Community-Building Before, During, and After Times of Trauma: The Application of the LINC Model of Community Resilience in Kosovo

Ferid Agani
University of Pristina

Judith Landau
Linking Human Systems, LLC, and LINC Foundation

Natyra Agani
Clemson University

A family's heritage and values have profound bearing on the stressors they encounter and how they cope. Socioeconomic change, natural and man-made disasters, and international migration are major influences on the integrity of society. In these times of global financial crisis, communities around the world are in danger of losing their intrinsic structure and protective factors. Connectedness or attachment to family and culture of origin correlate with reduced risk-taking behaviors and a reduction in family and societal violence, post-traumatic stress, addiction, depression, suicidality, sexual risk-taking, and other chronic and/or life-threatening health problems and illnesses. Facilitating these families' cultural and community ties and enhancing their access to extended-family and community resources can thus be protective against trauma. These relationships foster resilience and reduce the short and long-term effects of stress on families and communities. Targets of interventions may be individuals, families, or communities. Assessment of vulnerabilities, protective factors, vulnerabilities, goals, and resources encourages and facilitates collaboration across natural and artificial support systems. Such collaboration is important in building resilience rather than perpetuating vulnerability and long-term problems for individuals, their families, and the communities in which they live. The recent Kosovar experience in implementing the LINC Model of Community Resilience illustrates these principles, as applied in the context of substance abuse services and community rebuilding and in the period soon after armed conflict.

The occupation of Kosovo between 1989 and 1999 and the war that took place in 1998 and 1999 caused the destruction of the Kosovo health system and left mental health services in total disarray (World Health Organization [WHO], 1999). With the dearth of human and institutional resources, the old-fashioned, hospital-based system of psychiatric services was not able to respond to the overwhelming mental health needs of the severely traumatized population. Soon after the conclusion of the war, a veritable caravan of international non-governmental (non-profit) organizations (NGOs) appeared in Kosovo with "copy-and-paste" trauma programs that had been implemented in other societies soon after armed conflict. Although these relief efforts diminished the gap between supply of mental health services and demand, the NGOs generally gave little attention to Kosovo's special cultural and situational needs. As a result, they distracted the few remaining indigenous mental health professionals from their regular duties and, in so doing, fractured the modest system and reduced the national capacity for comprehensive solutions to mental health problems.

In May 2000, during the early postwar days, the second author (Landau) came to Kosovo as a part of a team of four mental health professionals from the United States, at the invitation of the first author (Ferid Agani), who was leading mental health reform in Kosovo. The purpose of the visit was to consult on the development of community-based, family-focused mental health services in the post-Communist, postwar era.

Family functioning and vital kin networks can be severely disrupted by complex, ongoing, or recurrent trauma, as experienced by those who have lived amid armed conflict. Groundbreaking studies of World War II and Vietnam veterans and their families (e.g., Catherall, 1992; Figley & McCubbin, 1983, Hill, 1949) revealed the stressful effects of combat experience on family systems. Mental health research and theory has also broadly emphasized the importance of families as natural support agents for people with mental illness. Health policy planners have come to recognize the importance of the family system—*family integrity* and *family values*—for social health and community functioning (Landau & Weaver, 2006; Landau, Garrett, et al., 2000).

A family's heritage, values, and predominant form (e.g., matriarchal vs. patriarchal) can have profound bearing on the kinds of stressors and risks it encounters and how it handles them. Migration provides a poignant case example. In reviewing the literature, Stanton et al. (1982) concluded that there is a much higher rate of substance abuse in the offspring of families that have migrated 200 or more miles from their hometowns. It is likely that migration threatens connections within the intergenerational family, thus increasing the likelihood of risk-taking behavior (Landau, 1982).

Studies that Blum (1972) conducted with adolescents at high and low risk for substance abuse showed that families of low-risk adolescents had a sense of family heritage and history, whereas the high-risk families did not. These findings are corroborated by the subsequent family research of Baumrind (1991) on adolescent drug use and other problematic behaviors. Stated differently, families who know where they come from, and are not cut off from their heritage, may be better able to maintain stability and navigate the risks of modern life (Landau, 1982). In fact, individuals who are closely connected to their culture and family of origin, as demonstrated by knowledge of intergenerational family stories and frequency of contact with family of origin, are significantly less likely to become involved in risk-taking behavior (Landau, Cole, Tuttle, Clements, & Stanton, 2000; Tuttle, Landau, Stanton, King, & Frodi, 2004). This is highly relevant to understanding the role of relationships in protecting people from the risk-taking associated with many of the stress-related illnesses that follow major trauma.

A series of studies explored the relationship between connectedness to family and culture of origin and level of sexual risk-taking in 2 samples of women—women in an STD (sexually transmitted disease) clinic and women in an inner-city Hispanic community organization. The results showed that knowledge of stories about grandparents or great-grandparents was a robust predictor of lower sexual risk-taking. In addition, having at least monthly contact with extended family members was strongly associated with lower levels of sexual risk-taking. Both measures held up independently and together (Landau, Garrett, et al., 2000).

In a subsequent study involving adolescent girls attending a mental health clinic (diagnoses included depression, anxiety, and sexual abuse), intergenerational family stories revealed themes of resilience (i.e., ancestors overcoming adversity) versus vulnerability (i.e., depression, family violence, and addiction). The results indicated that knowing a story with a theme of resilience was most protective. However, knowing *any* family story,

even if it contained themes of vulnerability, was more protective than knowing no story at all (Tuttle et al., 2004). These findings suggest that being able to draw on the rituals, strengths, stories, scripts, and themes of past generations helps people to reconnect their transitional pathways. This enables families to reunite their communities and thus to enhance their collective resilience.

After finding that the stories of families who interpreted themes as vulnerable or resilient were not that different from each other, an intervention—Link Individual Family Empowerment (LIFE)—was developed to enhance positive connectedness. LIFE focuses on helping families work together to change their themes of vulnerability to those of resilience (Landau, Mittal, & Wieling, 2008).

Bohanek et al.'s (2006) study of family narrative interaction and children's sense of self offers a possible explanation of why adolescents from families with themes of resilience are more likely to have high self-worth and are less likely to be involved in sexual risk-taking. It would be interesting to explore whether risk-taking is also reduced in children from families whose narrative style allows them to create a coordinated perspective on past events and to work through negative and positive events. Bohanek et al. suggest that determining narrative style might be applicable as a diagnostic tool in family assessment and treatment. It might be also be helpful to analyze family themes for resilience versus vulnerability.

Community resilience is defined as a community's capacity, hope, and faith to withstand major stress, trauma, and loss, to overcome adversity, and to prevail, usually with increased resources, competence, and connectedness (Landau, 2005, 2007). The capacity to access resilience, healing, and growth depends on a balance of stressors and resources, and the level of connectedness to family, community, culture, and spirituality (Landau, 2001). Therefore, mental health professionals can best foster trauma recovery by shifting from a pathology focus and expanding the predominant individual treatment approaches to mobilize the capacity for healing and resilience in families and communities (Landau, 1982, Landa 1985, 1986, 2004, 2005, 2007; Landau-Stanton, 1986; Rutter, 1999; Walsh, 2003, 2006).

Facilitating Collaborative Care

Family, Peer, and Family and Community Links can provide a bridge between professionals, families, and communities, particularly closed communities, for example, highly educated sophisticated communities, or traditional extended families and clans, where outside intervention is neither invited nor welcomed (Landau, 1982; Landau, Garrett, et al., 2000; Landau et al., 2008). This process is particularly important for Kosovar society, which is characterized by large traditional extended families with an average of six members (Mohanan, 2003).

Link interventions are based on transitional family theory, which blends here-and-now, transgenerational, and ecosystemic factors in the practice of family therapy (Seaburn, Landau-Stanton, & Horwitz, 1995). Family, Peer, and Family and Community Links serve as natural change agents in their own settings. Links collaborate with the relevant multidisciplinary professionals, but they also honor their own rules and rituals. They also do not invite the professionals to become an integral, long-term

part of their family and community. Facilitating natural change agents as Links allows the tradition, strength, pride, and privacy of the community to remain intact and draws on group resilience, while respecting the community's capacity for healthy change and survival.

Community-wide intervention involves all of the systems. It draws from each level of connections in the design of any program. These interventions provide the process, and the population itself designs the content. The participants include individual traditional and non-traditional families, natural and artificial support systems, all of the relevant professionals, and the entire community structure. This type of intervention engenders belief in the inherent competence and resilience of family and community. In such a context, an effective prevention or management context for change is built through collaboration across all systems, with due consideration of cultural, spiritual, ethical, and policy issues.

The aim of this type of community intervention is to build resilience that is sustainable over time with reduced long-term professional involvement. This approach is in stark contrast with those interventions that are pre-planned or taken from other settings in boilerplate form to impose on a different culture and context. Such boilerplate models have been shown over time to be less successful than flexible approaches that embody the culture and context of the target population.

Ethnic Cleansing and Subsequent Events

To appreciate our work in Kosovo, it is necessary to have some understanding of the traumatic events that preceded our collaboration. After numerous atrocities in the relationship between Serbia and its former Yugoslav neighbors, NATO took collective action to stabilize the situation, end the atrocities, and protect the populations that had become the victims of genocide. On March 24, 1999, NATO's bombing campaign started, and Kosovar Albanians fled to Macedonia because the Serbian military was forcing entry into their homes. About 1 million people were expelled from Kosovo within a few weeks (United Nations High Commissioner for Refugees, 2000). They traveled by foot, car, wagon, or any other means that they could find during the ethnic cleansing. Family and community connections extended throughout the Kosovar community, across all the borders to Montenegro, Macedonia, Albania, and even the Presheva Valley in southern Serbia. Each of the Albanian communities in these areas welcomed the refugees with open hearts, minds, and homes, according to the principles of Kosovar reciprocal hospitality. The resilience inherent in both national and international communities forged solidarity and community connectedness. The Family itself and the Family and Community Links served as the foundation for the survival of the group as a whole.

A study conducted during the postwar period (Cardozo, Agani, Vergara, & Gotway, 2000) showed that 25% of the total population above 15 years of age displayed the signs and symptoms of post-traumatic stress disorder. Unsurprisingly, anxiety and depression were also on the rise. The extreme stressors experienced by much of the population during the war were magnified by the corollary loss of the traditional network of social support.

Available professional resources for mental health services across the country were at an extremely low level: 1 psychiatrist per 100,000 inhabitants; 1 mental health nurse per 35,000 inhabitants; only 1 child psychiatrist; and only 5 psychologists with clinical experience. There were no substance abuse and forensic services. These shortages of human resources were rendered even more severe by the fact that Kosovar mental health professionals were burdened, of course, by their efforts to safeguard their own families, who often had also been refugees and who were trying to reconstruct ordinarily expectable conditions of life.

This situation of a highly traumatized population in combination with a severe lack of human and institutional resources in the formal mental health service system drove the need for the development of innovative mental health interventions based on the specific community resources of the Kosovar population, in particular extended family structures, and mutual solidarity. Developing services based on the family was the natural and culturally appropriate solution because the family serves as the fundamental unit of care and support in Kosovar society.

A Society in Transition

Even without its recent history of forced displacement of most of the population, Kosovo would be challenged to meet the social and health needs of its population. Indeed, even without the strains of political change per se after the fall of Communism and the subsequent break-up of former Yugoslavia, Kosovo was experiencing great need.

Kosovo has the youngest population in Europe. The data from various sources confirm that over 50% of the total population is below 25 years of age, and those below age 20 account for over 40% of the population (UNFPA, 2005). Hence, simply **12** by demographics, there is a high risk of substance abuse, dependence, and addiction in the population. The overall size of the population is also expected to grow as today's young people enter their reproductive years. In effect, the population boom that is seen today will produce another, likely even larger population boom in the next decade (Mohanan, 2003).

Poverty is an enormous issue. The Balkan region is the most economically distressed area of Europe, and Kosovo faces even greater challenges than other countries in the region. In 2001, the World Bank estimated that about 1 in 8 residents—250,000 people—lived in extreme poverty and in desperate need of social assistance programs. About 3 in 8 residents were marginally poor, bringing the overall poverty rate to 50%. The unemployment rate was staggering (more than 50%). The increasing population will certainly cause serious pressure in the already strained labor market.

The Problem of Substance Abuse

A major disaster (such as the recent war) and unpredictable or untimely losses are key risk factors for substance abuse (Garrett & Landau, 2006). In this context, soon after the war (in 2001), the WHO commissioned a research team—RAR (Rapid Assessment and Response) on Drug Use and Young People in Kosovo—to assess the prevalence and nature of substance abuse, identify obstacles and opportunities in relation to early intervention, and recommend priorities for action. The research team issued a series of findings:

1. Drugs of all types, including heroin, were available in Kosovo. (Drug trafficking routes pass through Kosovo, from Central Asia through Eastern Europe toward Russia.)
2. Among young people attending school, levels of substance (alcohol, tobacco, and other drugs) use were comparable with most European Union (EU) countries.
3. Among other groups of younger adults, levels of cannabis and ecstasy (MDMA) use were comparable with most EU countries.
4. The rate of heroin use among young adults was slightly higher than in many EU countries.
5. The social, political, and economic conditions all pointed toward the likelihood of a significant increase in problems related to drug use among young people.

Users of dangerous substances are found in all social classes and among people of varying educational background. Most users live with their families, although they often hide their drug use for as long as they can. Generally, the use of illicit substances is strongly condemned by the heads of the family, with the result that the use of illicit substances takes place outside the family context, mostly within a peer group setting. Often, however, when users become dependent and are under pressure to maintain their habit, substance use becomes primarily an individual behavior. Some users sell drugs in order to raise money for their own purchase of drugs, which can lead to involvement in the criminal justice system. Even in these instances, however, drug taking seldom results in exclusion from the family. Families commonly remain supportive even for dependent (heroin) users who have serious difficulty in remaining socially integrated.

Ethnographic interviews with parents and youth in the KADAH (Kosovar Attitudes Toward Drug Addictions and HIV/AIDS) project suggested that youth learn about substances from their friends and the mass media (Brisson et al., 2004). When parents do speak to their adolescent and adult children about drugs, they often use scare tactics. An implication was that a comprehensive and well-designed program to establish increased communication between young people and parents (and other key adults) would help to prevent drug problems. If problems did arise, the family would then be available as a critical source for intervening, stimulating motivation for treatment, and supporting recovery.

Of course, improved communication does not just happen. The family unit plays a vital role in many aspects of life in Kosovo, but new problems such as HIV infection and drugs are difficult subjects for parents (and other adult figures) to talk about with youth. Other professionals, including teachers and health care providers, rarely talk with patients or students about these risky behaviors, either. This hesitance is probably based on a combination of factors: (a) the problem is denied; (b) people do not know what to say or how to say it; (c) people are concerned that talking about it will make it happen; (d) there are so many other concrete problems to worry about (no jobs, poverty, lack of educational opportunities, inconsistent power and water supply, etc.) that it is easier to forget about this additional problem.

The success of a multifamily psychoeducation program with Bosnian families led to an ongoing project in Kosovo—the Kosovar Family Professional Educational Collaborative (KFPEC)—to develop community-based, resilience oriented, family-centered training and services to foster recovery in the war-torn region (Rolland & Weine, 2000). Over the past 5 years, the KFPEC has shown that a family-focused community resilience program can increase attendance and treatment compliance of both patients and family members, even in the case of serious mental illness (Weine et al., 2005).

The KADAH project interviews indicated that youth and adults (teachers, parents) recognize alcohol and drugs as a serious and growing problem for the society. Many families or parents want to be more informed and do something about the situation, but currently there is no place to get information, and education programs are minimal and uncoordinated.

Even amid the rapid rise in substance abuse, particularly among young people, KADAH indicated that there were no services for drug addiction in Kosovo. The only facilities available were emergency services for life-threatening situations. These emergencies were treated in the emergency room, but there was no provision for specific substance abuse treatment to follow, and patients were discharged with no long-term treatment or planning. Without a facility available for acute detoxification, addiction treatment, long-term healing, and recovery, the same patients would inevitably return for emergency care time and again. Because addiction is a chronic and intergenerational disease, it was likely that without intervention, generations of addicted persons would follow. All of these factors pointed to the urgent need for the establishment of substance abuse services.

In this context, Weine et al. (2005) documented the effects of a psycho-educational multiple-family group program for families in postwar Kosovo who had members with severe mental illness. A project was developed by the Kosovar American professional collaborative (KFPEC) to focus on this issue. The subjects were 30 families of people with severe mental illnesses living in two cities in Kosovo. All subjects participated in multiple-family groups and received family home visits. The program documented medication compliance, number of psychiatric hospitalizations, family mental health services use, among other indicators, for the year prior to the groups and the first year of the groups.

All the families attended an average of 5.5 (out of 7) meetings, and 93% of the families attended four or more meetings. After a year, there were multiple positive changes: decreased hospitalization ($p < .0001$); increased medication compliance ($p < .0001$); increased use of combined oral and depot medications ($p < .0005$); and increased use of mental health services by family members ($p < .05$). These findings again suggested that a family and community approach would be effective in Kosovar society.

LINC Community Resilience

The Approach. The Linking Human Systems (LINC) Community Resilience model assumes that individuals, families, and communities are inherently competent and resilient, and that with appropriate support and encouragement, they can access individual and collective strengths that will allow them to

14 transcend their loss (Landau, 2005, 2007). For the human spirit to prevail and be perpetuated across generations, we need to be able to draw on our mutual biological, psychological, social, and spiritual resources. LINC Community Resilience extends the concept of resilience to the level of community, encouraging people to view themselves as competent in the face of overwhelming circumstances (Landau, 2005, 2007; Landau & Saul, 2004; Landau, Garrett, et al., 2000).

This competence can be nurtured by helping people regain a sense of connection with (a) one another; (b) those who came before them; (c) daily patterns, rituals, and stories that impart spiritual meaning; and (d) tangible resources within their community. Rather than imposing artificial support infrastructures, LINC interventions engage respected community members to act as natural agents for change. The inherent resilience in individuals, families, and communities allows them to overcome tragedy and ensure that future generations survive and are strengthened by the hardship they endure. LINC Community Resilience draws on this capacity to heal. LINC is intended for intervention in communities that have experienced rapid, untimely, and unpredictable transitions or loss. This model has been applied to communities around the world, including Kosovo. Helping families and communities to harness their inherent resilience and optimize the use of their resources minimizes the scope of damage in the immediate wake of the trauma and the years to follow (Landau, 2007).

LINC interventions employ existing community resources, rather than installing artificial support infrastructures or imposing generic prescriptions for community health. They leave the ultimate decision making to the people whose lives will be most affected by the changes that are instituted. Participating professionals are responsible for providing the context and skills that will allow communities to access the resilience of their ancestors and of their cultural and spiritual histories. This approach allows professionals to intervene effectively without becoming embedded in communities or intruding on their privacy. As a result, the solutions that emerge are culturally appropriate and sustainable.

The practical aspects of resilience in the community are assessed in order to determine what resources are available, whether people are aware of them, and how they are being used. The clinician assesses how the transitional pathway has been disrupted and whether themes of resilience are being mobilized. LINC interventions draw on a variety of assessment techniques, including a number of maps: geographic and sociological maps, and maps that elucidate important transitions within the community. In the course of completing the maps, stories emerge that shed light on current events and transitions and on the community's ways of confronting their problems. Often the practical task of constructing maps helps to diffuse blame and anger and thus to make room for more constructive interactions that draw on a full range of resources and strengths.

Family and Community Links. LINC community interventions rely on community members to serve as Family and Community Links. They serve in all communities, but they are especially effective in those that are highly educated, sophisticated, or composed of traditional extended families and clans, where outside intervention is neither invited nor welcomed (e.g.,

Kosovar society). Although such communities might solicit some form of intervention in a crisis, they tend to drop out as soon as the immediate crisis is resolved. Groups that work with a community link stay connected long after the crisis has passed and do not drop out (Landau, 2005, 2007; Landau et al., 2008).

Coaching natural change agents to be Family and Community Links allows the tradition, strength, pride, and privacy of the group to remain intact. The Family and Community Links initiate, maintain, and sustain change long after the outside "experts" have departed. Ideally, Family and Community Links should be respected members of their communities who can communicate effectively with community leaders and with grass roots community members, their families, and their natural support systems. They should be flexible around community issues, unallied with any particular faction, and effective without engendering resentment or opposition from others.

Because the Family and Community Links' ability to convene representatives from all levels of the community is critical to the success of LINC interventions, it is important to avoid selecting leaders who cannot garner broad support or who might derail the process for their own aggrandizement. Spurious leaders do not empower the community so that residents experience new or renewed competence and confidence; rather, they sustain their efforts only to the point of personal gain. Often they are given the position because of their convincing and forceful presence, inevitably resulting in failure of the intervention if not immediately, then in the longer term.

The LINC Community Resilience model is a powerful tool for propagating and sustaining change in communities that have undergone rapid and untimely transition, whatever its cause. It has been applied in the prevention of substance abuse, HIV/AIDS, domestic and community violence, and depression and suicidality in widely diverse settings, most of which have been in transition after political change or a related disaster (e.g., Argentina; Taiwan; South Africa; Romania; Kosovo; New York City following September 11, 2001). The LINC model eschews the notion that only professional "experts" can rescue a community that is in dire straits; instead, it facilitates community members' achievement of long-term goals and independence, thus empowering them to embrace healing, pride, and connectedness.

The LINC Community Resilience intervention is a three-stage process. The work is performed primarily by the Family and Family and Community Links, and communication across the community is ensured when the Family and Community Links have forged a healing matrix and the entire community (both professional ancillary support system and natural support system) is engaged in the endeavor.

Coming together to share their transitional pathway, history, traditions, and current situation, the families and community then take charge of their own future. They select Family and Community Links who lead them to establish clear goals and to turn these into small workable tasks with committed work groups. Finally, the community takes over the process when the outside professionals withdraw.

Application in Kosovo

After the war in Kosovo, there was a clear need to establish a resource center to inform and educate families and the commu-

nity about substance abuse. The situation was dire. Prior to the war, there had been almost no drug use discovered in Kosovo. After the war, rates of use, dependence, and addiction were increasing at a dramatic rate. Because substance abuse had not been a part of the culture, when people recognized a drug user in their family, they felt isolated and ashamed and did not reach out for help. The problem was often not recognized even within the family, and for the first time family members were isolated even from one another with their new secret.

It was hoped that a multifamily, resilience-based approach to substance abuse treatment, similar to that implemented by members of the LINC model teams in numerous other settings and countries, would be welcomed and sustainable in Kosovo. From May 2000, with the beginning of building a new mental health system in Kosovo, the first author (Agani) worked collaboratively to combine the strengths, resources, and wisdom of the Kosovar mental health professionals. Using the LINC Community Resilience Model, these clinicians were trained in family systems by KFPEC, so that the Kosovars could design their new substance abuse delivery system.

The result of this 6-year collaboration was the establishment of the Kosovo Addiction Treatment, Education and Resource Center in the Department of Psychiatry of the University Clinical Center of Kosovo in 2004. The most salient components of the LINC Community Resilience Program used in this center were: local multicultural competencies; awareness of their own values, strengths, themes, scripts, biases, and prejudices; and the use of their own skills (concreteness, genuineness, and self-disclosure) to build a trusting relationship so the client and family could share their stories toward building sustainable recovery.

The initial step in applying LINC model in Kosovo was eliciting family and community scripts, themes, and strengths; then identifying goals, and applying the strengths as resources to achieve the goals. The main strengths and resources identified were: strong family values, loyalty, and closeness; protection and safety in the extended family; valuing children and youth as the future of the nation; adaptability, flexibility, and survival skills; solidarity in help to communities; religion and religious tolerance; education; altruism and caring for others; general enthusiasm and optimism; and organizational skills and leadership.

The LINC process focuses on accessing and using all available resources, which are matched to the goals and tasks. In the Kosovar situation, strong emphasis was placed on mobilizing the strength of extended-family connectedness, strong family values, and a sense of unity rather than division to resolve the overwhelming grief. The Family and Community Links encouraged the families to talk about their grief, rather than storing it for generations to come. They encouraged members of their own nuclear and extended family to talk about loss and grief and any stress. They then asked each family to spread the message to other families and to join together to talk on a community scale.

In this way, the Kosovar inherent spirit of altruism and caring for others was applied along with their strong organizational skills and leadership to take care of all the families and to rebuild community resources and new services. During the process, the families were reconnected so that those with more resources were able to care for those with less. One of the other core values in the Kosovar community is the importance of children. By reconnecting the community in recognition of the importance of caring for children and youth and enhancing their education, all were able to realize that they could build a strong, caring, and connected nation despite the appalling trauma that they had survived.

Conclusions

Toward this grand goal, both Kosovar and international mental health professionals united in re-building communities and initiating an enlightened community-based system of mental health services after extraordinary national trauma. The LINC Community Resilience model and KFPEC provided professional software for a contemporary model of mental health services in Kosovo grounded in indigenous resources and family and community resilience. This approach gave hope to overburdened Kosovar mental health professionals that they could in fact achieve effective and efficient mental health services.

The family-focused, community-based LINC method evolved from many years of experience in mental health and substance abuse prevention, treatment, and clinical research, including several U.S. federal and state research grants (Landau, Garrett, et al., 2000; Landau et al., 2004, 2008; Tuttle et al., 2004). Using the results from recent projects in Kosovo and other war-torn countries in the Balkans, the method was adapted and modified appropriately for the Kosovar situation. Accordingly, the LINC project in Kosovo stands as a model for community-based, culturally sensitive international cooperation in a time of national recovery from trauma.

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