that of policy liaison specialist. This role may be taken at the pre-conflict, conflict, and post-conflict stages . The pre-conflict stage can be defined as the point when hostilities between disputing groups are beginning to escalate and are reaching the upper limits of a non-violent threshold (see Figure 1 and Figure 2). This may be described as a stage of frustration and simmering discontent. Though the situation may clearly be heating up, it has not yet reached the point of boiling over into armed suppression or militant risk taking behavior. It is at this stage that information gathering and assessment are crucial. Information

collected from various media sources, intelligence organizations, and humanitarian aid and human rights agencies is important for gaining an understanding of facts as they may contribute to growing tensions. Bercovitch (1992, 1996) suggests that information gathered should be three types: the conflict history and its context; each party's status, traits, and objectives; and information on ethno-communal groups and their grievances. With the available information collected, psychologists, as part of a multidisciplinary team, can make an initial assessment and formulate early suggestions as to the best means of mitigating and resolving issues contributing to the escalation of ethno-political conflicts. Some of the factors taken into consideration in the assessment process are the ideological factors influencing the involved parties (Staub, 1989, 1993) as well as the psychological influence of the history of the groups involved.

Psychologists at this stage may function as consultants to policymaking bodies within the system experiencing ethno-political unrest and may help to facilitate inter-group dialogue, take part in mediation and conflict resolution, and contribute to the development of public oriented programs designed to support ongoing dialogue and conciliation (Mayor, 1995; Abu-Nimer, 2000). The initial efforts of bystander nations and humanitarian agencies (Staub, 1989, 1993, 1996) are important at this stage to pre-empt civil protest and disobedience by ethno-political factions from escalating into violent confrontation. Bystanders should be encouraged to speak out and express alarm regarding government-backed police or military forces taking aggressive armed action against innocent and unarmed civilians, as well as about terrorist or guerrilla acts of violence directed against government, religious or cultural institutions. British Prime Minister Tony Blair, in a 1999 speech, was speaking indirectly about bystander activation

when he said "if somebody comes after innocent civilians and tries to kill them en masse because of their race, ethnic background, or religion, and it's within our power to stop it, we will stop it" (McDougall, 1999).

In the early stages of pre-conflict, psychologists, mediators, and other interested parties may join together to persuade the disputant parties to begin constructive dialogue and work toward mutually acceptable non-violent solutions. Third parties can get involved either at the request of one or more of the disputants, or as interested and concerned members of the international community. In the past NATO, OSCE, United Nations, International World Court, the International Red Cross and Crescent, Amnesty International, The Carter Center, and other prominent individuals, humanitarian and human rights organizations have attempted to intervene in conflict torn regions through attempts at mediation, economic incentives, political isolation, and military intervention.

As in the pre-conflict stage, during the conflict stage the clinical psychologist would continue to be involved in the ongoing process of conflict assessment and the development of psycho-political strategies designed to bring about cease-fires and promote constructive dialogue. The conflict stage is the point at which opposing positions in a dispute have reached a level of frustration and polarization that they begin to feel that the only alternative for having their demands addressed is through violent action. Violence may begin with the implementation of government policies directed at silencing disruptive anti-government voices under the guise of routing out "rebel terrorists" through the use of government backed military or paramilitary forces. On the other side, more militant opposition voices may come to believe that the only avenue for bringing about effective change is the armed overthrow of the regime in power. In this

case, the downward spiral toward ethno-political violence would begin with the terrorist actions of armed opposition groups directed against governmental institutions and ethnic, political, religious, and economic groups that support those institutions. By this point, neither party may be interested in beginning a constructive dialogue. Still, the goal of psycho-political strategies is to find or establish opportunities conducive to the facilitation of mediation and conflict resolution through constructive dialogue.

The final point of intervention available to the policy liaison specialist, and one that is perhaps the most crucial for preventing future armed conflict, is the development of policies supporting national reconciliation and the reconstruction of ethically functioning and ethno-politically responsive institutions. The role of psychologists at this level would include post-conflict consultation with political, cultural, religious, judicial, internal mass media, and educational institutions with the goal of building a coalition of consensus for peace and reconciliation. Psychologists would also function as a liaison between well-intentioned humanitarian organizations and civilian and governmental grievance committees. This role would involve the ongoing assessment of community polarization and development of programs and strategies for the re-integration of polarized sectors of the multiethnic communities into a dynamic but non-violent multi-ethno-political civil society (Mayor, 1995). The clinical psychologist's contribution, as consultant and advocate, would be to assist in the development and implementation of humanitarian and educational programs in such a manner as to be sensitive to the psychological trauma of war victims, without perpetuating religious, ethnic and political discrimination, stereotyping, scapegoating, or hatreds.

As policy liaison specialists, psychologists can offer a great deal of expertise

related to understanding and predicting human behavior. This expertise may be valuable for the alleviation of ethno-political tensions, and in the creation of new multicultural institutions that can promote multi-ethnic cooperation and reconciliation.

Clinical Psychologist as Community Consultant

The second role for the clinical psychologist is in the area of program development and education. This role may seem to overlap with that of the policy liaison consultant but is fundamentally different due to its specific level of intervention. As community consultants psychologists would develop and help implement educational, community resource programs, professional training, and community-based treatment programs (Leuba, 1942; Mayor, 1995; Abu-Nimer, 2000). These programs would be implemented and directed at all levels of society without regard for party, religious affiliation, or ethnicity. Community consultants would develop and conduct specialty programs for training indigenous mental health professionals, humanitarian aid workers, and other direct service providers, including peacekeeping forces and their support personnel, diplomatic staff, civil servants, and medical professionals (White, 1998, Savin, 2000).

Training would focus on the implementation of specific strategies for assessing and treating the practical needs of the community, e.g., food, shelter, medical and mental health services. What sets the present approach apart is its emphasis on establishing ethical relations between antagonistic parties at all levels and stages of intervention. Training and community outreach programs should focus on the "legacy of survivorship" and the goal of due consideration and ethical concern through efforts to prevent future generations from experiencing the recurrence of war related traumatization. A key

component of any training program should be a focus on integrating traumatic experiences through validation, emotional and moral support, and providing practical and material assistance and guidance. Programs should be careful not to collude with the victims and survivors of conflicts in such a way as to encourage ethnic scapegoating and inadvertently perpetuating ethnic distrust, division, and plans for retribution. Programs should be culturally relevant and provide opportunities for members of disputing ethnic groups to work and train together in a safe, ethical, and non-political environment.

Programs should promote cultural understanding and ethnic sensitivity among their consumers, and maintain a multidirected stance in the allocation of available resources in ethnically and politically charged areas. The psychologist, as a function of the role as a community consultant, would provide input regarding the development of education programs focused toward laying the groundwork for post-conflict reconciliation and societal healing (Abu-Nimer, 2000). For the medical specialty of psychiatry, working in theaters of armed conflict is not a new area of practice. Psychiatry has provided important services to victims of armed conflict through the presumably neutral and non-partisan auspices of the International Red Cross and Crescent, Doctors Without Borders, United Nations world relief programs, and various other humanitarian and non-governmental organizations (NGO) programs. The clinical psychologist might similarly expand clinical practice outside of the classroom, hospital, or outpatient clinic.

The task of reconciliation begins with the first positive encounter with a professional or paraprofessional from the group that was formally viewed as an enemy. This type of interaction casts the former enemy in a different light. Whereas, prior to this encounter they may have been held with contempt and viewed as malevolent, the former

enemy can now be seen as a concerned caregiver. This change in role and in perspective is beneficial not only for the patient who is learning to trust a former enemy, but also beneficial for the professional caregiver who is gaining credit for their due consideration for another.

Clinical Psychologist as Direct Service Provider

The third role, and one that may be a more traditional role for the clinical psychologist, is that of providing treatment for war and trauma survivors and their families, both in their home country and in areas of resettlement. This level of contribution is separate from the second level in that it involves direct professional clinical intervention by the clinical psychologist with individual survivors and their families. These survivors have been victimized and psychologically wounded by the experiences of war, fleeing from their homes, the loss of relatives and friends, and the dehumanization and uncertainty of resettlement in refugee centers. Some refugee survivors may have been victims of torture, rape, and witnesses to the deaths of loved ones and close associates. Clinical psychology presently has a wealth of proven psychotherapeutic models for the treatment of stress and trauma (Montiel, 2000; Moore & Boehnlein, 1991; Katz, 1982). Clinical interventions, including psychodynamic, family therapy, psychopharmacology, and cognitive-behavioral psychotherapy for the treatment of trauma in refugee populations have been briefly discussed in professional literature (Silove, Tarn, Bowles, & Reid, 1991; Bustos, 1992; Keane, Albano, & Blake, 1992; Basoglu, 1995; Woodcock, 1995; Kudler & Davidson, 1995; Vesti & Kastrup, 1995b, 1996; Weine, Vojvoda, Hartman, & Hyman, 1997). One can also find supporting evidence for the efficacy of other psychotherapeutic paradigms (Figley, 1988; Fischman

& Ross, 1990; Gonsalves, 1992; Gonsalves, Torres, Fischman, Ross, & Vargas, 1993; Morris, Silove, Manicavasagar, Bowles, Cunningham, & Tarn, 1993; Weine & Laub, 1995; Butollo, 1996). Contextual therapy may also be an efficacious psychotherapeutic model for working with traumatized survivors of ethno-political conflict (Kuoch, Miller, & Scully, 1992). Although no therapeutic model fits all cases perfectly, Contextual therapy as a consequence of the non-exclusivity of the model provides a clinical framework that can accommodate specific intervention strategies from the various other prominent therapy models.

In individual terms, the contextual process involves an integration of the individual's past and present experiences which will facilitate the process of coming to terms with the capacity and limitations of the one who has caused harm, as well as one's own possible contribution in that destructive relationship. The focus of therapy should be directed toward this integration to bring personal insight, which includes working through the desire for retribution. This also means directing the client away from scapegoating and perpetuating a legacy of trauma, while providing the space and permission to express anger, loss, grief, and remorse.

Therapeutic interventions should be directed toward establishing a degree of personal integration and environmental mastery. That is, therapy must provide both a safe place and the opportunity for survivors to begin to understand the ways in which their experiences have forever changed them and their perception of the world that they live in. Therapy should be directed toward helping survivors to begin their individual healing process and to help them slowly reenter the community, and to once again have the desire and capacity to work and to love. Therapy should encourage survivors to work

through their bitter fantasies of revenge and retribution in favor of working to create a new society that will sustain civil institutions and will ensure peace and stability for the next generation. Clinical psychologists, as direct service providers trained in the Contextual model, can help families and individuals who have suffered the ravages of armed conflict to re-establish a sense of personal safety and environmental mastery. The therapist helps the patient to begin the process of self-delineation that will ultimately serve the health-promoting function of helping the patient earn a sense of self-validation. This process can assist not only the patient, but can begin to facilitate a bottom-up process of civil reconstruction that serves the needs and begins the healing of the greater community. This process can occur as the survivor begins to reconstruct his or her world in a way that promotes the cause of peace and safety for the next generation.

Clinical psychology presently has a wealth of clinical models for the treatment of stress and trauma. Through the implementation of the model with a well-trained practitioner in the role of direct service provider, the present author suggests that the contextual approach is certainly an efficacious clinical method in the treatment of war-related disorders, but can also provide the groundwork for the bottom-up process of societal reconstruction.

Conclusion

It has been argued that the problems of developing countries are political and economic, and to view them with a psychological lens may be both unproductive and immoral. Further, the problems of the developing world cannot be understood without taking into account historical experiences and the network of material and cultural dependencies inherited from those historical experiences. The argument continues that

no psychologist would be allowed to think about the ways and means of bringing about changes in attitudes and practices of those who control the bulk of the economic resources needed to deal with poverty and injustice (Mehryar, 1984). The realities relating to that argument cannot be disregarded. However, the Contextual model offers an approach that considers the historical experiences (e.g., Dimension I) and the material and cultural dependency or legacies (e.g., Dimensions II and III) that affect a nation's reality. The model also addresses the attitude and practices of those in and out of power (e.g., Dimension IV) with regard to dealing with poverty and injustices.

Though additional research and application is needed to assess the efficacy of the implementation of Contextual theory with larger systems (e.g., governments and governmental agencies), the model remains an important modality for the establishment of interactions that encourage and support dialogue, ethical relation, fairness, and justice between individuals. These outcomes at times appear in short supply in the modern disjointed reality of the new and evolving mechanistic world that encourages a win or lose philosophy, distance, and self-promotion. I believe that, with modification, this model could be useful in establishing common ground between the mutually hostile parties in troubled spots around the globe.

At present there is no empirical evidence to support the efficacy of the Contextual model in applications other than within clinical practice. While this does not serve as a disadvantage for the role of clinical psychologists as direct service providers or community consultants and trainers on issues of mental health or social work, it does raise questions concerning the efficacy of its application in the role of policy liaison consultant.

Certain of the propositions contained in this paper may face opposition from other disciplines within the fields of international diplomacy, economics, and the international industrial military complex, who may view the field of ethno-political relations as solely within their purview and sphere of expertise. Historically, their position may, with some exception, be accurate, however, the exclusivity of the past does not preclude inclusion of other psychology-oriented disciplines in the present or future. The Contextual approach is ideally structured to accommodate and facilitate the cooperative involvement of other professional practices within the domain of ethno-political relationships and policy formation. In fact, an important aspect of the approach in clinical psychological practice is its non-exclusivity of other theoretical models.

Some experts in the field of international relations may argue that there can be no peace as long as there continues to be inequality and inequity in the distribution of resources between the poor, middle class and the wealthy. Economic issues often are at the core of intra-national and international conflict.

Dialogue frequently does not lead to complete agreement on all points of contention, but rather provides insight to each side of a conflict as to which points are shared concerns, and therefore surmountable by mutual accord, and which positions are not shared and require cooperation and compromise. There are psychological and political, as well as economic ramifications of compromised outcomes however, not the least of which are the potential loss of prestige, the appearance of weakness, and the ultimate loss of popular support. These ramifications should not be underestimated, but can be overcome with an appropriate level of international assistance and by the formulation of ethical policies directed toward civil reconstruction.

This paper has suggested three roles for clinical psychologists as members of a multidisciplinary team. Violent ethno-political conflict prevention and intervention are both top-down and bottom-up processes. Leaders sensitive to the psychological and material concerns of their constituents employ a top-down methodology when they develop and implement ethical and equitable public policies that convey due concern and provide a forum for opportunities for constructive dialogue to take place. Constituents themselves contribute to the prevention and intervention of violent ethno-political conflict through a bottom-up process of challenging public policies and traditional practices that marginalize, subjugate, scapegoat, or cause unethical treatment of other ethnic, political, social, or religious groups residing within their communities.

One of the goals of peace psychology is to find ways in which international and intra-national disputes can be mediated through non-violent processes. With the present adaptation of the Contextual therapy paradigm, this paper has provided a theoretical construct for addressing the assessment, prevention, and intervention of violent ethno-political conflict. Clinical psychologists, as members of multidisciplinary teams working collaboratively within the herein described Contextual paradigm, have a valuable contribution to make in the understanding of conflict, and the development of ethical strategies for conflict resolution before the conflict escalates to the level of violence. The degree to which these concepts remain theoretical, and their efficacy in the domain of ethno-political conflict subject to speculation, will be determined by the degree to which the psychological and diplomatic communities are willing to engage in the exercise of taking the theoretical out of the laboratory and into the field of practical application.

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Jay, P. (Producer), & Hutton, J. (Director). (1991). Albanian journey: End of an era. [Film]. (Available from High Road Productions, Inc., 235 Carlaw Avenue, Suite 603, Toronto, Onario M4M 2S5.

Figure 1: The Role of Clinical Psychology as Policy Liaison Specialist, Community Consultant, and Direct Service Provider

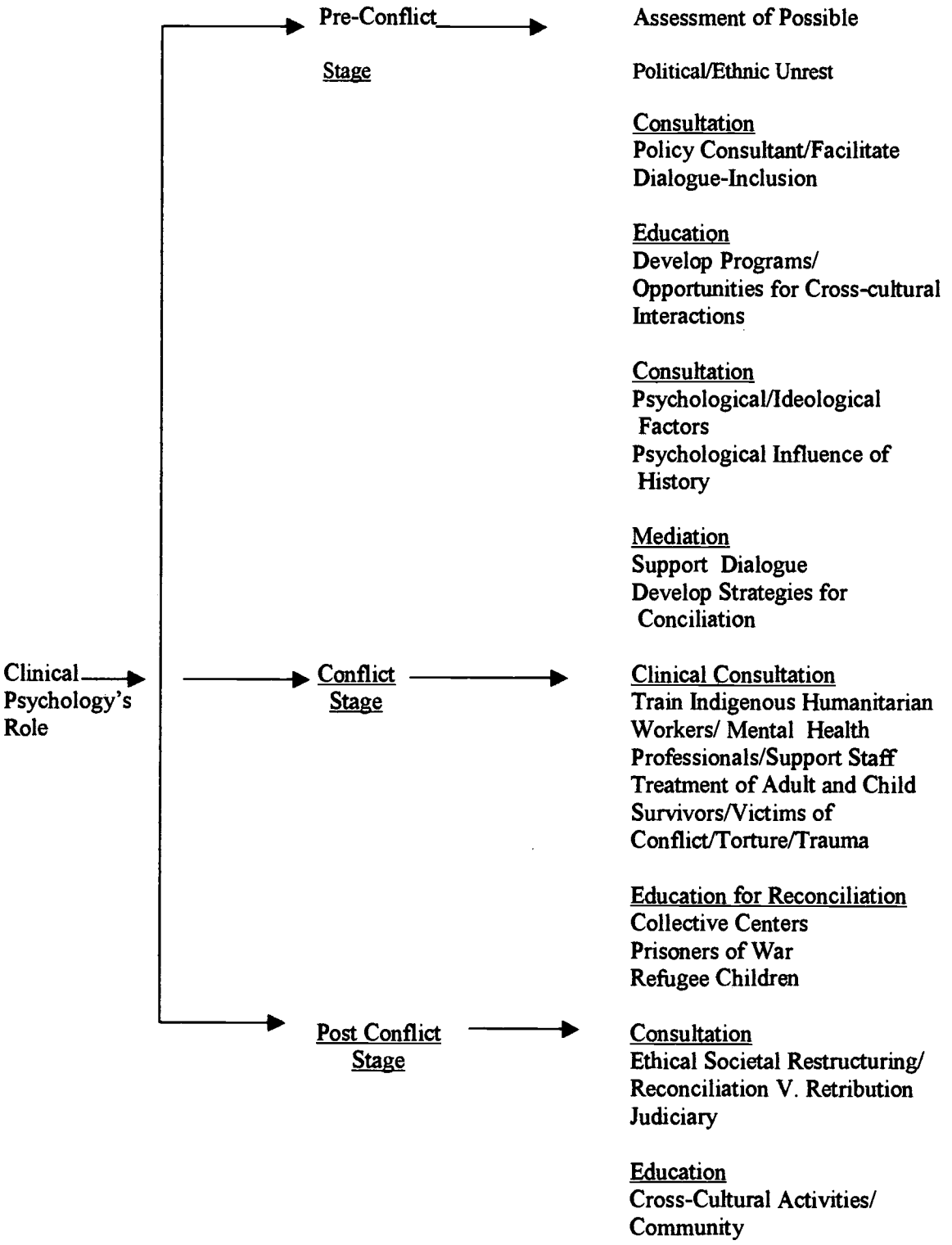
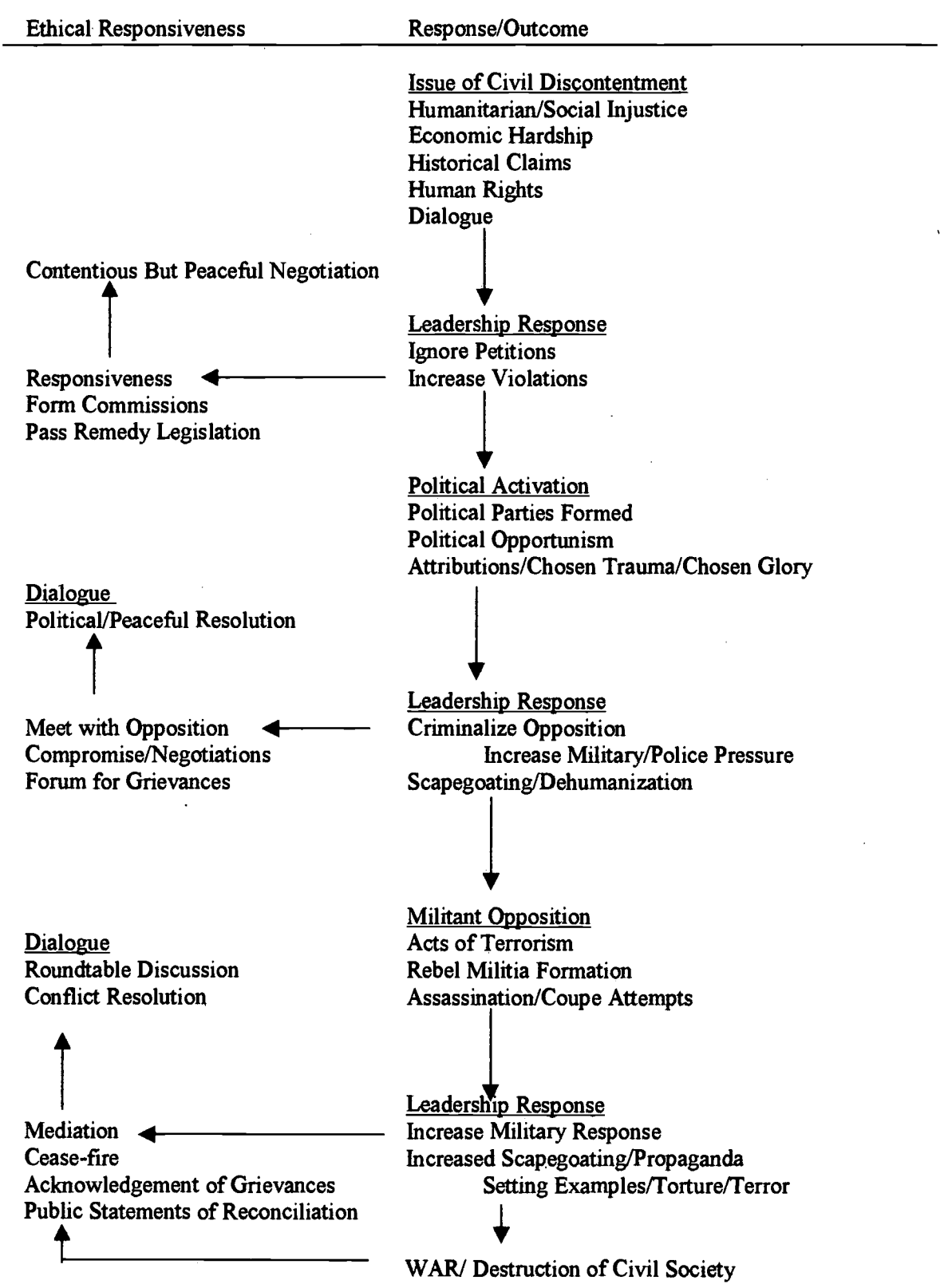


Figure 2: Policy Liaison Intervention and Leadership Response



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