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THE DIALOGUE-ACTION PROCESS

**An analysis of the dialogue process IRSS has used
in its work with groups
in former Yugoslavia, and the Caucasus**

by
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FOREWORD

This paper was written at the request of Harold Saunders, director of International Affairs at the Kettering Foundation and author of A Public Peace Process: Sustained Dialogue to Transform Racial and Ethical Conflicts. This seminal book analyzes and describes the use of sustained dialogue to transform conflictual relationships. In response to Saunder's request that we respond to his book, this paper explores the field experience of the Institute for Resource and Security Studies (IRSS) with dialogue processes. We analyze our experiences in order to confirm or add to what is known about the process of dialogue as it works within and between groups in conflict.

The paper begins with a description of the dialogue-action process as defined and used by IRSS. Examples from IRSS field experience in the former Yugoslavia and in the Caucasus are sprinkled liberally throughout the text in an effort to bring to life the situations in which the dialogue-action process has been used and the results it has wrought. In particular, we explore what dialogue experience of this type can teach us about how human beings heal, individually and as a social unit, from traumatic events, and how the human need for relationship is manifest in the dialogue process. Furthermore, the paper provides an opportunity to discuss the social utility of dialogue-action and how it can be sustained through the deliberate integration of facilitated dialogue with essential social functions.

I was asked to contrast the IRSS dialogue-action process with Saunders' sustained dialogue process as it is described in A Public Peace Process. It was difficult to contrast these two processes because the dialogue-action process was inspired by Saunder's sustained dialogue process. The two processes share the same fundamental belief in using dialogue to restore healthy human relationships. Those differences which do exist relate to differing modes of application of the two processes. Used appropriately, these processes can compliment each other as they strive to build a culture of peace on the ruins of violence and war.

ABOUT THE AUTHOR

Paula Gutlove is the director of international conflict management programs at the Institute for Resource and Security Studies. She was trained in social science and medicine, and has been working in social change, conflict management and program development since 1979. Dr Gutlove founded the international Health Bridges for Peace project, has been a program consultant to numerous non-profit organizations, and has facilitated dialogue and conflict resolution training in the USA, Canada, USSR, CIS, Europe, the Balkans, Japan and Australia.

ABOUT IRSS

The Institute for Resource and Security Studies (IRSS) is an independent, non-profit corporation. It was founded in 1984 to conduct technical and policy analysis and public education, with the objective of promoting international security and sustainable use of natural resources. IRSS projects always reflect a concern for practical solutions to resource, environment and security problems, and can range from detailed technical studies to preparing educational materials accessible to the public. IRSS actively seeks collaborative relationships with other organizations as it pursues its goals.

To complement its analytic and educational work, IRSS engages in public participation, dialogue facilitation and conflict management through its international conflict management programs. These programs work with people of diverse perspectives and interests, to improve communication, build understanding, promote cooperation, and develop new models for sustainable community reconstruction and reconciliation. IRSS designs and convenes workshops and training sessions to facilitate dialogue, promote collaborative problem-solving, encourage cooperative actions, and develop inter-communal networks.

THE DIALOGUE-ACTION PROCESS

CONTENTS

1. Introduction
2. What is "dialogue-action"?
3. When is a dialogue-action process useful?
4. Dialogue-action in the field: selected examples
5. Healing principles of dialogue-action
6. Stages of the dialogue-action process
7. The dialogue-action process contrasted to Saunders' five-stage sustained dialogue process
8. Dialogue-action as a strategy to promote sustainable change
9. Conclusions

THE DIALOGUE-ACTION PROCESS

1. INTRODUCTION

"Brotherly love is based on the experience that we are all one. The differences in talents, intelligence, knowledge are all negligible in comparison with the identity of the human core common to all men. In order to experience this identity it is necessary to penetrate from the periphery to the core. If I perceive in another person mainly the surface, I perceive mainly the differences, that which separates us. If I penetrate to the core, I perceive our identity, the fact of our brotherhood."¹

At the turn of the millennium, the world is plagued by seemingly intractable conflicts, marked by violence and inhumanity. Conflicts occur within and across a variety of political, economic, ethnic and religious boundaries. In response, a growing number and diversity of international and indigenous actors are engaged in a range of peace-building efforts. Many of these actors work to facilitate dialogue between groups divided by conflict.

In a facilitated dialogue, an outside party -- the facilitator -- creates and fosters an environment conducive to effective communication between parties. In the context of conflict management², facilitated dialogues are often held in a workshop setting with participation from members of disparate groups. The explicit aim is to promote cooperation and problem solving. Usually, the underlying goal of these dialogues, often unstated and sometimes unacknowledged, is to rebuild relationships between people whose connections have been severed by conflict, hatred or violence.

There is a wide diversity of facilitated dialogue efforts, using differing approaches. This diversity has some merit, because there are varying needs within conflict-torn societies, and a range of approaches may be necessary to fill these needs. However, the effects of some dialogue efforts can dissipate once the dialogue workshop is over. When participants leave the organized, facilitated setting, they may reenter their conflict-divided communities, taking few of the achievements of the workshop with them. This is understandable, because conflict-ravaged societies often have strong structures within them that promote division between communities, but few opportunities to support inter-communal cooperation. As a result, there has been criticism of facilitated dialogue as "just talking for the sake of talking".

¹ Erich Fromm, The Art of Loving, Harper and Row, New York, 1962, page 47.

² Conflict management refers to non-violent processes that promote dialogue, cooperation, problem-solving and reconciliation, with the objective of preventing the escalation of conflict and promoting its de-escalation.

In spite of this criticism, or perhaps in response to it, many dialogue practitioners are adapting the facilitated dialogue process so that it can be linked to practical activities which encourage sustainable, inter-communal cooperation. Indeed, there is now a general body of effort in this realm, integrating facilitated dialogue with cooperative action.

2. WHAT IS "DIALOGUE-ACTION"?

In an effort to make the potential gains of facilitated dialogue broader and more sustainable, the Institute for Resource and Security Studies (IRSS) has developed a dialogue process which focuses on developing shared actions by the participants. (As will be discussed, the dialogue-action process was developed using principles articulated by Saunders for his Public Peace Process.) We use the term "dialogue-action process" because the dialogue is built around shared interests and shared actions. By embedding dialogue in a plan of shared actions by parties in conflict, the dialogue-action process can provide an incentive for initiating interaction between disparate groups, and a context for sustaining that interaction. Dialogue-action is a process of relationship building using facilitated dialogue to promote cooperative action.

Relationship building and reconciliation are the central objectives of the dialogue-action process. In the context of rebuilding a community after violent conflict, reconciliation refers to the restoration of human relationships and the building of trust, hope and mutuality within a violence-ravaged community. Restoration of trust can encompass both trusting other individuals to behave compassionately, and trusting that the political system will be fair and equitable. Restoration of hope means that people can begin to believe that the future life of their community can be better than its recent, violent past. The healing of mutuality comes from the knowledge that values and experiences, and the desire for trust and hope, are shared throughout a community.³

If a group's cooperative action is integrated into existing societal functions, (e.g., health care, education) the dialogue-action process can have both sustainability and social utility. We term the integration of conflict management with existing societal functions "integrated action". Societal functions are often an effective meeting ground for parties divided by conflict, because parties frequently share a need to have these societal functions operative. An integrated-action process usually relies on a process of facilitated dialogue between parties as the vehicle by which parties engage in the shared action. Through integrated action, a dialogue-action process can build on what is natural and adaptive within a particular society; thus, it can provide a context in which to spread and strengthen processes that support reconciliation and nonviolent conflict management. Furthermore, through the dialogue-action process it is possible to

³ The author wants to acknowledge the [Resource Packet for Conflict Transformation](#), International Alert, November 1996, Book 3, Capacity Building, pp. 77-79, for basic information and inspiration about reconstruction and reconciliation.

address differences between groups, to promote understanding of the basic human needs of all parties, and to set up systems to meet these needs.

3. WHEN IS A DIALOGUE-ACTION PROCESS USEFUL?

The dialogue-action process requires time to achieve results. All parties, including the third party, must be prepared to make a long-term commitment, over a period of many years, to the engagement. Given such a commitment, the appropriateness and utility of the dialogue-action process will depend upon many factors, including: (a) societal conditions; (b) motivation of the parties; and (c) the shared needs and capabilities for cooperative action. Even with ideal fulfillment of these factors, the dialogue-action process must be designed and implemented with great care if it is to be useful, constructive and sustainable.

Societal Conditions

In stable, peaceful communities with diverse members, cooperation among different segments of society is integrated into the fabric of the civil society; an explicit dialogue-action process is not necessary. By contrast, in communities undergoing economic and/or societal transition, and in societies that have experienced violent conflict, a deliberately introduced dialogue-action process can be very useful.

A society that has experienced violent conflict is, in some ways, uniquely open to transformative processes. In a war, cultural patterns have often been disrupted, and societal structures have been rendered useless, inappropriate or even dangerous. New patterns of interaction are needed, as war-weary people search for new ways to do things, seeking to "get on with the important business of living" as opposed to continuing the horror of killing and dying. Yet, while a post-conflict society may provide unique opportunities for dialogue-action, the process must be initiated with utmost care, and with a commitment to continue the process for as many years as necessary. Contact between groups experiencing violent conflict must be evaluated carefully, so that engaging in dialogue, or cooperative actions, does not pose a risk to the parties themselves, or to the facilitator. When dialogue-action is part of a long-term program, it can promote useful interactions between parties despite changes in the political landscape. It can function while the landscape changes from peace to war to peace again, as has been demonstrated in our work in the former Yugoslavia (see below).

Motivation of the Parties

Careful selection of participants is crucial to the success of a dialogue-action process. The process is most useful when it can be used to bring together parties who appreciate the potential for mutual gain if they engage in cooperative actions. The key here is that participants actively want to meet with counterparts on the other side(s). They must be ready to explore the possibilities for interaction, using the dialogue-action process as the vehicle for this exploration. The participants' degree of motivation for dialogue, cooperation, understanding and, ultimately, reconciliation has a direct, positive, correlation with the success of the dialogue-

action process. Also, success is more likely if participants have clearly defined common interests, such as similar professional backgrounds and areas of expertise.

We have found it highly effective to work with medical professionals, for a number of reasons. Often, the health infrastructure of a post-conflict community is bolstered by international and NGO assistance, which may provide options for communication, transport, technology transfer and educational support that are otherwise unavailable due to destroyed infrastructure. Furthermore, medical professionals can play a special role in healing physical and psychological wounds in violence-ravaged communities. Health care providers have an intimate association with the people who have suffered mentally and physically from armed conflicts. They are often well educated, and have stature and access to a wide range of community groups. Health care providers can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation. The involvement of medical professionals from different sides of a conflict in the delivery of health care can be a model for cooperative action using a dialogue-action approach, and can create the long-term community involvement that is essential for social change and sustainable peace.

Shared Needs and Capabilities

Our experience is that parties are most able to come together for shared actions when they share professional expertise, interest and needs, particularly in areas of social welfare, humanitarian aid and development. In this way, dialogue-action can be used wherever it is possible to develop an integrated-action program. A community that has been traumatized by violence will benefit from humanitarian and development activities that reflect the need for reconstruction of the physical, political and social aspects of the community. Often, these activities can be advanced through inter-communal cooperation, even more so if outside agencies are aware of the potential for integrated action and encourage and support it. Dialogue-action is also applicable in situations where there is a risk of violence but violence has not yet broken out. Indeed, the use of dialogue-action in this preventive mode can be highly cost-effective, because it can avoid the heavy human and material costs of violence.

Whether used to prevent violent conflict or after violence has occurred, a dialogue-action process can be used in an integrated-action program for many humanitarian and development functions, such as: health care; education; humanitarian assistance; social services; news and entertainment media; peacekeeping; policing, sports; business; and public works. Indeed, most social functions offer prospects for the integration of conflict management. Some functions offer better short-term prospects than do others. Certain functions -- such as humanitarian assistance and peacekeeping -- are temporary but might nevertheless offer fruitful opportunities for dialogue-action.⁴

⁴ Paula Gutlove and Gordon Thompson, A Strategy for Conflict Management: Integrated action in theory and practice, IRSS working paper #7, March 1999.

The shared, cooperative actions must be judiciously identified, having regard for their appropriateness and feasibility of implementation. There are situations in which parties are not ready, logistically or psychologically, to cooperate. In such cases, it is wrong to stipulate that assistance in meeting a basic need, such as food, shelter or security, is conditional upon cooperation between divided communities. Such a stipulation may make it more difficult for parties to fulfill basic needs and/or may put parties at risk. This would be an inappropriate use of the dialogue-action process.

4. DIALOGUE-ACTION IN THE FIELD: SELECTED EXAMPLES

At IRSS, we have used a dialogue-action process in different contexts in former Yugoslavia, Eastern Europe and the CIS. This paper discusses what has been our most prominent dialogue-action effort to date, our Health Bridges for Peace project, which strives to integrate conflict management with the delivery of health care⁵. This project has field programs in the former Yugoslavia⁶ and the Caucasus⁷, which involve collaboration between IRSS, local NGOs and intergovernmental organizations, including the World Health Organization (WHO). In fact, the program was initiated in part as a result of WHO observations about the potential for using health as an incentive for dialogue between disparate groups:

*"Health is valued by everyone. It provides a basis for bringing people together to analyse, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict."*⁸

Our involvement in the former Yugoslavia began on the eve of the nine-day war between Slovenia and the Yugoslav Federation in July 1991. A Slovene physician and colleague asked us to help by introducing concepts of conflict management to other physicians. She felt that they were in a position to use these skills to try to head off the impending violence in the region. Within weeks, similar requests came

⁵ Paula Gutlove, "Health Bridges for Peace: Integrating Health Care with Community Reconciliation", *Journal of Medicine, Conflict and Survival*, (Volume 14, 1998, pp. 6-23).

⁶ Medical Network for Social Reconstruction in the Former Yugoslavia, Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals: Report on an International Conference, 23-26 April 1998, Sarajevo, Bosnia (Cambridge, Massachusetts: Institute for Resource and Security Studies, November 1998).

⁷ Paula Gutlove, Health as a Bridge for Peace in the North Caucasus: Final Report on a Workshop for Health Professionals, Pyatigorsk, Russia, 29 October - 2 November 1998 (Cambridge, Massachusetts: Institute for Resource and Security Studies, 14 December 1998).

⁸ "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

from individuals and groups, both medical and non-medical professionals, in Slovenia, Serbia and Croatia. Thus began our long-term commitment to the former Yugoslavia. We convened numerous dialogue and training workshops for a range of professional groups, including politicians, educators, religious leaders, refugee workers and health care providers, working with people from Serbia, Croatia, Slovenia, Macedonia, Montenegro and Bosnia-Herzegovina.

Gradually our work came to focus on the unique and crucial role that health care professionals, primarily physicians, can play, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconciliation. We launched the Health Bridges for Peace project in 1996 in order to utilize a shared concern for the restoration of public health as a vehicle to convene a dialogue-action process with health care professionals.

The first field program in the Health Bridges for Peace project was initiated in response to requests from medical professionals in the former Yugoslavia in 1996. A group of medical professionals from the region had been meeting as an adjunct to regional international medical conferences since before the war began in 1991. Throughout, they had a desire to maintain collegial relationships in spite of the conflicts that were raging in their countries. However, they were not immune to the anger and pain caused by ongoing violence, in Croatia, Serbia, and later in Bosnia. They would convene meetings, but found it increasingly difficult to relate to each other. By 1996 they were unable to talk to each other without risking angry eruptions, so they carefully structured their time together to minimize unstructured discussion. For the most part, they would meet to present professional papers on issues of shared interest, consciously avoiding time for discussion. They had seen that non-facilitated verbal exchange had highly destructive potential that could escalate rapidly. In 1995, dialogue between Bosnian and Serb members became abusive and destructive, until an Austrian colleague intervened to terminate the exchange, not to resolve it. In 1996 they asked me to help, but they did not ask me to facilitate dialogue. Instead, they asked me to present a paper about Health Bridges for Peace at a large conference they were planning in Austria. When I suggested that it might be more useful to hold workshops in which to promote dialogue, I was told that dialogue was not possible at that time.

At the conference I spoke in a plenary session to about 70 people about the unique role that the health profession can play in community reconciliation.⁹ I explained that reconciliation meant the restoration of human relationships and the building of trust, hope and mutuality within a violence-ravaged community. It was interesting that the interpreters had difficulty with the term "reconciliation", and told me that there was no good word in the Serbo-Croatian language that adequately captured what I was trying to convey.

⁹ For more information see: "Community Reconstruction and Reconciliation, Past, Present and Future", by Paula Gutlove, paper presented at a meeting of the Medical Network for Social Reconstruction, Bled, Slovenia, November 21-23, 1997.

In my presentation I discussed the ways in which violent conflict damages relationships between people and groups. In so doing, it damages the sense of wholeness that is essential to a healthy community. Reconciliation aims to heal the damaged sense of wholeness. I discussed how medical professionals are ideally placed to take a leading role in the healing processes of community reconciliation because they have a shared interest -- across ethnic boundaries -- in public and community health, and because of their access to a wide range of community groups. I closed by inviting people to join me in an ad hoc workshop session to think together about how we could design, cooperatively, a community reconciliation process that would reflect and be sensitive to the cultural and experiential nuances of their communities.

About twenty people came to the workshop session. They worked cooperatively on the development of a community reconciliation process for medical professionals. As the time allotted for the workshop drew to a close, people lamented that they were not ready to break, so we agreed to reconvene during the lunch period. When we reconvened, the group had doubled in size. More and more people wanted to be part of a cooperative endeavor, a facilitated dialogue that had a tangible goal--the development of a reconciliation process--and that would enable people to rebuild relationships in a safe, facilitated setting.

At the close of the conference, the 70 people present unanimously agreed to rename their group the Medical Network for Social Reconstruction in the Former Yugoslavia. Their goal was to be a "network of health care providers that serves to reconcile existing conflicts and to prevent root causes of new conflict throughout ex-Yugoslavia." They publicly recognized the role and responsibility of the health care profession to heal wounds, whether individual or societal, physical or psychological, in a violence-ravaged community

A Contact Group was identified, made up of 24 people, two each from 12 significant geo-political points in the former Yugoslavia (Slovenia; Croatia: Rijeka, Osijek and Zagreb; Serbia: Belgrade, Vojvodina, and Kosovo; Bosnia: Sarajevo, Banja Luka and Mostar; Montenegro; and Macedonia). The goal was to have a medical professional and a medical student from each geographic area. There was a concerted effort of the group to develop an ongoing network made up of the most committed participants, with maximum diversity and representation. The Contact Group agreed to meet at least twice a year, and have monthly telephone, fax and email communication. The Contact Group's goals were to work together to develop the Network, to actively develop cooperative actions, and to rebuild relationships within their collegial community.

Since spring 1997 the Contact Group has met consistently, twice a year, in different locations: in November 1997 in Slovenia; in April 1998 in Sarajevo; in fall 1998 in Slovenia; in Macedonia in spring 1999; and in Slovenia in fall 1999. Meetings generally last 4 days and participants often arrange to stay an extra day or more to allow informal meeting time. They have engaged in a prolonged process of dialogue-action and plan to continue this process. The group has organized numerous cooperative actions for the delivery of health care. They

have also worked on the development of a reconciliation process for use with traumatized communities. Of the 24 original members there is a core of about 12 who are deeply invested in the dialogue-action process. They participate regularly in the meetings, and are the people who make the actions discussed a reality. They are in regular communication with IRSS and with each other between the meetings.

The author's role as an outside facilitator has varied, depending upon the actions the group is trying to achieve and the social/political situation in the region. Some actions have been undertaken successfully with minimal intervention on my part. For instance, in late 1997, two convoys of medical equipment were collected by the entire group, and brought to two different hospitals in Bosnia, one to a Serbian hospital, the other to a Muslim hospital. Also, the group is developing an electronic library for medical information about treatment of war-related injuries, broadly defined, bringing together experiences and expertise from all parts of the region. With more assistance from IRSS and from the WHO, a medical student group with members from across the region has been publishing a quarterly newsletter, focussed on issues of particular interest to medical students. More recently, the group has been working cooperatively to develop programs for psychological assistance to victims of the spring 1999 war in Yugoslavia, providing assistance to war victims in Kosovo, Macedonia, Montenegro and Serbia. I have played a facilitative role in the development of these programs by assisting the group's dialogue process and by providing information and training in specific areas. I have played a leadership role with the group in the development of programs to integrate the treatment of psychological trauma for the individual with the treatment of the traumatized community, helping the group to develop culturally sensitive processes for inter-communal healing and reconciliation.

At a meeting of the Contact Group in Slovenia in September 1999, the group experienced what they termed a "qualitative step forward" in understanding, trust, and cooperation. One participant from Serbia stated that: "Working through our disagreements with the guidance of a facilitator has been the key to this success. It is crucial that we continue to communicate in this qualitatively different way. What has made it possible is that Paula has been a catalyst for our dialogue, framing it so that we can move forward, making it safe to discuss our true thoughts with each other."

The Medical Network has also reached out to physicians from other war-devastated areas. In April 1998, physicians from Chechnya were guests at a Medical Network conference in Sarajevo. This stirred an interest in the North Caucasus for a Health Bridges field program, and a request to IRSS for assistance. In October 1998, IRSS convened a meeting in the North Caucasus that brought together 22 Chechen, Ingush, North Ossetian and Russian health professionals for conflict management training and guidance in developing collaborative public health activities. From this meeting the Medical Alliance for Peace through Health in the North Caucasus (Medical Alliance) was born. The Medical Alliance's planned cooperative public health projects, to be assisted by WHO, include: a regional network on tuberculosis control; cooperative centers for psycho-social rehabilitation; a North Caucasus inter-

regional training center for the prevention of drug addiction; and a cooperative program for prosthetic assistance to amputees in the North Caucasus.

The dialogue-action process has evolved differently for the Medical Alliance than for the Medical Network. The Medical Alliance started with a commitment to engage in a facilitated dialogue-action process. This has been enthusiastically endorsed by the WHO office responsible for the region, which intends to maintain close involvement with the process, and which has a strong interest in the identification and execution of cooperative actions. While concrete cooperative projects have been set up through the WHO, the present violence in the region has made it difficult to bring the group together for facilitated dialogue. As is discussed later, engaging in shared actions provides only some of the ingredients necessary for community reconciliation.

5. HEALING PRINCIPLES OF DIALOGUE-ACTION

*"Rebuilding society implies a restoration of the people in social, psychological and spiritual ways. If these forces are not a part of the rebuilding of society at the end of war and in the post-war context, we just put the lid on a boiling cauldron that will eventually blow off because the pain, anger and fear of war were never dealt with."*¹⁰

Dialogue-action is based on principles of healing that derive from what is known about trauma recovery. These principles, and their relevance to the dialogue-action process, are discussed in this section. A practical process to implement these principles is discussed in Section 6, below.

Trauma recovery is closely related to peace-building efforts; both are ultimately about developing or restoring healthy human relationships. Trauma recovery implies the decrease of loneliness, mood improvement, a sense of inner peace, a decrease in isolation, anger and bitterness, and a decrease in feelings of animosity and hatred toward others. Trauma recovery can only take place in the context of relationships. Recovery cannot occur in isolation because it is necessary to heal the psychological faculties that were damaged by the trauma, and this healing can only occur through relationships with other people.

In her excellent book, Trauma and Recovery, Judith Herman discusses three stages through which patients move as they recover from a traumatic experience.¹¹ These stages are safety, acknowledgement, and reconnection. Herman states that while it is not necessary or even expected that patients will move from one stage to another in a linear fashion, recovery from trauma is predicated upon the patient's moving from a feeling of unpredictable danger to one of reliable safety and security; from a sense of dissociated trauma to

¹⁰ Barrett Hart, "Transforming conflict through trauma recovery training," in Trauma Recovery Training, ed. Dean Ajdukovic, Society for Psychological Assistance, Zagreb, 1998.

¹¹ Judith Herman, MD, Trauma and Recovery, (New York, Basicbooks, 1992).

acknowledged memory; and from feeling isolated and stigmatized to restoring meaningful social connections. The dialogue-action process works with war-traumatized parties to help them move through these three stages, both as individuals and as members of conflict-divided communities.

Safety

In an evaluation of psychosocial assistance programs during and immediately after the Croatian and Bosnian wars in former Yugoslavia, it was noted that the most important thing these programs could provide was a safe space for people to rebuild their social contacts and make new contacts. The safe space was more important than any particular type of psychological intervention or therapy.¹²

Similarly, in the dialogue-action process, one of the most important roles of the outside facilitator is to assure that the dialogue feels and is safe for the participants. The meeting space must be safe from outside dangers or threats. The dialogue must be facilitated in such a way that the participants do not feel threatened by words or deeds of the other participants, and speak as freely as they feel comfortable.

Securing a location that feels safe for all participants has been an important consideration in our dialogue-action work in both the former Yugoslavia and the North Caucasus. The group in the former Yugoslavia had met several times in Austria before they felt the need to start hosting meetings on their own soil. The first "home" meeting was held in Slovenia, by far the safest of the possible places - logistically, politically and emotionally - for the participants. After the success of the Slovenia meeting, the contact group decided unanimously to hold their next meeting, in spring 1998, in Sarajevo. This was a more complicated and ambitious venue. The participants coming from Serbia, and from the Republika Srpska, were concerned about their physical safety traveling to and from Sarajevo and about their reception in Sarajevo. I discussed these concerns with Serb participants before opening the discussion, with their permission, to the whole group. The dialogue-action process allowed these participants a safe space in which to express their concerns and then to explore with the group what it would take to make them feel, and to actually be, safe in Sarajevo. It was important for the group to see that concern for the safety of all of its members was an important responsibility shared by every member of the group. Through the dialogue-action process the group outlined what shared actions they could take to make all of its members feel safe and cared for. Different participants had different requirements and needs for safety.

A different situation arose at a meeting of the Medical Alliance in the North Caucasus. The meeting took place in Pyatigorsk, about 60 miles from the Chechen border in Southern Russia. Upon arrival, Ingush, North Ossetian, Chechen and Russian participants were checking into the hotel that had been

¹² Jadranka Mimica and Inger Agger "NGO perspectives: an evaluation of psychosocial projects and a retrospective" in *Trauma Recovery Training*, ed. Dean Ajdukovic, Society for Psychological Assistance, Zagreb, 1998.

reserved weeks earlier by the meeting convenors (a Chechen and an Ossetian physician). Suddenly the hotel owner appeared and declared that everyone was welcome except the four Chechen participants, whom, he feared, might be terrorists. There was another hotel a mile away that was willing to accept the whole group, but it was a much less desirable hotel. It had no hot water, running water was available only 4 hours a day, the kitchen was partially closed, and there were many other inconveniences. The group stood with their luggage on the street in front of the first hotel to discuss their options and decide what to do. They decided that it was important that they stay together as a group, that their comfort was less important than that every member of the group feel safe and accepted, so they all moved into the second hotel.

War creates many obstacles, but a sincere desire to maintain or build relationships can spark the creativity needed to overcome these obstacles, and may even provide an opportunity for dialogue and action that can dramatically build relationships. Health Bridges actions during the 1998-1999 violence in Kosovo demonstrate this point. We held a meeting in Slovenia in December 1998. Until the day before the meeting began it appeared that all members of the Network, from all parts of the former Yugoslavia, would be able to attend. At the last minute, our Kosovar colleagues were refused visas to enter Slovenia. With regret for our missing colleagues, we decided to proceed with the meeting and managed to include the Kosovar members during key parts of the meeting by speakerphone. This was quite successful. Colleagues in Kosovo felt supported by all members of the Medical Network. The group was able to plan joint actions specifically to assist the Kosovar colleagues and their communities in their crisis situation. Carrying on the dialogue-action process while there was violence in the region made this interaction, if anything, more meaningful to the diverse participants.

Safety also refers to a feeling of safety within the group. This means that all group members will be treated with respect, that their confidences will be respected and that no one will engage in verbal or physical abuse. It also means that participants do not feel pressure to talk outside their comfort zone. Having the facilitator start each meeting by getting agreement among the group members on some simple ground rules can be very helpful in fostering a safe atmosphere of mutual respect. Similarly, the respect with which the facilitator treats participants sets a standard of behavior for all to uphold. Participants have told me that my presence as a trusted third party, with a long-standing relationship to the group, has helped to promote a sense of safety for all parties. Individually, they want to maintain with me our relationship of mutual respect. They are aware that in order to do this they must behave in a way that is respectful of all participants.

Acknowledgement

"Reconciliation is to understand both sides, to go to one side and describe the suffering being endured by the other side, and then to the other side, and describe the suffering being endured by the first side."

*Thich Nhat Hanh, Vietnamese Zen master*¹³

Herman states that when a survivor tells the story of her trauma, in detail and depth, this action can transform the traumatic memory so that the survivor can then integrate it into her life story. Herman states that recovery can only occur in the context of renewed human relationships, because survivors need to recreate the psychological faculties damaged by the trauma, including trust, autonomy, initiative, competence, identity and intimacy.¹⁴

Looking at how groups recover from the trauma of war, we have found that the traumatic events of the past need to be discussed, acknowledged, and mourned within and between communities if there is to be successful reconciliation between these groups. According to Joseph Montville, "Storytelling is an essential part of the process, not only for the victim reconstructing the story, but also for the persons representing the aggressor group."¹⁵ There is within individuals and groups a tremendous need to grieve and to mourn the losses that they have suffered themselves and that they have inflicted upon others. Acknowledgement of the past could include acknowledging the role of bystanders, active and passive, individuals and nations, in addition to the role of victims and perpetrators.

The story-telling must be facilitated in a safe and carefully structured environment so that it does not rekindle conflict or deteriorate into a competition for the greatest "victim hood", but unifies divided communities with a collective acknowledgement of the past.

To create the most helpful environment for the telling of personal stories, thereby promoting acknowledgement, I have developed a specific facilitation process. The process begins with discussion about "constructive communication", noting that it is marked by curiosity and interest among the parties; listening with an open mind; empathy; compassion; honesty; and humility. We also discuss the differences between debate, which is a frequent mode of exchange between adversaries, and dialogue.¹⁶ Finally, I provide training in active listening, a process which simultaneously allows the listener to understand and empathize with the speaker, and the speaker to achieve a clearer idea of what he or she is thinking and feeling.

¹³ Cited in J. Montville, "The Healing Function in Political Conflict Resolution" in Conflict Resolution Theory and Practice: Integration and Application, Dennis J.D. Sandole, Hugo van der Merwe, Eds. (Manchester University press, 1993), page 115.

¹⁴ Herman, p. 175

¹⁵ Joseph Montville, "Peace, Justice and the Burdens of History" unpublished paper, June 1999.

¹⁶ A useful teaching tool is "Distinguishing Debate from Dialogue" a chart produced by the Public Conversations Project of the Family Institute of Cambridge, 51 Kondazian Street, Watertown, MA 02172.

In order to achieve the intimacy and safety required for people to tell their personal story, I have designed an active listening exercise, in which a larger group is divided into small sub-groups. Each member of the subgroup takes turns listening, facilitating and answering questions that explore different aspects of her experiences as a health care provider during war conditions. Using the questions as a jumping-off point, participants can talk about their traumatic experiences and then acknowledge, grieve and mourn together.¹⁷

The active listening exercise helps participants learn to acknowledge the impact of every person's traumatic experience. This lesson was apparent at a training program convened in Macedonia in May 1999 by the Medical Network for Social Reconstruction in the former Yugoslavia. For this program, health care professionals from all parts of former Yugoslavia came to Macedonia to work with Macedonian and Kosovar Albanian health care professionals. At that time, NATO was bombing Yugoslavia, and large numbers of Kosovar Albanians were living in refugee camps in Macedonia. The focus of the program was to train health care providers in trauma recovery concepts and techniques for the treatment of both the individual and the larger community.

In one workshop, Kosovar and Macedonian participants used active listening to tell each other stories about the impact of the war on their personal and professional lives. As the workshop progressed it was clear that there was something amiss. The Kosovars were telling their stories and the Macedonians were listening, but not reciprocating. We stopped the session to find out what was going on. One Kosovar explained that he felt the pain felt by his group was so great that the Macedonians didn't dare talk about the impact of the war on their own lives, where the impact must have been so much smaller.

We called a break, during which the Macedonian group requested a private audience with the facilitators. We began by acknowledging the concerns that many Macedonians had as NATO bombs fell near their borders, large numbers of foreign troops were deployed within their country, and refugees flooded into their country, upsetting their delicate social balance and undermining their fragile economy. The Macedonians sighed with relief, and were free at last to unburden themselves of the fears and traumas they had experienced during the months of war. One person said, "No, I have not lost my home, not yet, but I have lost my job and I fear that my country may have lost its future."

When the group reconvened, we discussed the importance of acknowledging each person's experience, rather than viewing acknowledgement as a competition in which only the most extreme experiences are admissible information. The tone of the session then changed dramatically. The Macedonians were assured that their experiences were valid and they would be

¹⁷ Described in detail in: [Conflict, Conflict Management and Trauma Recovery: Briefing Manual for Workshop Participants](#) by Paula Gutlove, (Cambridge, Massachusetts: Institute for Resource and Security Studies, May 1999).

listened to with empathy. The Kosovars were able to talk about their experiences without needing to prove the extremity of their situation. Both groups felt listened to with empathy and understanding, and were able to validate the importance of each other's experiences. People were able to grieve and mourn together, to embrace, and some to cry. It was only then that they were able to think about what their potential shared future might hold.

Gradually, the processes of effective dialogue can become incorporated into the habits of an ongoing dialogue-action group. Once people become familiar with the process, it becomes a natural and adaptive way to relate. Sometimes, acts of acknowledgement can become cumulative, and will then dramatically transform a long-standing hostile relationship. When the Medical Network members met in Macedonia in spring 1999, visa restrictions made it impossible for the Serb members of the group to enter Macedonia. Representatives from all other Network regions were present. The group engaged in a joint action, writing a press release to petition NATO to end the bombing of Yugoslavia and to set up programs to provide medical relief for all parties, including Serbs, Kosovars, Montenegrins and Macedonians. The Serbian colleagues were unable to leave Serbia, and conditions made it impossible for them to take part by speakerphone (as the Kosovar colleagues had done some months earlier). They were nonetheless able to play an important role in the shared action. They reviewed the petition by email before the meeting, and were able to pass on their comments, criticisms and their provisional endorsement; subsequently, they were able to sign onto the agreement after the rest of the group had discussed and endorsed it.

Several months later, in September 1999, at a Network meeting in Slovenia, participants from Serbia expressed their gratitude to the rest of the group for their support and acknowledgement throughout the war, letting them know they were neither forgotten nor alone, but a part of a larger Network, a "safety net" as one person put it. The Serb participants acknowledged the terrible pain their Kosovar colleagues had endured, not only during the months of the war but in the years leading up to it. They also spoke about their own feelings of being cast out from civilized society, at the mercy of a leader they don't want and don't know how to rid themselves of. As the meeting drew to a close two days later, the participants reflected that after years of meeting together something dramatic shifted at this session. One said, "I found myself addressing my colleagues in the familiar "ti (you)" form rather than the formal "vi (you)" form. For years we have been meeting and it never occurred to me to be so intimate, so informal. Now, all of a sudden, I was aware that I had changed my form of address, and my attitudes, without knowing when or exactly how it happened."

Reconnection

Herman describes reconnection with society as the final stage of trauma recovery. Particularly if a survivor's personality has been formed in a traumatic environment, Herman notes, this individual finds that the beliefs that gave meaning to her life before the traumatic event have been challenged, and the survivor must find a new sustaining creed through which to live her life.

Relationships have been challenged, changed or severed by the trauma, and it is only through rebuilding relationships that the survivor is empowered and can reclaim her health and social role.

Such reconnection is also crucial to reconciliation within a violence-ravaged community, where the ultimate goal is the restoration of healthy human relationships and the building of trust, hope and mutuality. Such reconciliation promotes a restructuring of the present with new, mutual respect and acceptance, and a reopening the future for new risks and spontaneity.

We use the dialogue-action process to assist parties to rebuild trust and hope for their potential shared future. By identifying areas of mutual interest, in which they can work together cooperatively, the dialogue-action process allows participants the opportunity to rebuild their relationships in a sustainable, meaningful way. When people work together, exchange with each other, or seek medical care from the same sources, these acts will contribute to the development of trust between groups. What is important here is the knowledge that the integrated whole is stronger than the individual or the separate unit.

The development of trust and its role in guiding a group's decisions and actions was dramatically demonstrated in Sarajevo in 1998 during a discussion by the Medical Network about the membership of its governing body, the Contact Group. The discussion had reached an impasse, some arguing that membership should be apportioned along ethnic lines, others that it should be based on a functional division of responsibilities. The argument was particularly pointed in regards to the representation of the group from Mostar, a Croatian/Muslim-split city. Some argued that the group should have a representative from each side to represent the ethnic divisions in the town. Others argued that the two sides of Mostar should be able to cooperate, so that only one representative was necessary. As the argument escalated, tension in the room became palpable. One participant (a Muslim woman from Sarajevo) stood up and announced that if membership in the Contact Group was drawn along lines of ethnicity then "...of the time we have spent together, the work we have done together, we have learned nothing. Those people who want to rob us of our ability to trust each other have won." She went on to argue that the Network could succeed in its mission of reconciliation only if each person would try to trust each other to act for "our shared goals", with each person behaving as a responsible partner. She looked around the room with tears in her eyes. She turned to the two participants from Mostar, a Croat physician and a Muslim physician, and said, "I trust you two to make the best decision between you as to how to represent Mostar, to work out a practical system of cooperation that works for both of your communities." Instantly, the tension in the room dissolved. The two physicians from Mostar stood up and crossed the room to clasp each other around the shoulders and told the group they would discuss a functional division of responsibilities and then present their solution to the group. The Croat physician said, "we have learned to teach reconciliation to others, but we must not forget to learn our lessons ourselves and to use them with each other."

Another example of reconnection occurred in a meeting of the Network in Slovenia in September 1999. I have described already the effect of acknowledgement and the transformation of relationships marked by a change from the "ti to the "vi" form of address. At this meeting there was a dramatic reconnection between the

participants from Belgrade and those from Zagreb, who agreed to organize and participate in professional exchanges between their respective universities, marking the first such exchange in this area since 1991.

Empowerment is an important side-product of reconnection. Through reconnection and the rebuilding of relationships, the survivor is empowered to reclaim her place in the world. We have found in the Health Bridges project that it has been extremely empowering for individuals in the group to feel that their collective actions have the capacity to effect societal change. Before participating in the dialogue process, many of the participants were embittered by the human and physical destruction they had experienced. Their work with the group and the Health Bridges project provided new opportunities, a new vision, and a new role in their community and in the world. It demonstrated the potential of healing and collaborative action, and built bridges between colleagues who thought they could never again work together. Similarly, for international collaborators such as WHO field staff, their involvement expanded their mission and sparked great excitement.

We have observed in our fieldwork that people feel good when they are in productive relationships with colleagues. Engaging in cooperative actions that have the power to change the course of events feels even better. Thus, empowerment and reconnection can operate in a healthy cycle, each building on the other.

6. STAGES OF THE DIALOGUE-ACTION PROCESS

The preceding section has shown how general healing principles are applicable to trauma recovery and societal peace building. The effective realization of these principles requires careful organization of the dialogue-action process. Experience has shown that the process works best when it employs the five stages discussed below. While these five stages represent a progression, earlier stages are often revisited after the group has moved to a later stage, as the needs of the group evolve over time.¹⁸

Stage 1. Initiation

The initiation of a new dialogue-action process has three parts: invitation; assessment; and logistics.

(a) Invitation

All IRSS dialogue-action projects have begun in response to a request from indigenous, often influential, individuals to come to their country to initiate a project. The requests are often supported by a request from an international agency working in the region, e.g., WHO, UNHCR, OSCE, etc. Invitations

¹⁸ As will be discussed in Section 7, these stages were inspired by the five stages of the Saunders Public Peace Process.

usually follow a presentation by IRSS about the concepts of dialogue-action and its practical application. For example, I was invited to initiate the first Health Bridges field project in former Yugoslavia after I presented a workshop at an international medical conference about the role of the medical profession in peace building, using the Health Bridges project as an illustrative model. The Caucasus field project began after physicians from the Caucasus attended a conference of the Medical Network in former Yugoslavia. In September 1999, I was a panelist at an international conference convened by the WHO addressing the connections between health and violence. After my presentation, physicians from Sri Lanka, Lebanon and Jordan invited me to come to their countries to initiate Health Bridges programs there. In November 1998, I presented the dialogue-action concept at an international conference of the OSCE. Subsequently, a UNHCR representative who was present invited IRSS to initiate a dialogue-action process for them in the CIS.

(b) Assessment

Once an invitation has been received, an assessment of the situation is necessary to determine if dialogue-action is suitable. As discussed in Section 3, above, the appropriateness and utility of dialogue-action depends upon societal conditions, motivation of the parties and the shared needs and capabilities of the parties. These factors need to be assessed before a dialogue -action process is initiated. Some questions to ask during the assessment phase include:

- Is this a society in transition with opportunities for social change?
- Is it possible to bring parties together safely, and if so how?
- What are potential areas of shared action?
- Who are the parties that should be included? How will it be possible to gain the best access to them?
- Are there local protagonists who want to be key players in working with IRSS to develop the dialogue process and who can handle the local logistical and practical arrangements?
- Is there a critical mass of interest and motivation among the parties to build a core group of influential, inspired participants?
- Is IRSS willing and able to make a long-term commitment to the area?
- Is IRSS the right facilitator? Are other facilitators needed instead of or in addition to IRSS?
- Will it be possible to support, financially and logistically, a sustained dialogue-action process?

(c) Logistical arrangements

It is important to arrange enough support for the dialogue-action process so that the facilitator can make a commitment to a sustained effort, and participants can be brought together safely and repeatedly. It is most efficient to have local coordinators, representatives of each side, who can assist the facilitator in developing a balanced agenda that responds to the groups needs. The local

coordinators will also communicate with local participants and make logistical arrangements.

Stage 2: Orientation: who, why, what and how

Every dialogue-action meeting should start with an orientation: who is present, why they have come, what they hope to achieve, how they hope to achieve it. The orientation is an important part of the process. At a first meeting, orientation is when participants get their bearings within the group. At a subsequent meeting, orientation is the time when people renew their relationships, remember what was accomplished at previous meetings and think about what they want to accomplish at this one.

It is important to start each meeting by assuring that all participants feel safe, comfortable and welcome (as discussed in Section 5, in the subheading "safety"). It is preferable if the meetings can be held in a location away from the conflict areas. This way, participants can leave behind some of the tension of the day-to-day life of the conflict, begin to relax, and focus on the work they are about to do together.

Before the meeting, it is useful to develop, with input from participants, a preliminary agenda. Once participants are clear about who is present, why they are together and what they want to achieve, they can decide together if the preliminary agenda will suit their needs and, if not, they can work together to change it.

Stage 3. Exploration: the past, present and future

In the dialogue process, participants are helped to explore their past, their present and their potential shared future. This is a joint process of releasing the past and its pain; restructuring the present with new, mutual respect and acceptance; and reopening the future for cooperation and interaction. The dialogue does not progress sequentially, looking first at the past, then the present, and then the future. Instead, dialogue proceeds through a gradual process that touches on each area in turn, more superficially in the beginning, then at progressively deeper and deeper levels. Facilitation of the dialogue process will vary depending upon the needs of the participants and the task. (This was discussed in Section 5, under the subheading "acknowledgement".

Exploring the present situation is done in the context of the group's shared areas of interest. For example, for the Health Bridges for Peace project, discussion of the present situation is framed by the public health situation in each area. For this discussion, health refers to physical, mental and social (community) health. Dialogue begins by allowing participants to caucus within their regional groups, followed by regional presentations to the plenary. Participants are asked to explain the current situation in their region, emphasizing war-related public health issues. Participants are also asked to discuss specific public health needs and concerns in their communities. Finally, they are asked to present what they think their communities might be able to offer to the larger group in response to health needs of other areas.

Framing dialogue around shared areas of interest and potential action is important for several reasons. When relationships are stressed, it is easier and safer for people to begin dialogue about their common interests. Participants have the opportunity to talk about their regional situation without pressure to be overly personal. Underlying the discussion of the public health situation is an implicit conversation about the relationships between different groups, and how these relationships impact upon the health of communities. By couching the discussion in the context of public health, participants can maintain the degree of professional distance that they choose. They can become more personal as the dialogue progresses, as trust and relationships evolve. Furthermore, the public health focus reminds participants that they have come together to further their common professional areas of interest, seeking to improve public health in all regions. Finally, framing the discussion in terms of needs, concerns and offers encourages everyone to think about what they can give to the group, not only what they might want to take from it. It is empowering for everyone, especially people who have been victimized, to think about what they can offer.

As the dialogue develops, participants will see that the exploration stage has generated a map of where they have been, where they are now, and of the needs and resources within the group, thus pointing the way to a potential shared future.

Stage 4: Generating options

As participants learn more about each other and themselves, they can begin to explore potential shared actions. At that point, it can be useful to look at similar cooperative efforts that have been carried out elsewhere. In the context of Health Bridges for Peace projects, we look at a variety of international efforts that combine health and peace. We then promote a brainstorming discussion to elicit from participants, drawing from their experience, descriptions of situations where health and peace have been or could be combined.

In this stage it is important to encourage participants to play, creatively, with a wide range of ideas. Participants should be allowed to be as creative as possible. Sometimes this is done through a visioning exercise, where participants articulate positive visions of what they would like to see in their community or in the field of public health, in 1 year, 5 years, 10 years, and 20 years.¹⁹

Stage 5: Implementing a strategy

In this stage, the group works together to move from visions to specific programmatic goals through the development of action plans. These action plans are not written in stone but are guidelines that will change and evolve over time. In developing action plans, participants will discuss what aspects of

¹⁹ Examples of workshop exercises for generating options are available in: [Health as Bridge for Peace in the North Caucasus, Briefing Manual for Participants](#), by Paula Gutlove, Cambridge, Massachusetts, Institute for Resource and Security Studies, December 1998.

potential positive futures can be achieved through inter-communal collaboration. They will be asked to define specific goals and a strategy for achieving these goals. The strategy will include a time-line, description of the necessary resources, and ideas about where these resources could be sought.

In addition to developing goals and strategies for shared, outer-directed, specific actions, the group also needs to discuss its development as a sustainable group. Participants are asked to consider these questions:

- Who is this group?
- What shall we do?
- How shall we do it?
- Who else should be involved?"

This brings the group back to the questions posed at the Orientation stage (Stage 2): who, why, what and how. As relationships evolve among members of the group, the answers to these questions will also evolve.

While the group may become involved in the planning and execution of a variety of shared actions, the development of a sustainable, working network of committed, activated people from across conflict lines, and the deepening of trust between members of the group, are often among of the most significant shared actions and most satisfying achievements of a dialogue-action process.

7. THE DIALOGUE-ACTION PROCESS CONTRASTED TO SAUNDERS' FIVE-STAGE SUSTAINED DIALOGUE PROCESS

We are indebted to Harold Saunders for the basic framework of the IRSS dialogue-action process. It was modeled on the Saunders sustained dialogue process, as described in two articles: "A Public Peace Process," by Gennady I Chufrin and Harold S. Saunders, *Negotiation Journal*, April 1993; and "Dialogue to Change Conflictual Relationships", an International Concept Paper by H. Saunders and R. Slim, October 1994. It is therefore no surprise that the similarities between the two processes far outweigh their differences. The differences that do exist reflect primarily the differing applications of the two processes. IRSS' dialogue-action process evolved as our field programs developed, in response to the needs of the program participants, political exigencies, and the skills of participants and facilitators.

The dialogue-action process and the sustained dialogue process share the same fundamental belief that they are, as stated by Saunders, "a political process through which citizens outside government come together in dialogue to design steps for changing conflictual relationships in ways that create the capacities to build the practices, processes and structures of peace."²⁰

Because the dialogue-action process was modeled on the sustained dialogue process, and they share the same fundamental belief, the two processes are more alike than they are different. What differences do exist show up primarily in the differing modes of applications of the two processes and the selected populations in which they have been applied. Their differences make them, if anything, synergistic rather than in opposition to each other. In looking for points of

²⁰ Harold Saunders, *A Public Peace Process*, St. Martin's Press, New York, 1999 page 9.

contrast between the sustained dialogue process and the dialogue-action process, two points can be made. These reflect different degrees of emphasis in the processes, not a difference in basic philosophy. First, there is a difference in the degree to which the dialogue within each process focuses on the nature of the conflictual relationship rather than the shared activities in which the group will engage. Second, the processes vary in the degree to which dialogue is viewed as a tool to change conflictual relationships rather than as therapy to heal social and psychological wounds.

Relationship versus Action

In exploring the first point of contrast, it is useful to think about the broader spectrum of third party-facilitated dialogue efforts that one finds in the area of international conflict management. Imagine this spectrum as a continuum. At one end of the continuum is the "Contact Approach", whereby parties divided by conflict are brought together to work on joint tasks. Here, the communication is task-oriented and the emphasis is on getting a job done. The conflict is not explicitly discussed, as it is deemed "too hot". The relationship between the parties is not explicitly discussed, as this subject is felt to be too divisive. Participants interact as members of groups, not as individuals. The explicit goal is completing the shared task.

The other end of the spectrum is the "Interpersonal Approach." In this approach, participants are brought together to discuss their relationships. They are asked to interact as individuals, putting their social identity aside. The goal of the group is to explore the psychological aspects of the conflictual relationship. There is no program of joint activities outside of the dialogue itself.

Both the sustained dialogue process and the dialogue-action process fall somewhere between these two extremes. In both, there are joint actions in addition to an exploration of relationship. In both processes, participants interact both as individuals and as members of different identity groups. The differences between the two processes lie in their respective emphases. The sustained dialogue process places greater emphasis on explicit exploration of the conflictual relationship. By contrast, the dialogue-action process emphasizes developing a plan for cooperative action, and addressing the relationship in the context of this action. The sustained dialogue process focuses on probing specific problems to reveal the dynamics of conflictual relationships. The dialogue-action approach, particularly in the context of the Health Bridges for Peace Project, focuses on healing psycho-social wounds and through this healing process, on promoting the renewal of healthy relationships.

In the sustained dialogue process, Saunders describes a crucial and difficult transition occurring in Stage three of the process, "Probing problems and relationships". Through in-depth probing of specific problems to reveal the dynamics of the relationship, the participants move from relating to each other as adversaries to seeing each other as co-workers. In the dialogue-action process, this transition occurs differently. The dialogue-action process starts by selecting participants who are committed to working together. In the case of the

Health Bridges project, medical professionals who want to work together to improve public health are invited to participate. In this case, an emphasis on thinking and working together in an operational way is established at the start of the process through the definition of the task and the selection of participants.

This is not to say that discussion of the relationship does not occur or is off limits. Discussion of the relationship as it relates to the defined joint tasks is a crucial part of the healing process. It is my experience that when discussion of the conflict or the relationship is forbidden, as in the "Contact Approach" described above, the group does not develop trust and cannot work together effectively to accomplish a joint task.

While there remain many difficult issues to be resolved in developing a heartfelt spirit of cooperation across conflict lines, these issues may be dealt with earlier or differently in the dialogue-action process, particularly in the Health Bridges project, for several reasons. First, the participants are joined by a shared professional identity, which was the basis for their selection to participate in the dialogue. Second, for Health Bridges participants, the immediacy of working on life-and-death issues can propel a sense of greater urgency and promote greater cooperation. Third, medical practitioners often have outside experience with inter-communal cooperation to address a health crisis. Fourth, between neighboring states there may be a pre-conflict tradition of working together as medical colleagues, which may be reawakened in the dialogue-action process. For example, in the former Yugoslavia, many of the participants went to medical school together, and participated in inclusive professional societies before the break-up of the Yugoslav confederation.

Relationships versus Healing

The second point of contrast between the sustained dialogue process and the dialogue-action process is that the sustained dialogue process utilizes dialogue as a tool to change conflictual relationships, while the dialogue-action process utilizes dialogue as therapy to heal social and psychological wounds. The concept of healing encompasses social reconnection and the renewal of healthy relationships. The dialogue-action process, particularly in the Health Bridges for Peace project, treats the post-traumatic conflictual relationship as a wound that needs healing. One of the most important joint tasks in the dialogue-action process is the development of appropriate therapies so that healing can take place, first within the context of the dialogue group and then later within the larger community.

Saunders notes the importance of "reconnecting the torn tissues that might help the body politic function again as a whole."²¹ It is clear that he views the renewal of healthy relationships as a fundamental goal. In the dialogue-action process, reconciliation is framed as an integral part of healing from trauma. In the Health Bridges project, the helpers and healers of society are assembled to work

²¹ Harold Saunders, *A Public Peace Process*, St. Martin's Press, New York, 1999 page 27.

together to develop the most culturally appropriate methodologies for healing torn relationships. They seek to promote good public health, encompassing social, mental and physical health. In that context, they seek to develop adequate trauma recovery therapies, which can be promoted widely throughout communities, rather than being used only within a workshop setting.

8. DIALOGUE-ACTION AS A STRATEGY TO PROMOTE SUSTAINABLE CHANGE

The ultimate goal of dialogue-action is to have a long-term sociopolitical impact. Properly applied, dialogue-action can be a strategic instrument for spreading and strengthening conflict management throughout a society. It can help to heal communities, to make them a better place to live, to promote peace and justice, to promote tolerance, to raise consciousness about human rights, to empower citizens and encourage self organization, and to contribute to the development of a healthy civil society.

Dialogue-action can be effectively promoted by designing common tasks that will bring people together to work cooperatively, and by integrating into these tasks some training and facilitation in conflict management. Spreading and strengthening conflict management through dialogue-action is an undertaking that IRSS has termed "integrated action," as discussed in Section 2 of this paper.²² Integrated action weaves together conflict management with other humanitarian activities for several purposes. The humanitarian action is an incentive for parties to come together and provides a basis for continued engagement of indigenous parties. As parties work together they create a context for dialogue and for training in reconciliation and conflict management skills, which can be applied on many levels, promoting community reconciliation among ever-larger circles. The first circle encompasses the providers of a humanitarian action, the second circle encompasses people directly reached by the humanitarian action, and the third circle encompasses the surrounding community. Other, wider circles will be reached by replication of this process in other locations. Finally, the conscious integration of conflict management with humanitarian actions can provide a sustainable structure for long-term cooperation and community reconciliation.

In the short term, integrated action can have practical advantages of at least five kinds:

- Conflict management can enhance the effectiveness with which a social function is performed, and vice versa.
- The social function can provide an infrastructure for the delivery of conflict management.

²² for more information about Integrated action, see Paula Gutlove and Gordon Thompson, A Strategy for Conflict Management: Integrated action in theory and practice, IRSS working paper #7, March 1999.

- Certain functions -- such as the delivery of health care -- can create a climate of trust, which assists conflict management.
- The personnel who perform a social function can demonstrate conflict management principles through their actions, thus encouraging the propagation of those principles.
- Integrated action can be the most cost-effective and sustainable way to build indigenous conflict management capacity and create opportunities for its application.

The full value of dialogue-action will only become apparent over a period of years, as the principles of conflict management become known and put into practice throughout a community. Thus, when conflict management is introduced into a region undergoing transition, there should be a long-term strategy for spreading and strengthening conflict management in the region. Here, "spreading" refers to the introduction of conflict management to progressively wider circles of people, while "strengthening" refers to the improvement of conflict management capabilities and the effectiveness of their application. Both spreading and strengthening should occur primarily through integrated action channels. Indigenous conflict management expertise -- in the areas of practice, scholarship and strategy -- will be needed to support integrated action programs. The building of indigenous expertise will require specific attention and resources.

An effective strategy for spreading and strengthening conflict management in a region is likely to have several stages. As a simplified illustration, consider the following five-stage strategy:

- Stage 1: A region-wide group of conflict management organizations, practitioners and scholars is established, providing the base of expertise for subsequent stages of the strategy.
- Stage 2: The principles and practices of conflict management are introduced to small groups of professional people (e.g., health care or education professionals) who are in a position to implement integrated action programs.
- Stage 3: These small groups of professionals demonstrate conflict management through their work, and spread its principles and practices to other members of their professions.
- Stage 4: Most members of a profession become familiar with conflict management and introduce it to their clients (e.g., medical patients, and school students) via integrated action.
- Stage 5: Conflict management becomes subsumed within a wide variety of social functions, and becomes familiar to most members of the general population. At each stage, after conflict management has been introduced to another group of people, ongoing effort is made to improve conflict management capabilities and enhance the effectiveness of their application in the context of that group.

When conflict management is first introduced into a community undergoing transition, there will be a need to import facilitators and conflict management expertise from other communities. Imported expertise must be adapted so that

it is culturally appropriate and applicable. During the 1980s and 1990s, many countries undergoing transition received conflict management expertise from North America and Western Europe. Yet, as conflict management spreads throughout a community, the need for expertise will increasingly be met from indigenous sources. Moreover, a community with newly acquired expertise in conflict management could become a supplier of expertise to other communities undergoing similar transitions and experiencing similar conflicts. Ultimately, the deepest understanding of conflicts will come from within cultures that have direct experience of those conflicts.

As noted by international peace builder and professor of conflict resolution, Adam Curle: "the most important resource for the mental health of a community are its people. If the latent capacities for courage, wisdom, and compassion of the multitude of public-spirited and good hearted citizens is evoked, they can do more than the best of imported 'experts'."²³ Clearly, the most important role of the outsider is to provide specific know-how, material and spiritual encouragement, and support.

9. CONCLUSIONS

Dialogue-action is a process of relationship building using facilitated dialogue to promote cooperative action. By embedding dialogue in a plan of shared action between parties in conflict, the dialogue-action process can provide an incentive for initiating interaction between disparate groups, and a context for sustaining that interaction.

The dialogue-action process requires time to achieve results. The appropriateness and utility of the dialogue-action process will depend upon many factors, including: (a) societal conditions; (b) motivation of the parties; and (c) the shared needs and capabilities for cooperative action.

The most prominent example of a dialogue-action effort to date is the IRSS Health Bridges for Peace project, which utilizes a shared concern for the restoration of public health as a vehicle to convene a dialogue-action process with health care professionals. The project strives to integrate conflict management with the delivery of health care, and has field programs in the former Yugoslavia and the Caucasus.

Dialogue-action is based on principles of healing that derive from what is known about trauma recovery. Trauma recovery is closely related to peace building efforts as both are ultimately about the development of healthy human relationships. Violent conflict damages relationships between people and groups. In so doing, it damages the sense of wholeness that is essential to a healthy community. Trauma recovery through reconciliation aims to heal the damaged sense of wholeness. Recovery cannot occur in isolation because it is necessary to

²³ Adam Curle, "Violence and Alienation: An Issue of Public Mental Health" in Medicine, Conflict and Survival, Vol12, 14-22 (1996).

heal the psychological faculties that were damaged by the trauma, and this healing can only occur through relationships with other people.

The dialogue-action process works with war-traumatized parties to help them move through the stages of trauma recovery both as individuals and as members of conflict-divided communities. Recovery from trauma is predicated upon the patient's moving from a feeling of unpredictable danger to one of reliable safety and security; from a sense of dissociated trauma to acknowledged memory; and from feeling isolated and stigmatized to meaningful social reconnections. Empowerment is an important side-product of reconnection. Through reconnection and the rebuilding of relationships, the survivor is empowered to reclaim her place in the world.

Because the dialogue-action process was modeled on the sustained dialogue process, and they share the same fundamental belief in the restoration of healthy human relationships, the two processes are more alike than they are different. Two points of contrast can be made. First, there is a difference in the degree to which the dialogue within each process focuses on the nature of the conflictual relationship rather than the shared activities in which the group will engage. Second, the processes vary in the degree to which dialogue is viewed as a tool to change conflictual relationships rather than as therapy to heal social and psychological wounds.

Ultimately, dialogue-action programs strive to make a long-term sociopolitical impact. In this way, dialogue-action can be a strategic instrument for spreading and strengthening conflict management throughout a society. It can help to heal communities, to make them a better place to live, to promote peace and justice, to promote tolerance, to raise consciousness about human rights, to empower citizens and encourage self organization, and to contribute to the development of a healthy civil society.

The most important roles of the dialogue-action facilitator, the third party, are to find the nucleus of women and men with the heart, will and ability to work across conflict divides, and then to support them in the difficult, often heroic, process of building a culture of peace on the ruins of war.