Review of Psychology
1996, Vol 3, No. 1-2, 69-75 UDK 159.9

A salutogenic model of psychosocial help

MIRJANA KRIZMANIĆ and VLADIMIR KOLESARIĆ

Psychosocial care and support for victims of war and catastrophes as well as other forms of professional help usually follow the medical model of mental health and illness. Thus professionals offering psychosocial assistance to war survivors mostly look for signs and symptoms of maladjustment but rarely or not at all for possible positive changes. Inspired by the work of Joseph et. al (1994), the authors developed a questionnaire aimed at measuring positive and negative psychological consequences of war trauma. The first results obtained by this questionnaire served as a basis for a tentative salutogenic model of psychosocial help, which was later tested on 8 different groups of war victims, survivors and participants. The proposed model of the impact of traumatic experiences on adaptation suggests that positive and negative changes of cognitive and emotional functioning influence adaptation through the choice and implementation of coping skills and mechanisms.

War in Croatia and in Bosnia and Herzegovina (1991-1995) has, among other things, resulted in hundreds of thousands of traumatized persons, like: refugees and displaced persons, widows and parents of fallen soldiers, raped women, invalids, prisoners of war etc.

War victims in Croatia and Bosnia and Herzegovina have for the most part experienced multiple traumatization. Displaced persons - (people chased away from their homes within their own country) and refugees (persons forced to leave their country and escape to other countries) have been subjected to terror, i.e. systematic use of violence against specific local communities and ethnic groups. They have witnessed the killing of unarmed civilians, seen dead and mutilated bodies, lost their family members. Many war veterans with combat experience were at the same time refugees or displaced persons who have lost some family members or have themselves been prisoners of war.

Most widows, parents of fallen soldiers or civilians, and invalids were also uprooted, i.e. forced to leave their homes. Although most of them expected to return to their homes in a few weeks, at the most a few months, they were forced to live in exile for 3-4 years. There are still, after 5 years of exile, hundreds of thousands of exiled people waiting for their return home, some of them already near their former homes (e.g. in Croatia), many of them scattered all over the world.

The exiled people's expectations of a quick return to their former homes and way of living made the adaptation to a new environment superfluous. For most of them it was enough to live on a 'day by day' basis, hoping that all of this would soon be over.

Like parents of missing persons who never started to mourn for their missing sons and husbands, the refugees regarded their attempt at assimilation into the new environment as "giving up the hope of returning home". There were, of course those who have decided never to return home anyway, because of the impossibility to live ever again together with the neighbors who have chased them away. Such refugees and displaced persons assimilated themselves quite quickly into the new environment, trying to get asylum or some kind of permanent stay in their countries of exile.

The unfulfilled expectations of a quick return home, and the constant postponement of organized return despite many political decisions to the contrary (e.g. the Dayton agreement) had a strong psychological impact on many exiled persons. They started losing hope of ever going home, or were swaying between hope and hopelessness.

It has to be pointed out that for the greatest part, people in Croatia and Bosnia and Herzegovina were completely unprepared for the ensuing war, which includes professional helpers too. It could be said that everybody living in these two countries was, in one way or the other, surprised, traumatized, and shocked. Due to this general unpreparedness as well as because of such a great number of traumatized people, both countries were compelled to

Mirjana Krizmanić, Department of Psychology, Faculty of Philosophy, I. Lučića 3, 10000 Zagreb, Croatia (Correspondence concerning this article should be sent to this address); Vladimir Kolesarić, Department of Psychology, Faculty of Philosophy, I. Lučića 3, 10000 Zagreb, Croatia.

This article is one of keynote lectures hold at 4th Alps Adria Psychology Symposium, October 3-5, 1996, Zagreb, Croatia.

gratefully accept every kind of help offered by various humanitarian organizations.

It soon became obvious that psychosocial care and support as well as other forms of professional help (e.g. psychological counseling) for war victims mostly followed the medical model of mental health and illness, or some "alternative" religious or bioenergetic approaches.

At the same time most foreign professionals believed that their experiences gathered in one country or with one kind of catastrophe could be directly applied to other countries or to victims of similar disasters.

Both approaches could and should be carefully reexamined because: a) qualitative research has shown "that the way in which symptoms are regarded and reported, and actions taken to manage them, are a profoundly social phenomenon" (Yardley, L., 1996), and b) consequences of traumatic experiences are the end-product of interactions between many factors, which include not only characteristics of trauma itself but of victims as well. In other words, the professional helpers should be well acquainted with the cultural norms of the society in which the victims live, as well as with the present state of this society - which is seldom the case. c) Traumatic experiences do not inevitably cause pathological changes or disorders.

Applied to our situation this meant that professional helpers seldom regarded regional and cultural differences existing between various parts of Croatia and Bosnia and Herzegovina. Nor did they think about the fact that most people struck by war were before this mentally healthy people. Most of them came from closely-knit communities which did not in any substantial way differ from the usual Middle-European townships and villages. They were accustomed to solve their everyday problems within their communities, mostly with some help from their friends, relatives or neighbors. For the most part, they were not accustomed to introspectively analyze their emotional or psychological troubles, much less talk about them to complete strangers. Despite all of this, our war victims living in refugee camps, and grateful for humanitarian aid they were living on, willingly participated in any kind of help bestowed upon them. Traumatized, scared, exiled, and speaking, for the most part, only some regional dialect, they were willingly answering all kinds of questions, or taking part in any kind of psychotherapy.

Although it has been shown that there are pathological and nonpathological responses to trauma (e.g. Bulman and Wortman, 1979; Taylor, 1983; Quarantelli, 1985; Wortman, 1987; Hodgkinson & Stewart, 1991) it is still widely believed that all victims of catastrophes and disasters suffer from some negative if not even pathological consequences of traumatic experiences. Such expectations are especially common for war victims because war is justifiably viewed as one of the most intense stress situations. Besides threatening the lives and property of people, on the individual level war is the greatest threat to control of events and the control of oneself, because comprehension and prediction of events or of one's own behavior is often not possible (Milgram, 1986).

War, as a catastrophe caused by deliberate human actions, has an especially deleterious impact on basic human beliefs and assumptions about oneself and the world (Janoff-Bulman & Frieze, 1983). Perceiving the world as threatening destroys the illusion of personal invulnerability, thus causing feelings of fear, anxiety and insecurity. Traumatic experiences caused by other people's actions also act upon personal values, which could lose their meaning or become completely destroyed.

Many disaster and trauma studies have shown that there are good and bad copers, (e.g. Antonovsky & Bernstein, 1986) with the majority of people falling somewhere in-between. This fact already shows that people struck by a disaster or involved in a war should not in a simplified manner be divided into victims and survivors, weak and strong, or even healthy and sick. Despite the fact that most traumatized people show some changes in their behavior and cognitive or emotional functioning, psychological consequences of trauma depend on the coping capacities of the individual, protective factors in his/her personal environment, additional stress and many other factors which determine the individual psychological meaning of the traumatic experience (Van der Veer, 1992).

Contrary to this view practical work of helping professionals is predominantly influenced by psychiatric approach according to which all victims are considered at least "damaged" if not even "ill". Thus professionals offering psychosocial assistance and support to war victims mostly look for signs and symptoms of maladjustment, like PTSD, anxiety or depression, hostility and aggressiveness, hopelessness and helplessness, but rarely or not at all for some possible positive changes.

Research encompassing both positive and negative consequences in victims of disasters and catastrophes is still rare. One of the reasons for this lack of interest in positive consequences could be that most psychological measurement tools are devised to measure only adverse changes and do not offer the respondent any chance to indicate some positive feelings, beliefs, attitudes or behaviors. One of the exceptions is the Change in Outlook Questionnaire developed by S. Joseph, R. Williams and W. Yule (1993) and intended to measure positive and negative responses following disaster. Their results, obtained on survivors of a boat accident, showed that a large number of survivors has indicated not only negative changes (e.g. that they have very little trust in other people) but some positive changes too. Expressed in percentages the majority (94%) claimed that they do not take life for granted anymore, that they value their relationships (91%) and other people much more (88%) etc..

Our experience, gathered in a counseling service for war victims, taught us that it is to be expected that people traumatized by war are distressed, sad, desperate, aggressive or helpless. Most of our clients were able to express quite well their worries, troubles or distress. Many of them came with problems which were existent in their lives before the war, but exile or other war experiences made them unmanageable.

The majority of war victims needed only psychological counseling to help them take some control over their lives again, or to give them the opportunity to check their own opinions, attitudes or actions with some unbiased professional. They were all trying to understand what has happened to them, to find some meaning in their suffering. And of course, they were all suffering in one way or an other, struggling to survive and go on with their lives. Although some war survivors needed various forms of psychotherapy and medical treatment most of them were functioning surprisingly well without any psychological help whatsoever, patiently enduring their pain and loss. This realization prompted us to search for a suitable model for psychosocial help adapted to these circumstances and not based on medical notions of health and illness. Inspired by the work of Joseph et al. and their Change in Outlook Questionnaire we have developed a questionnaire aimed at measuring positive and negative psychological consequences of war trauma and displacement. Our main goal at that time was not *research* but *search*; search for the remained or newly developed strengths and resources of our clients, as well as for some more adequate way of helping them.

The main idea was not to look just for symptoms and signs of maladjustment, but to search for positive changes too, be they cognitive, emotional or behavioral. This search was supposed to be *interactive*, that is, it was not of paramount importance that we as helpers discovered some positive changes, but that our *clients themselves* became aware of them. Instead of letting them talk only about their pain and loss, we have tried to make them realize that there were either some positive changes too, or that they were still in many respects the same persons they had been before all the tragedies they have experienced.

The Positive and Negative Consequences of War (PANCOW) questionnaire comprises 15 positive and 15 negative statements, each one accompanied with a four point scale ranging from "completely right" to "completely wrong". Added to it was the answer "same as before", intended to give respondents the opportunity to manifest some aspects of their functioning where they did not experience any change.

Each item describes a positive or negative change caused by war. All items are phrased in such a way that respondents are reminded to compare their present attitudes, beliefs, values or behavior with those they had before their traumatic experiences. In other words, all statements include phrases like "After all I've been through I do not believe...", or "In these difficult times I have learned...".

Positive and negative statements were formed on the basis of an a priori classification in which changes of behavior, attitudes, beliefs or values enhancing short and long-term adaptation of war victims were considered "positive", while all changes hindering adaptation to the present situation were considered "negative". In other words, beliefs, attitudes and behaviors which point to some still existing or newly acquired source of strength, trust in other people or oneself, plans for future or appreciation of life etc., were considered positive, while e.g. an all pervading loss of trust in other people, oneself and the world was considered negative. Although a good part of the statements was formulated on the "common sense" basis, consideration of the present situation of the victims as well as the experiences gathered in daily encounters with them were used too.

Example:

After all that has happened I believe that there are more bad than good people.

* completely right	* mostly right	* mostly wrong	* completely wrong	* same as before

If the respondent has chosen the answer "completely or mostly right" he/she got a mark for a negative change, but if the respondent has chosen the answer "completely or mostly wrong" she/ he got a point for a positive change. This means that a respondent without any answers "same as before" could get a maximum of 30 positive or 30 negative changes, or any combination of them. A respondent without any change whatsoever would get 0 for positive and 0 for negative changes.

The questionnaire was first applied to displaced persons from Vukovar , some refugees from Bosnia and Herzegovina, and citizens and students in Zagreb. The idea was to compare the average amount of positive and negative changes caused by war in people who were directly exposed to it and those who only experienced air-raids and alarms, like citizens of Zagreb.

All participants voluntarily took part in the study, and were given the opportunity to fill in the questionnaire anonymously. They were only asked to mark their sex, age and education.

These first results showed us that refugees and displaced persons reported much more positive changes then people not so directly victimized by war. At the same time exiled persons experienced much more negative

changes too, although the difference between them and the so called "normal citizens" was not as great as for positive changes.

It seemed to us that a lot of positive changes encountered in exiled persons could explain their ability to patiently wait for their return and keep functioning without any professional help.

On the basis of these first results we have formulated a tentative model of psychosocial help for war victims, graphically presented in Figure 1.

The proposed model graphically shows the main idea that traumatic experiences cause positive and negative psychological changes, as well as leave the person unchanged in some aspects of his/her functioning.. These changes can then act either as additional stress factors (negative) or as protective factors (positive changes, and remaining the same).

Negative changes, e.g. loss of trust in other people or oneself, intensive vengeful feelings, or change of some traditional values and mores could impede a person in

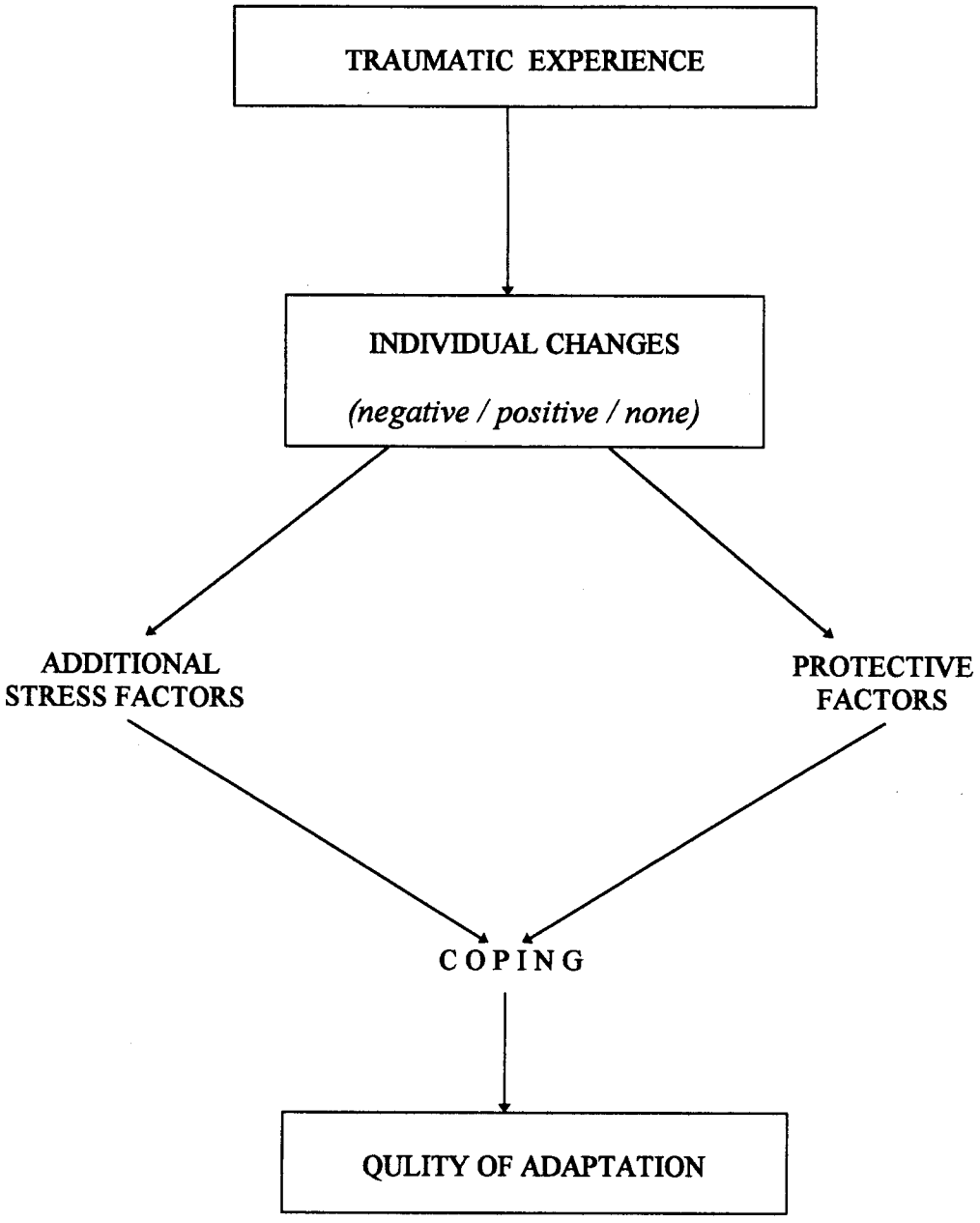

Figure 1. Graphic presentation of the salutogenic model.

his/her efforts to successfully cope with traumatic experiences. A person experiencing acute trauma caused negative psychological changes may not be able on his/her own to notice some positive changes in him- or herself. By drawing the attention of traumatized persons to possible positive changes they might have experienced, they could be helped to use those positive changes to counteract the influence of negative changes, or "lean on" these positive changes to establish some new balance.

Trauma caused changes of cognitive and emotional functioning influence adaptation through the choice and implementation of coping skills and mechanisms. Depending on the nature of changes, a person experiencing a lot of negative changes could e.g. become withdrawn and passive, or hostile and aggressive. On the other hand, positive changes could activate a victim to e.g. seek social support or even offer his/her help to others.

These first applications also showed that the questionnaire itself provoked some positive effects, because many participants upon reading the statements in the questionnaire verbalized their surprise at some positive changes they have not recognized in themselves before.

In order to test the proposed model the PANCOW questionnaire was applied to 8 different groups of war victims, survivors and participants. Altogether there were 657 respondents. The average amount of positive and negative changes endorsed by the examined groups is graphically presented in Figure 2.

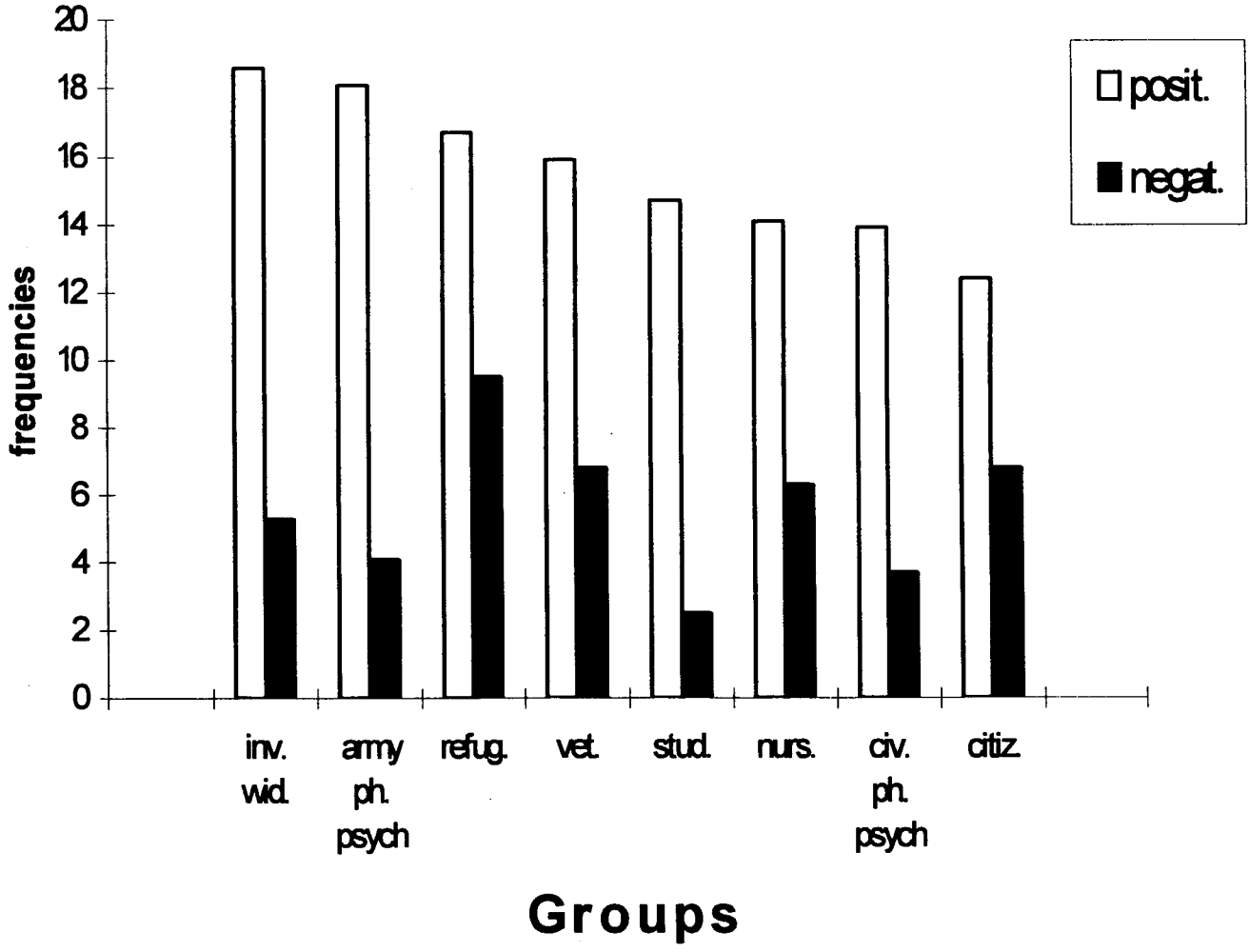

Figure 2. Average number of positive and negative changes in various groups of respondents.

The most interesting facts emerging from the obtained results seemed to be: (1) that all groups of participants endorsed much more positive then negative changes (group averages for positive changes are between 12 and 19, while group averages for negative changes fall between 2.5 and less then 10); and (2) that all participants, although they vary in age, education, sex and war experiences show similar positive and negative changes. Although our main purpose was not research, nor were we in a position to select the participants on the basis of some demographic characteristics, we have looked at possible differences between younger and older, less or more educated and male and female participants. Taking into account the fact that splitting the various groups into younger and older etc. subjects did leave us with much smaller numbers, it is still surprising that there were no statistically significant differences in the average amount of positive and negative changes endorsed by men and women, younger and older, and more or less educated war victims. The only significant differences were found between younger and older citizens of Zagreb, who were not directly traumatized by war. It seems as though being traumatized by war events overrides certain demographic factors.

On the average the greatest number of positive changes was found in four groups of people who have been most directly involved in war events, either as victims (disabled and wounded, widows, refugees) or as army personnel (army physicians and psychologists, soldiers) . They all showed significantly more positive changes than medical staff working in civil hospitals or citizens and students of Zagreb.

All groups endorsed much less negative changes. The greatest number of negative changes was reported by exiled persons, veterans, nurses and "normal" citizens, and the least number of negative changes was reported by invalids, army and civilian physicians, psychologists and students.

As already mentioned, all groups agree in the most frequently chosen changes, which for positive changes were (the numbers in the parentheses indicate the place of the statement in the questionnaire):

(9) Despite everything, I believe that children should be taught to believe in human goodness.

(2) I still believe that it is important to be a good person.

(30) I think that everything that has happened to me has make me more experienced, and has increased my understanding of the world we are living in.

Despite the differences in the amount of reported negative changes there is again agreement in the most frequently chosen changes, which were:

(16) I fret for my life and the life of people close to me.

(8) I do not believe anymore that good deeds are rewarded and bad ones punished..

(24) Nowadays I wish I could take justice in my hands and punish all evildoers.

Our participants also agree in the most frequently chosen "same as before" answers:

(10) Nowadays I value much more the sympathy/love of my relatives, friends, colleagues..

(15) In these difficult times I have learned to forgive other people.

(22) Nowadays I do not get into conflicts with other people as easily as before.

Similar patterns of changes as well as of their absence seem to point to some *common sources* of these changes.

One of these sources could be that most people share the same basic assumptions about themselves and the world, and for the most of them the loss or destruction of these basic beliefs evokes fear, despair and increased sense of vulnerability (Janoff-Bulman & Frieze, 1983). Besides pain and suffering, traumatic experiences cause some positive changes of values, attitudes and beliefs, and in some aspects they seem to have no influence at all, because people have the feeling that they have remained the same.

It seems that this fact alone could help a person to adapt to his/her fate, because there are some aspects of their personality which preserve the sense of one's own *continuity* and *identity*. "They did not destroy my faith", or "They (meaning 'the enemy') cannot make a bad person out of me" were some of the comments made by our participants.

Besides basic assumptions about the world and themselves, there are also some culturally determined values which most people of similar origin share, like the way one is supposed to bring up children or bear the cross fate has assigned him/her.

It could be proposed that numerous positive changes endorsed by people directly touched by war were provoked by their exceptionally strong motivation not only to survive but stay healthy out of spite to the enemy. This is especially true for refugees and displaced persons whose most often expressed statement was: "We have to return to our homes". Maybe this rightful decision that they have to go back where they belong gave to many of them some kind of additional resilience and strength to preserve some of their values, attitudes and habits of conduct. Great number of positive changes shown by the army personnel - most of them volunteers- could be the consequence of an exceptionally high motivation to take an active part in the defense of their country.

The possibility proposed by Tailor et. al (1983), that some victims were minimizing their traumatic experiences in an attempt to avoid victim status should also be taken

into account. Tailor et al. claim that some victims tend to focus on the positive side of their experiences, on what they have learned from them, or they are inclined to compare their situation with those who are much worse off, or are less capable of coping with their traumatic experiences. But one could claim that an attempt to avoid being regarded as a victim should be appraised as a positive reaction to trauma, and that comparing one's fate with people whose fate is even worse has some adaptive value.

Although there are great individual differences in the kind and amount of positive and negative changes experienced by traumatized persons, there is enough similarity in the overall structure of these changes to support the proposed model. Properly planned and organized research should test the applicability of the salutogenic model to chronically or severely ill people as well. Future research should also concentrate on studying the effects of positive psychological changes on the overall well-being of a person. It could be supposed that better adaptation to trauma, illness or other painful experiences could enhance one's quality of life.

The knowledge the amount and kind of individual changes caused by traumatic experiences could and should be used in planning psychological assistance and/or counseling for victims of war or any other catastrophe. The proposed model is supposed to encourage the use of *salutogenic approach* instead of the now prevailing pathogenic one. Pathogenic approach, focused on searching for signs and symptoms of maladjustment and/or disorders pushes trauma victims into passivity or imposes upon them a "sick role". Thus instead of relying mainly on their own resources, trauma victims passively accept and expect professional or medical help which will "cure" their pain and suffering.

In accordance with the salutogenic model, the basic question helpers should ask should not be a pathogenic one, like: "What is wrong with this person?" but *salutogenic*: "Are there some positive changes caused by trauma, and how should we discover and use them?" Or "In what respect has this person remained the same as he/she was before?"

This suggestion does not in any way exclude psychiatric interventions whenever they are necessary. It only stresses the fact that many victims of war, without having received any psychological assistance, showed more positive than negative changes, and that any psychosocial help or support should be based on these changes.

REFERENCES:

ANTONOVSKY, A.,& RNSTEIN, J. (1986). Pathogenesis and salutogenesis in war and other crises: Who studies the successful coper? In A. N. Milgram, (Ed.), *Stress and coping in time of war* (pp. 52-65). New York: Brunner/Mazel,

HODGKINSON, P. E., & STEWART, M. (1991). *Coping with catastrophe: A handbook of disaster management* (pp. 23-24), London: Routledge.

JANOFF-BULMAN, R., & FRIEZE, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues, 39*, 1-17.

JOSEPH, S., WILLIAMS, R., & YULE, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to asses positive and negative responses. *Journal of Traumatic Stress, 6*, 271-279.

QUARANTELLI, E. L. (1985). An assessment of conflicting views on metal health: the consequences of traumatic events. In C. R. Figley (Ed.), *Trauma and Its Wake* (pp.173-215). New York: Brunner/Mazel.

TAILOR, E., WOOD, J. V., & LICHTMAN, R. R. (1983). It could be worse: selective evaluation as a response to victimization. *Journal of Social Issues, 39*, 19-40.

TAYLOR, S. (1983). Adjustment to threatening life events: A theory of cognitive adaptation. *American Psychologist, 38*, 1161-1173.

VAN der VEER, G. (1992). Counselling and therapy with refugees: Psychological problems of victims of war, torture and repression. Chichester: John Wiley & Sons.

WORTMAN, C. (1987) Coping with irrevocable loss. In A. Baum, C. J. Frederick, H. Frieze, & C. Wortman (Eds.), *Cataclysms, Crises and Catastrophes: Psychology in Action,* (pp. 189-226). Washington, D.C.: American Psychological Association.

YARDLEY, L. (1996). Reconciling discursive and materialist perspectives on health and illness. *Theory & Psychology, 6* (3), 485-508.

Accepted: December 1996