Women of War: Emotional Needs of Ethnic Albanians in Refugee Camps

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This qualitative study identified the emotional needs of female Kosovar refugees in southern Albania in May 1999, about 1 month following their flight from Kosovo. Common themes that emerged from the interviews included dealing with trauma, anxiety, and boredom and maintaining the hope that they would return home. On the basis of the findings, along with feminist theories as guiding concepts, the authors offer recommendations for the prevention of further trauma and treatment options for women in refugee camps.

Women around the world struggle to make their voices heard and their visions known, but in times of war, "women's voices and visions are pushed aside, shunted off to the margins" (Evangelista, 1997, p. 38). What may women need to survive the traumas they experience as war refugees? Relief agencies have historically been involved in offering basic food, shelter, and medical assistance to refugees. Although these efforts are undoubtedly beneficial and life sustaining, the decisions of what types of help to offer invariably come from people other than the refugees themselves. How would the help that is offered change if refugee women could express their needs and desires directly?

Feminist theories and helping approaches call for clients to be active participants in the helping process with the goal of

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empowerment (Bricker-Jenkins, Hooyman, & Gottlieb, 1991; Hartman, 1993; Worell & Remer, 1992). In addition, feminist values focus on clients' strengths, creating social networks, and understanding the meaning of events from the clients' perspectives (Hanmer & Statham, 1989; Laidlaw & Malmo, 1990; Lewis, 1992). In the tradition of qualitative research, this article reports on a study of the voices of women who are caught in the difficult circumstances of refugee life. Specifically, it addresses the emotional needs of Kosovar women in refugee camps in Albania following their flight from Kosovo in 1999. We focus on women's needs as refugees and, using feminist perspectives as guiding concepts, present suggestions for lessening the resulting trauma through prevention and treatment efforts in war-torn areas.

THE REFUGEE EXPERIENCE

By definition, a refugee is an outcast, fugitive, or escapee. Refugees' experiences often begin years prior to exile, with ethnic or religious discrimination escalating to harassment and persecution (Gorst-Unsworth & Goldenberg, 1998). Refugees flee their homes and countries to save their lives and the lives of their children. "If given a choice, most refugees would prefer to stay in their countries and not seek shelter in strange foreign lands, where they can be isolated, ostracized, and impoverished" (Williams & Berry, 1991, p. 632).

The refugee experience is marked by stress, loss, uprooting, trauma, and isolation (Stein, 1986). It is not surprising, therefore, that research has found "higher rates of symptoms and mental disorders in refugees, compared with the general population" (Williams & Berry, 1991, p. 632). Whenever war causes refugees to flee, it is often women and children who are the refugees. Men usually remain in the country fighting the enemy, and women are assigned to take care of the children and flee.

This change in family structure to women-headed households often leaves women with new social roles with which to contend and adds to the stress of dislocation (Russell & Stage,

1996; Wali, 1999). Besides the difficulties they face as new heads of households, women often experience a change in employment status. For example, Rasekh, Bauer, Manos, and Lacopino (1998) found that although 62% of the women studied were employed before their flight as refugees, only 20% were employed afterward. This shift in gender roles contributes to psychological distress that should be addressed through mental health interventions (Chung, Bemak, & Wong, 2000). In addition, today, as in the past, women are subjected to rape and other forms of sexual abuse by the enemy and military personnel (Chelala, 1998; Epp, 1997; Pelka, 1995; Salzman, 1998; Swiss & Jennings, 1998) that traumatize them and require both medical and mental health interventions.

EMOTIONAL NEEDS OF REFUGEE WOMEN

The age-old debate of nature versus nurture endures even among scholars of the recovery of refugees. Thus, scholars have debated the question, Which contributes more to difficulties among refugees, the traumas they have suffered (nature) or their experiences surrounding the trauma (nurture)? Researchers who adopt the nature perspective have linked poor emotional outcomes to the amount of trauma (Almqvist & Brandell-Forsberg, 1997; Herkov & Biernat, 1997; Mollica, McInnes, Poole, & Tor, 1998). For example, Almqvist and Brandell-Forsberg (1997) concluded that the amount of "traumatic exposure is of major importance for future post-traumatic symptomatology among preschool children, as well as in older children and adults" (p. 363). Researchers have also investigated the personal characteristics of survivors of trauma, concluding that genetics plays a role in the survivors' outcomes. As Roscoe, Ackerman, and Joseph (1997) noted, "It is furthermore assumed that PTSD [post-traumatic stress disorder] will not occur in the absence of a genetic susceptibility that may vary from zero to absolute certainty" (p. 9).

Researchers who hold the nurture perspective view the refugees' environments to be as important as the trauma itself or as

more indicative of future emotional difficulties (Gorst-Unsworth & Goldenberg, 1998; Llabre & Hadi, 1997; Silove, Sinnerbrink, & Field, 1997). According to Gorst-Unsworth & Goldenberg (1998), "Poor social support is a stronger predictor of depressive morbidity than [are] trauma factors" (p. 90).

In addition to general social support, the immediate family environment affects mental health outcomes. One study found that "refugee children exhibited a significantly higher incidence of stress reactions if their mothers had difficulty coping with the stress of displacement" (Ajdukovic & Ajdukovic, 1993, p. 843). The converse is also true. When parents maintain their typical pattern of caregiving in spite of war, they are more apt to shield their children from the negative aftereffects of trauma (Macksoud & Aber, 1996). This type of caring and involved response from parents is an important mediating factor in children's future adjustment (Garbarino, Kostelny, & Dubrow, 1991). The same may be true for women. In a qualitative study of women refugees from Southeast Asia, Davis (2000) concluded that the "stories told by the women in this study portray an extraordinary resilience of the human spirit, which is fortified through strong family and community affiliations" (p. 166). On the other hand, Aroian and Norris (2000) found that although resilience protected women against depression, it was not helpful for general distress in their lives as immigrants.

Although disputes among researchers abound, scholars agree that people who suffer traumatic events, such as refugees, are at a high risk of emotional difficulties that require mental health intervention (Ajdukovic & Ajdukovic, 1993; Almqvist & Brandell-Forsberg, 1997; Mollica et al., 1998; Williams & Berry, 1991). The sooner the intervention is available, the better. In discussing the mental conditions of trauma victims, Amir, Kaplan, and Kotler (1996) concluded that "the longer a person remains ill, the worse his or her situation becomes, regardless of the nature of the original trauma" (p. 346).

Knowing that many refugees are women and children who are at a high risk of emotional difficulties, it is vital that social work researchers examine these needs in a more systematic and

timely way. The more risk factors that accrue without protective relief, the more likely it is that psychological damage will occur (Garbarino et al., 1991). Thus, preventing increased risk factors and providing expanded opportunities for resilience should be part of a research and practice agenda for women in social work today. This article discusses the emotional needs of Kosovar refugee women in four camps in southern Albania. From the findings, guided by feminist principles, we suggest both prevention interventions and treatment initiatives that may contribute to more positive emotional outcomes.

METHOD

Our qualitative study was undertaken at the request of the Adventist Development and Relief Agency (ADRA), a nongovernmental organization, to assess the emotional needs of refugees under its purview. The research team, consisting of the authors, three female social work professors, had experience conducting needs assessments, using qualitative methodology, and performing crisis intervention.

Participants and Procedures

We interviewed 53 Kosovar refugees individually and conducted eight focus groups with an additional 56 refugees. We also interacted with approximately 40 children, both in groups and individually. The participants ranged in age from 7 to 81. All but 3 or 4 of the adult participants were female, but among the child participants, there was a fairly even mix of boys and girls.

We interviewed the refugees at four camps in the southern region of Albania chosen by ADRA. The interviews were conducted through interpreters hired by ADRA, two of whom were Albanian and one of whom was a Kosovar refugee. The Kosovar interpreter, a nurse, had been identified and hired previously by ADRA to act as an interpreter for its international staff.

We selected the participants by approaching refugees and asking them, through the interpreters, if they would like to talk. The interpreters explained to the refugees that the purpose of the talk was to find out about the emotional needs of the people in the camp. All the refugees whom we approached were eager to volunteer and, in some cases, sought us out.

The interviews ranged from short, 5-minute conversations to full 1-hour interviews. The majority of the data-gathering sessions lasted approximately 20 to 30 minutes and were conducted on 1 day. The interviews took place primarily in tents, warehouses, or dormitories housing the refugees or outdoors.

Data Analysis

In qualitative research, data collection and analysis occur simultaneously (Lofland & Lofland, 1995). Therefore, after interviewing at each camp, we debriefed by discussing the major themes and findings before we started the next set of interviews. In this way, we could be aware of emerging themes that would lead to common directions in investigation. For example, in the first camp, the Kosovar refugees did not participate in the camp operations, which limited opportunities for meaningful activity among them. Thus, the participation of Kosovar refugees in the camp operations became an issue to ask specifically about at the next camp.

We held a lengthy debriefing session at the end of the day to identify several predominant themes that were common among the participants and reported these themes to the ADRA officials at a session following our return from the camps. This type of debriefing, known as peer debriefing (Lincoln & Guba, 1985), offers an external check on the study process. Using peer debriefers, we were able to confirm and clarify the emerging findings through insiders who had been associated with the camps from the beginning.

The data were initially processed using the computer program Ethnograph to assist in coding the emerging themes. Codes are "labels that classify items of information pertinent to a topic, question, answer, or whatever" (Lofland & Lofland,

1995, p. 186) and permit researchers to organize, categorize, sort, and identify the data. Because coding is the primary connection between the data and their theoretical interpretation, it is a crucial step in developing the analysis (Lofland & Lofland, 1995).

As coding continued in the analytic process, we discussed specific incidences of the codes to clarify similarities and differences. Discussing differences offered the opportunity to gain a clear understanding of each category and its relationship to other categories. Using the constant comparative method (Glaser & Strauss, 1967), we generated both descriptive and explanatory categories. This process led to interpretive insights as we began to recognize and record the emerging themes. The Findings section summarizes the major themes that emerged in analyzing the data.

Limitations of the Study

This study offers an initial direction for further inquiry into the refugee women's emotional needs. It was limited in several ways. First, we were unable to communicate with the participants directly because of the language barrier and hence used translators to help bridge that communication gap. To increase the translators' effectiveness, we followed several recommendations by Amodeo, Grigg-Saito, and Rogg (1997): (a) We met with the interpreters as a group before we left for the refugee camps; (b) we explained to the interpreters the goal of our mission and what we hoped to accomplish; (c) we took the time to clarify specific terms, such as *emotional needs*, *trauma*, and *counseling*; and (d) we discussed the role of the interpreters and were clear about how important they were to the success of the mission.

In spite of the appropriate precautions, there were some difficulties. First, the interpreters differed in their proficiency both in English and in communicating with the Kosovar refugees. For the two Albanian interpreters, the dialects were different enough that they had difficulty communicating with confidence. Second, it appeared that some of the Kosovar partici-

pants distrusted the Albanian interpreters. The Kosovar interpreter pointed out that the participants would not likely be as open with the Albanian interpreters as they were with her. Whether this situation was true is unknown; however, ethnicity may be an important consideration in choosing interpreters.

Another limitation was the small sample size. We were able to spend only 1 day in the refugee camps, and although we contacted more than 100 participants, more in-depth work is needed to gain a comprehensive view of the refugees' emotional needs.

FINDINGS

Physical Needs

Using Maslow's (1954) hierarchy of needs as a guiding principle, we hypothesized that if there were crucial unmet physical needs, it would be difficult to find out about the refugees' emotional needs. Maslow postulated that people strive to meet their needs to "self-actualize," or become the persons they were meant to be. He believed that human needs drive human behavior and that these needs ascend along a hierarchy. That is, people need to fulfill certain basic needs, such as for food and water, before they can move up to more complex needs, such as belonging and self-esteem. Therefore, our first objective was to assess the camp conditions for satisfactory food and water supplies, as well as the adequacy of other basic necessities.

In general, the participants thought that the camp conditions met their basic physical needs and did not report being hungry, thirsty, or in need of sleeping space. However, they did complain about the limited choice of foods. One focus group member said, "We are only getting bread and cheese and tea. Sometimes we have beans or potatoes. The cooking is not good here." Another participant continued, "We can't cook here at the camp. They send us away when we offer to help. The food is tasteless. There's no salt or pepper. There's not enough bread. There is a water shortage sometimes."

Besides the limited choice of food and other supplies, the primary complaint was the lack of sanitation. A refugee from one camp pointed out, "There are 300 of us here and only two bathrooms." In another camp, there were approximately 2,000 refugees with only six toilets. One interpreter pointed out that two of the toilets were locked and could not be used. The camp manager was not available for us to ask about the situation.

Emotional Needs and Issues

After we concluded that the refugees' basic physical needs were being met, we examined the refugees' emotional needs and issues. Several clear themes emerged in this regard: pervasive trauma to the refugees before their flight to Albania, high anxiety accompanied by physical symptoms, the boredom of camp life, and the need for hope that they would return to Kosovo.

Trauma

All the participants told of some form of trauma prior to their arrival at the camp. The primary type of trauma was from military violence resulting in the deaths of family members, friends, and other fellow Kosovars. Secondarily, the participants experienced trauma throughout their flight from home.

Military violence and death. Military violence was rampant in Kosovo, causing hundreds of thousands of civilians to flee their homes and seek refuge in neighboring countries. Most of the participants shared stories of the trauma they either experienced or witnessed, including murder; torture; rape; theft; and the destruction of homes, property, and animals. What follows is a sample of the experiences that they disclosed. The first experience was recounted by a 15-year-old girl:

> One time a soldier from the army came to our house and said, "Give me money or I'll kill you right now." The soldiers lined us up and asked for money. We didn't have any, so we gave them

> jewelry. We were scared. We said, "Don't kill us, please; we don't have any more money." The soldiers put the women and children in one room and told us to give them money. They thought we were hiding money from them. The soldiers beat all the men. Then the soldiers took me out of the room of women and children and my uncle and his son out of the room with the men. They told me they were going to kill us now. Then they gave me the gun and ordered me to kill my uncle and cousin. I was crying and told them, "You'll have to kill me and kill us all because I won't kill them." After 2 hours the soldiers left. I did not have to kill my uncle and cousin. My family fled to the mountains, and I saw my village being burned as we left. Just as we were leaving, I remember watching our neighbors running away, and one of them was killed.

Although rape was not a predominant theme in the data and no one disclosed a firsthand account of rape, a few participants told us of others whom they believed had been raped. For example, a woman in her 20s said,

> Rape is a big problem. One of my cousins was raped in front of her father. Being raped in front of one's father is the worst thing that can happen to a person. Because the soldier raped her, he didn't kill the father.

Research reminds us that religious and cultural beliefs "may differentially influence the meaning and subjective experience of trauma" (Marsella & Friedman, 1996, p. 24). Therefore, the circumstances under which the rape occurred may be as important as the act itself.

Evacuation of refugees. The refugees were further distressed by their forced evacuation from Kosovo. The participants recounted their experiences of escaping from their home country, emphasizing that the evacuation experience itself was not only difficult but traumatizing. As a 20-year-old woman said,

> My family drove for 5 days from our town to the border [of Albania]. There were 80 family members traveling together. We started out in five cars and a truck. On the way, the Serbs took the cars and all our money. The soldiers said, "You have to stop here, and we'll kill you if you don't give us money." They took

> our cars, so 80 of us piled on top of each other in the truck to cross into Albania. The dead lined the roads on the way out of Kosovo. We saw maybe 50 or 100 dead bodies the Serbs left to scare us.

Another woman in her 20s recalled,

> The children were crying during the trip. There was nothing to eat. I was worried for my three children because they had nothing to eat. My youngest is 3 months, and I was not able to change her diaper. All day my child had to keep it on no matter what it was. It was 5 days and 5 nights for the whole trip.

Anxiety and Physical Symptoms

Anxiety among the refugees was nearly as pervasive as trauma. The anxiety theme from the data was consistent and strong. The primary condition leading to anxiety was the lack of information about their family members still in Kosovo. One participant said,

> We don't know what's going on. We don't have enough information. It's been 2 months, and we still haven't heard anything. We've been here 6 weeks and 2 weeks in the mountains in Kosovo. We can't eat or sleep because of worry. I have a husband and son who is 15 years old, and I don't know anything about how they're doing.

An elderly woman reiterated the theme, "I am the only woman from my family that is here. I don't know anything about my seven sons, daughters-in-law, and grandchildren."

The participants reported physical symptoms associated with anxiety, such as difficulty eating and sleeping, high blood pressure, and digestive problems. One participant reflected a common theme when she said, "We are all worrying a lot about our family members in Kosovo. We fear for their safety and well-being. When I eat, I wonder if they have something to eat." "I am experiencing a nervous stomach," one participant stated as she tried to explain the difference between a symptom's being emotionally based versus a physical illness. She realized

the toll the anxiety was having on her health. Another participant said, "I have a lot of brothers and sisters in Kosovo that I don't know about. I have high blood pressure because of all the worry about them."

Boredom

The participants indicated that in the refugee camps, the lack of meaningful activities led to feelings of boredom—a problem that has been documented in the research literature (Russell & Stage, 1996). Without activities and the ability to use their skills and talents, the refugees had more time to think about their missing family members, which, in turn, increased their anxiety. "We need newspapers, books, and magazines to spend time and take our minds off suffering," one participant said. The participants shared their concerns about the lack of activities for the children. As a 19-year-old man put it, "There is nothing for the children to do and there is no school for them here. The kids play ball with a stone." And a 24-year-old man said, "The children need activities. They need balls and some toys. There are no TVs, radios, videos, paper, pencils, or crayons to keep the children occupied."

In addition to not having activities to pass the time, the participants were concerned that their talents were not being used. The focus-group members clearly stated that they would welcome the opportunity to use their individual skills in the camp. Two members said, "Working would help us survive here. We would like to fix hair." Another said, "I finished a course in sewing and would like to sew clothing for the children."

Need for Hope About Returning Home

Returning to their homeland was a primary objective for the Kosovar refugees. When asked how conditions at the camp were for the young people, one 19-year-old woman said, "They are very bad." When asked, "What makes it so bad?" she replied, "Because we want to go back to Kosovo." Other than

wanting family members to be safe, going home was what the refugees longed for most.

The desire to go home served as a source of strength for enduring the hardships of refugee life. A 15-year-old girl reported that she was "getting crazy" from thinking about the trauma she suffered in Kosovo. When asked, "Why aren't you crazy now? What's kept you from going crazy?" she replied, "Hope. I have hope that I'll be able to go home. I'm afraid I'll lose hope. I don't know how I'll do it [stay hopeful]."

Although some refugees were able to keep alive the hope of going back, they voiced the need to hear messages of hope from others. When asked about the need for counselors, a 23-year-old woman answered, "We want them to come. We want to hear from counselors that everything will be all right and we can go to Kosovo. It's like a mother telling her child that it will be all right."

RECOMMENDATIONS

When women become refugees, their emotional health is at risk on many levels. These findings suggest several areas of concern that could be addressed through preventive interventions as well as treatment initiatives. This section presents ideas that bridge the findings with feminist perspectives to propose interventions that may be helpful in future work with refugees.

Preventive Interventions

Primary prevention refers to the efforts made to target normal or at-risk populations in a universal way to ward off future problems. When high-risk populations are involved, these interventions are usually referred to as selective interventions (Durlak, 1998). From a feminist perspective, preventive efforts are essential because social and economic action is an important part of the helping process (Breton, 1999; Weil, 1986; Zippay, 1995). Because many of the interventions discussed

here require the mobilization of resources, advocacy with funding agencies would be required for implementation. The primary preventive interventions that we suggest are managing the flow of information into the camps, developing local capacity, and providing planned activities for individuals and groups.

Managing information. As the participants all noted, when they were uninformed about their family members who were still in Kosovo and heard nothing about the progress of the war, their anxiety increased. Therefore, increasing the flow of information into refugee camps would be a form of primary prevention.

Although the participants reported that family-tracing databases were being developed, none was evident. Relief agencies need to develop databases of camp residents that could be posted to a shared network to allow for the wide dissemination of information. If family members could know that one of their missing members was safe in another location, they would feel greatly relieved.

One camp we visited provided a television set for the residents that was centrally located, and we noted that the camp residents were steadily watching it. This camp lent itself to this type of intervention because of its available electric supply and proximity to a small city; however, these types of interventions could be approximated in more remote areas on a smaller scale through the use of radios.

Developing local (within-camp) capacity. Recognizing the strengths and talents that people bring to a difficult situation helps to develop those strengths and capacities. It is important for relief agencies to tap into refugees' talents and skills, giving them the message that they have abilities that can contribute to their own and others' well-being. One way to do so is to discover the natural leaders in the camp and delegate capacity-building tasks to them. For example, these leaders could form task groups, interviewing each refugee and screening for strengths and talents they may contribute to the camp. Skills such as teaching, nursing, cooking, community organizing, and

being proficient in foreign languages may be useful to camp life. Focusing on the strengths of the refugees and helping them to use their abilities may lead to more positive outcomes.

Providing planned activities. Boredom in the refugee camps contributed to low morale and increased anxiety. This finding supports the findings of other studies that have linked boredom with anxiety and depression (see Silove et al., 1997). Introducing planned activities, both individual and group, into the camps would be a primary preventive intervention to help reduce boredom. Relief agencies, of course, must be aware of cultural preferences in planning activities. Therefore, someone who is knowledgeable about the refugees' culture must be consulted before group activities are planned. As one expatriate worker suggested, "It would be easy to get the ladies to do something like knit. Lots of them knit and would do so if knitting needles and yarn were provided."

Mental Health Treatment Initiatives

Assessing emotional trauma. To prevent further traumatization, relief agencies should be prepared to assess and deal effectively and promptly with refugees' emotional trauma. However, from our research observations, no coordinated treatment initiatives were under way in the camps we visited. Offering mental health treatment may seem like an impossible task because of the refugees' overwhelming physical needs. However, in an age of multitasking, while one relief crew is working on food, shelter, and water supplies, another crew could be assessing the refugees' emotional needs. The idea of providing mental health support during the emergency phase of refugee work is supported in the literature (Jong & Ford, 1999). Researchers have called for "cultural workers who, alongside the water and sanitation experts, logistics personnel, protection officers, and health workers, negotiate, communicate, and collaborate with those affected" (Hyndman, 1998, p. 256).

Because people deal with trauma, loss, and grief differently, it is not surprising to find a wide spectrum of emotional states, ranging from active crisis to moderate coping. This wide variation in emotional coping calls for appropriate assessment in the early stages of people's lives as refugees, with ongoing assessment throughout the time the refugees are in the camps and beyond. From a feminist perspective, this assessment should include some qualitative components if clinicians are to hear women's unique voices (Bloom, 1996; Giblin & Chan, 1995; Lindsey, 1997; Summerfield, 1991). If left to standardized assessment instruments alone, the primary voice heard from the resulting assessment may be that of the tool's developers (Walters & Denton, 1997). The interpretation of the results of the assessment may also be in question. Because many assessment tools are culturally validated, feminists and researchers argue for the cautious use of standardized assessment instruments on which to base large-scale treatment initiatives (Cariceo, 1998; Davis, 2000; Jimenez, 1997; Norman & Wheeler, 1996). We concur with these cautions and recommend that women in refugee camps be involved in the assessment process from the beginning. For example, researchers and clinicians could ask women, "If you were going to try and find out who needed what types of emotional help, how would you go about it in this camp?" Then, program developers should use the women's answers to direct assessment efforts.

Following the assessments, professional mental health workers may be needed, particularly if indicators of PTSD or trauma, such as rape, are present. In our needs assessment, one female refugee said, "When I am thinking about what happened, many times I cry. I get nightmares at night. I see houses burned. When I hear airplanes, I am afraid. It's the same noise as when they were bombing Kosovo." This refugee appeared to be in the beginning stages of posttraumatic stress because she discussed reliving her experiences through nightmares and feelings of danger. She also had symptoms of increased arousal, such as an increased startle response. With early intervention, this woman might have been better prepared to begin the healing process.

In the case just cited, professional mental health interventions were clearly needed. At the same time, feminist clinicians remind practitioners to involve women in their treatment, to form partnerships with them, and to ask women what may be most helpful (Ballou, 1995; Bricker-Jenkins et al., 1991; Giblin & Chan, 1995; Van Den Bergh & Cooper, 1986). "Feminism and postmodernism view the client as the expert in her own life and work toward creating a collaborative and egalitarian therapeutic system" (Biever, Fuentes, Cashion, & Franklin, 1998, p. 172). In our needs assessment, we asked, "What has helped you cope with your trauma?" From the participants' responses, we learned that in addition to professional clinicians, trained listeners or peer helpers may be an important service. A 20-year-old woman responded, "Talking helps. Talking to someone from outside my country. We [Kosovars] don't talk to each other because everyone has had the same experience. To talk to someone else is better." Just talking to an interested party seems to be something the refugees view as potentially helpful. In one focus group, a member said, "It's a relief to talk to someone. We believe in you. You came here for us. You came to help us. [We know this] because you are talking to us." Initial research on training refugees in counseling techniques to supplement professional therapies appears to have positive outcomes (Kanyangale & MacLachlan, 1995). Nonprofessionals, whether refugees or volunteers who are trained as skillful listeners, could provide some relief to the refugees.

In terms of the types of treatment to initiate, we again recommend an empowerment approach that involves engaging women in their own treatment paths. Women could be informed about various treatment approaches that have been found to be helpful to other women (Hanna & Hanna, 1998). Some of these treatments include psychoeducational groups (Allen & Kelly, 1997; Lubin & Loris, 1998), facilitated self-help groups (Tribe & De Silva, 1999), support groups (Nicholson & Kay, 1999), the Wits trauma intervention model (Eagle, 1998), eye movement desensitization and reprocessing treatments (Rothbaum, 1997), exposure and cognitive restructuring

groups (Echeburua & Zaretta, 1997), and cognitive-behavioral interventions (Foy, 1992; Scott, 1997).

Feminist social workers are uniquely positioned to initiate new directions for women who have been caught in the by-products of war, such as women who are living in refugee camps. Whereas traditional help for refugees has come from the top down, social workers should insist on an inclusive, empowering, mutual process that invites women who are refugees to have a voice that affects their living and healing conditions.

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