The Integration of Traumatic Experiences in a Cultural Context

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Abstract: The author describes her experiences with traumatised survivors from a transcultural perspective. Specific and non-specific signs and symptoms of ASR (Acute Stress Reactions) and PTSD (Post-Traumatic Stress Disorder), coping capacities and intervention strategies are described in terms of transcultural differences and what they have in common. She asks whether it is possible to find similar structures in efficient intervention strategies from different theoretical backgrounds. She compares traditional ritual approaches with psychodynamic, cognitive behaviourist-oriented, hypnotic and recent heuristic techniques. The role of society in acknowledging the traumatic experiences is discussed with respect to prosecution, conviction, justice and punishment. In three short case studies the author illustrates three different approaches, each varying according to the cultural context.

Introduction

Based on the author‘s experience with survivors of very different forms of violence, this study aims to describe universal psychophysiological reactions, on the one hand, and culturally-bound ways of dealing with problems, of integrating them and of finding meaning, on the other. It is important to take both aspects into account if one assumes that traumatic experiences must be integrated on both these levels in order to give those affected the best possible chance of survival in the future. The conclusions to be drawn for professional helpers, especially in the transcultural context, will be examined below. As a psychiatrist from central Europe my origins place me squarely in the first world. Family, professional and personal socialisation have determined which culture I belong to, although there is a certain amount of multiculturalism from spending time in various countries in Europe during my childhood and exposure to European languages (PONTEROTTO 1995). As far as my ethical orientation goes, I consider myself to be bound by the Universal Declaration of Human Rights. Medically I share the diagnostic and pathogenetic oriented view. As a participatory observer and promoter of change in the field of mental health, I also make use of the salutogenetic (i.e. resources-oriented) approach, the insights of radical constructivism and the cybernetic understanding of communication (v. GLASERFELD 1987). My work is based on the following basic assumptions:

Neuro-biological reactions as such, including those to stress, are similar or identical in all cultures. Doctors, who have a similar professional training throughout most of the world, have observed these reactions everywhere.
Human beings construct their reality with the help of cognitive images (BECK 1976). This is also true for the observer, which is why it is important to take a salutogenetic view (ANTONOVSKY 1988).

Human beings are goal-oriented.

Human beings are social beings, embedded in groups according to their languages, formed by these languages, just as they in turn form the languages.

Human beings react on both the conscious and the sub-conscious level (PERRIG 1993).

Human reactions to violence

In all human beings, the experience of violence leads to similar observable reactions. These can be perceived on the biological (physical), psychological and social levels. Just as physical traumas heal through forming scars, so the experience of violence leaves behind scars on the psychosocial level which, in the most favourable cases, are no longer sensitive.

Not only the traumatic reactions themselves, but also the perception of such events are considered threatening, are interpreted very differently depending on the culture of those affected. It is important not to lose sight of this as the appraisal (LAZARUS 1994), interpretation and the giving of meaning are central to the integration of traumatic experiences (FRANKL 1984).

In many cultures religion offers models or rituals for working through distress after threatening experiences, and is important for the integration of what has happened. In the so-called first world, in which there are generally no binding religious mores any more, psychology and psychiatry have taken over the task of supporting the survivors when difficulties arise in dealing with the aftermath of violence. The consequences are not necessarily positive, however.

Mankind, using many different models of interpretation, has been familiar with the consequences of violence from time immemorial. Our oldest written records bear witness

to this. Tales of family violence (Cain and Abel, Gen. 4, 1ff), persecution and torture (Babylonian imprisonment, Jer. 51, the deliverance from the fiery furnace, Dan. 3), violence against children (Herod, Mt. 2, 13ff), war (Kings, Josh. etc.), being stoned for adultery (Jn. 8, 4ff) are well known. In this century two world wars, the wars of liberation as a response to decolonisation, countless wars in which those fighting are only the pawns of more powerful interests, the growing awareness of violence in our own back yards in the family and in the society as a whole, and structural violence, have helped to sensitise us to the psychological consequences of extreme stress experienced by survivors.

We are indebted to the psychiatrists in the USA who, after the Vietnam War, demonstrated the massive and lasting extent to which the violence of war can affect people, whether as victims or as perpetrators. A great deal of effort and co-ordination was required before the strange reactions of the veterans could be acknowledged, treated and compensated as the direct consequence of horrors of war.

The diagnostic concept of post-traumatic stress disorder (PTSD, DSM IV, APA, 1994) is the direct result of these efforts. In one sense the formulation of this diagnostic unit was a positive step for the victims affected. At the same time, however, the concept must be seen to be culturally bound. For what has happened in a society, affecting individuals or groups in this society and causing them suffering and illness, is placed in the context of a disorder i.e. of an illness to be treated. Consequently, suffering caused by the society's inability to solve conflicts peacefully will be privatised and individualised at a later stage. This is particularly so if the suffering was caused by a senseless war which ended in defeat. Other acts of violence such as rape and sexual abuse, which are often taboos, have a similar effect. It took a long time to come to the realisation that violence in any form leads to a recurrence of the same disorders. Despite these findings, however, a kind of collective blindness is still common. A wall of silence (ASGEIRSSON 1998) is built up around the psychological consequences of violence, although they extend even to the second generation (KLEIN 1974). Societies repeatedly fall into the trap of turning the survivors of violence into heroes, victims and perpetrators. As a result all three groups are denied the chance to integrate what they have gone through and of a future worth living.

In order to understand the reactions to violence, it is important to define trauma and to distinguish between Type I and Type II traumas (TERR 1989).

A trauma is an experience which lies outside of the norm and which seriously endangers the physical and/or psychological integrity of a person or a group of people. To become traumatised it is sufficient just to be a witness or someone close to such events (DSM III R).

A Type I trauma is a single occurrence with a clear beginning and end. It can be brought about by experiencing crime, traffic accidents or accidents at work, or by natural or man-made disasters.

Type II traumas are recurrent events which are permanently present as threats. The victims feel too helpless to prevent them. Examples are family violence or abuse, persecution and the ongoing deeds of war. Secondary traumatisation is also a Type II trauma.

Violence affects not only the direct victims, but also the perpetrators, witnesses, members of the family and those involved in helping. The latter group may react with the same psychological indications as the primary victims. The concept of vicarious traumatisation has been introduced to cover this phenomenon. (FIGLEY 1995).

Specific culturally-independent reactions to violence

People with a western training are able to recognise specific reactions to violence in members of all cultures. These reactions can be directly linked to the physical-humoral reactions of human beings in maximal negative stress situations (KLEBER 1992). They occur immediately after exposure to violence in the form of an Acute Traumatic Reaction (called Acute Stress Disorder, ASD, in the DSM IV, 1996), a natural and normal reaction which occurs among almost all survivors.

Some time later some of those affected will start to suffer from the symptoms of Post-Traumatic Stress Disorder (PTSD). Their reactions will vary according to the intensity of the exposure and distress of the perceived threat (BASOGLU 1994), the coping capacities, pretraumatic personality, age, state of health and social support available. All these factors are dependent on the culture in question.

Both acute traumatic stress reaction (ASR), and PTSD are characterised by three groups of reactions/symptoms:

Physical hyperarousal, with startle response, heightened vigilance, aggression, impatience and insomnia.

Recurrent intrusive memories in the form of flashbacks, nightmares, traumatic play and acting out.

Numbing on both the physical and emotional levels and avoidance behaviour.

In addition to these specific reactions, there are always non-specific reactions to violence (MOLLICA 1990) which may also occur among people who have not been traumatised. They can be explained by the sense of helplessness during the exposure, and consist mainly of extremely unpleasant

feelings such as shame, anger/irritation, guilt, loss of basic trust, loss of self coherence, grief, depression and confusion (particularly with respect to values). These reactions are aptly referred to as „shattered assumptions" (JANOFF-BULLMANN 1992). It is more difficult to observe them directly, as they are expressed differently depending on the cultural context and may be beset with various taboos. Consequently, they are often not allowed to be expressed directly. They therefore assert themselves in different ways: physically, as emotional dysthymia or as dissociative disorders (van der Kolk et al. 1996) with virtually total amnesia. These patterns of reactions are bound at least in part by class or culture. It is, therefore, not so easy to link them to the extreme event; consequently, they cause less consternation in the affected society. In the long run, however, they are less adaptable than PTSD and those affected will suffer longer as they get no help from the group or help is inadequate in many areas.

Dealing with the psychological/psychosocial reactions to violence

Coping has an important role to play in dealing with ASR and PTSD. Coping abilities are part culturally bound and part culturally independent. The conceptualisation of these abilities in relation to trauma is still not clear. Of the various theoretical perspectives, the following are the easiest to observe and tend to be the most likely to be useful for structuring in the transcultural context:

Coping on a cognitive, emotional and behavioural level.

Confrontation with what has happened versus avoidance.

Placement of the locus of control inside or outside.

An integral part of the traumatic experience is the virtually inseparable mixture of cognition and emotion. It manifests itself in behaviour on the inner (thought, emotion) and outer level. People differ in their ability to separate out this mixture after a traumatic event. But this is necessary to bring some order to cognition and emotions and, thereby, to their own behaviour. The following are necessary for this to take place:

Cognitive confrontation with what has happened. The person affected needs, on the one hand, to be able to face up to the experience with all its horror and unpleasant emotions and to examine what has happened. On the other hand, it is also possible to do all in one's power to avoid thinking about the experience, by suppressing all emotions and avoiding situations which could trigger one's memory. This avoidance behaviour increasingly limits one's life internally (emotionally) and externally (socially). The person becomes trapped in his or her own disappointment, anger, helplessness and traumatisation. Thus chances of experiencing something new or better (again) are blocked substantially. This dissociative behaviour is more common in some cultures than in others: «It was so terrible that I've forgotten everything» is a typical response. It appears to be common in cultures in which the people believe it is possible to be possessed, or where the Jinn can influence people's lives.

The locus of control (HOROWITZ 1976) also plays a role when interpreting external events. It is important to what extent the person thinks that he or she has actively participated and taken control (locus of control within the person), and to what extent elements are considered to be beyond his or her influence (locus of control outside). In cultures in which elements which we consider to be magical play a role, the locus of control tends to be constructed and experienced from outside, i.e. external factors are decisive. In cultures which put the individual first, i.e. where the autonomy and responsibility of the individual are central, the locus of control is constructed and experienced as internal. The locus of control is closely linked to the way in which a traumatic experience is given meaning, and is an important precondition for working through the experience.

A South American political prisoner described to me how he was able to take control (locus of control constructed from within) during torture. Each day he would ask himself whether he was ready for torture, for on certain days he knew he would commit suicide if they fetched him. In answer to my question how he had done this, he described a complex mechanism which he had thought out to enable him to commit suicide on the days when he was unable/or unwilling to bear the torture.

So-called blunting during traumatic exposure (MILLER 1980), a way of withdrawing to achieve internal control (in hypnosis the term is dissociation), and indifference to the outside world while remaining secure within oneself is also a manifestation of the internal locus of control:

Another South American prisoner explained to me how during torture he left his body behind and was able to feel deeply peaceful within himself, triumphant in the knowledge that his tormentors could only reach his body.

Helpers from the first world observed several signs of ASR/PTSD in the Cambodian refugee camps in Thailand. The Cambodians themselves, however, interpreted their symptoms as a sign from their ancestors. They said the latter were angry with them because they had left the flock and no longer prepared the daily offerings for the dead. In such a situation it would be absurd to prescribe medicines or psychotherapy (belief in the locus of control from within). In this case only rituals which appease the ancestors and build a new relationship with them under changed circumstances can help (EISENBRUCH 1991), as the locus of control is experienced as external.

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Other essential conditions which supplement coping are:

The physical ability to resist maximum stress (in traumatic experiences such as accidents, criminal acts of violence, natural disasters, in the first world; persecution, war, torture and flight elsewhere) is partly genetic. Security plays an important supplementary role in various circumstances. It begins with early childhood development and continues in the socialisation process. Other external conditions such as the satisfaction of minimal basic needs (food, housing, medical care) are all directly related to the sense of security.

Being prepared for the eventuality that something terrible will / may happen is a protective factor, as the surprise effect will have less impact (PERREN-KLINGLER 1990; BASOLGU 1995).

Social reactions such as support, help and solidarity - when necessary during reconstruction - contribute to a faster integration of trauma in all cultures. All these coping abilities are mobilised when dealing with ASR, in the above-mentioned informal debriefing, as well as in formalised psychological debriefing.

The sense of coherence (ANTONOVSKY 1979): The person's identity is not questioned during the event, as is often the case with rapes. Instead it is strengthened. This often happens with political activists who have been tortured, PERREN 1990; BASOGLU 1995. The sense of coherence is closely linked to the concept of the locus of control.

Working through acute stress reactions (ASR)
ASR is a normal/natural reaction to an abnormal, violent event (KEILSSON 1979) and from earliest times all cultures have dealt with it in many ways, which show similar structures.

By talking about the experience in the family, with friends, in the religious community or in the preventative setting of psychological debriefing, a narrative is constructed (constructive narrative perspective, MEICHENBAUM 1993). The event is gone through once again and a central idea is found and developed to make it easier for the listeners to understand what has happened. This leads to cognitive confrontation with the facts of the event once more. The concerned reaction of the listeners makes it easier to release one's emotions in the protection of the group. The spontaneous solidarity provides a supportive climate (FLIESS-CAROLE, RICHMAN, both in PERREN-KLINGLER 1995). It is also possible to find a meaning for what has been experienced in the group. This way of working has a prophylactic function and protects those affected from fixating the ARS, thus preventing it from degenerating into PTSD. Political prisoners who had been tortured made spontaneous use of this technique in Chile (BECERRA in PERREN-KLINGLER 1995). From the above it is clear that the setting of the psychological debriefing (TURNBULL 1995; MITCHELL 1993; DYREGOV 1997; PERREN 1998 in press) is nothing new, but rather a ritually structured psychological group process which has reintroduced a well-tried practice into the western world.

Dealing with PTSD and appropriate interventions
From our western diagnostic perspective, post-traumatic stress disorder has been observable since man first committed violence on man. But it was only formalised as a diagnostic unit in 1980.

It seems reasonable to treat PTSD with psychiatric-psychotherapeutic methods in western cultures. For mental suffering and madness this seems the most popular approach. It was used systematically for the first time after the Second World War with survivors of the holocaust in the USA, and in Holland and Scandinavia with veteran prisoners of war from the German camps. Psychoanalysis was usually the main method used.

Victims of torture from the military dictatorships in Latin America who had fled to Europe were treated with analytical methods in many places without much success. In many cases the treatment was lengthy and ended with the disability of the patients. In this form of treatment the individual was „captured“ in an exclusive relationship to the therapist, and the participation of the society was virtually ignored. As a reaction to these unsatisfactory and prolonged experiences, fresh attempts were made to work with the traumatised with the explicit goal of alleviating their suffering. Increasingly, different, non-psychodynamic approaches developed,

some of which will be described below. It is astonishing to observe how, with time, there has been a steady move away from the hermeneutic-interpretative psychoanalytic approach towards totally heuristic methods. In many of these approaches words are used mainly to give instructions. The therapist no longer functions as an interpreter, but assists the patient in doing it himself. The therapist/patient relationship still has a role in non-analytical cases in which holding (WINNICOTT 1960) is essential and must be retained for these situations.

Testimonial therapy with the politically persecuted (AGGER 1990) can be seen as an attempt at working on the past cognitively. The most detailed possible history of the events is reconstructed with the help of the therapist. The psychological consequences are also recorded, and the entire report is used as a document for political ends.

Children and youth who survived the Jupiter and Herald of Free Enterprise boat disasters in England described the support they got from the group. These group discussions worked mostly on the cognitive and emotional level separately (YULE 1990).

Since the beginning of the eighties Chloe MADANES (1997) has worked on a systemic approach in families in which there has been sexual or other violence. In 17 steps she not only introduces cognition, emotion, confession, asking for forgiveness, punishment and atonement but also resocialisation and relapse prevention.

MEICHENBAUM, BASOGLU, FOA, ROTH and many others (all in MEICHENBAUM 1994) report on cognitive and behaviourist interventions which have led to an improvement in the symptoms of PTSD over a short period. Combining these techniques with hypnosis and a salutogenetic orientation to resources available can accelerate and intensify the process (PERREN-KLINGLER 1990, 1998)

Pharmacological relaxation has been used as a starting point for cognitive restructuring and in dealing with physical symptoms in some places for a few years now (BAETTIG and VELARDI, personal communication).

Over the last few years supplementary «magical» methods, such as EMDR (eye movement desensitisation reprocessing, SHAPIRO 1995), TFT (thought field therapy, CALLAGHAN 1990), which have also proved to be very efficient in dealing with symptoms have come into play. Unfortunately, they are often only used outside of conservative university circles (GRAINGER 1995) and sometimes in settings which do not care about the necessity of holding patients with PTSD.

For chronic PTSD supplementary pedagogic and restructuring interventions are, of course, also necessary to treat distorted behaviour and perceptions. Additionally in this case it is often reasonable to use psychiatric drugs.

Interventions for and the understanding of trauma or fright in other cultures

All societies have recognised the damaging influence of traumatic experiences on the mental heath and well-being of their members.

Closer questioning has shown that most cultures have come up with appropriate interventions for working through and integrating what has happened. Rituals are a visible way of ascribing meaning to violence and its aftermath, enabling those affected to return to the society.

From time to time one has the fortune as a therapist from the first world to meet healers from other cultures and learn from their knowledge. A few experiences will be recorded here.

While working with Bosnian asylum seekers and refugees in the canton of Argovia in Switzerland, we learnt about a Bosnian healing ritual to drive away terror. It is practised by Muslim women in the countryside and the knowledge is passed down from generation to generation by the women, usually from mother to daughter (cf. LONCAREVIC in PERREN-KLINGLER 1995).[1]

In central Mexico there is a Toltec fright ritual.[2]

In Mozambique there is a ritual for people who have killed («Chirove», RICHMAN in PERREN-KLINGLER 1995) which enables them to return to their communities. Intervention towards reconciliation with the ancestors of Cambodian refugees in the Thai camps has been mentioned above.

In all these rituals what has happened is reflected on cognitively. The emotions involved are acknowledged in a socially protected framework, and through religious customs. What appears to us to be magic brings relief to those affected.

Personal experiences

The author's approach will be described in three short reports in very different settings. In each case the aim was to help survivors of traumatic experiences who were suffering from PTSD to integrate what had happened and help them to take control of their lives again.

In as few interventions as possible the author (in the first two cases) and a colleague (in the third) wanted to find the

1 The client contacts the healer and appears before her when invited. Other people are always present. The client is instructed to think about his or her terror while sitting in front of the healer who is busy melting lead in a spoon over a flame. She softly recites surahs from the Koran. The molten lead is poured into a pan of water. During the to and fro movement of the lead-filled spoon the client watches the spoon. This act is carried out three times at the head and chest, twice at the stomach and once at the knees. Then the terror flows out through the feet into the ground. The water used to cool down the lead is handed to the client to take home for special cleansing purposes.

2 The client thinks about his terror and turns his head from right to left while breathing out, and then from left to right while breathing in, until the terror has disappeared.

resources available to the clients and mobilise them for self-help and self-empowerment through homework exercises. By giving clear information they hoped to guide the clients to informed consent, conscious and voluntary cooperation and, finally, to bring the whole procedure to a satisfactory close.

Most survivors can find meaning by themselves and integrate what has happened once they are freed from the specific traumatic symptoms. This is not an unrealistic goal as the survivors of trauma are a sample of the average population and functioned like the rest of the population prior to the traumatisation. The coping abilities which have been temporarily paralysed by the trauma must be (re)mobilised.

Intervention with an American-Swiss patient with PTSD

A 58 year old American woman, married and living in Switzerland, survived a crash landing in which there were fatalities and injuries. She was on Beta Blockers for high blood pressure, had completely dissociated herself in the accident. During the evacuation of the aeroplane she had jumped over the wing without even spraining an ankle. Three months after the accident she came for a consultation because she could not carry on because of emotional numbing and had the feeling that she needed professional help. She had found out what her problem was and what she needed to do through the Internet. She herself had made the diagnosis PTSD. At the first consultation she was severely dissociated and could feel nothing in her body, although her neck was visibly at an angle. She denied feeling any emotions in relation to the accident. She suffered from severe lack of concentration, had difficulty in finding her words and refused to listen to music as she feared that her beloved music would be contaminated by the horror of the accident and that she would then never be able to listen to it again.

The therapeutic procedure was explained, and why the use of hypnosis and cognitive behaviourist techniques were appropriate for her. She then agreed to go through with the procedure.

Once the patient had placed her trust in me and a breathing exercise had calmed her down somewhat (i.e. once a good holding had been established), we went through the whole accident again in the first session, not leaving out any details. We worked cognitively using hypnotic techniques. For the first time the patient became aware of the risk of being hurt and the horror and felt these emotions intensely. We went on to talk about her „control of pain“, i.e. her dissociation from the pain in her neck, and she was encouraged to have her neck vertebra examined by a doctor. Whiplash was treated by physiotherapy, and the severe muscular tension gradually disappeared.

In further sessions we worked on her nightmares, which had appeared after the first session, her hyperarousal was gradually reduced. After each session the patient received homework tasks to learn to manage her overarousal. They consisted of sport activities, music and social contacts. As the dissociation gave way to normal emotion, the relationship to her husband and colleagues at work improved. The death of her mother, which happened during therapy, could be placed within its own framework and separated from the accident. She was able to fly to the USA again. Her lack of concentration was the most difficult obstacle, but it too gradually receded.

In seven sessions (spread over ten months) the therapy was so successful that we were able to talk about bringing it to a close in the eighth session. I asked her to think of a ritual through which she could express her gratitude for having survived unscathed. She told me spontaneously that she would be in the US on the anniversary of the accident and was thinking of making a donation to an art gallery in the town where she would be staying.

Soon after the Luxor act of terrorism in Egypt, which mobilised symptoms amongst many traumatised people in Switzerland, I found out in a phone call that the patient‘s husband had now begun to panic whenever she flew to the USA. She however was not at all worried.

It was easy for me as a psychiatrist and psychotherapist from a similar, enlightened culture to work with the patient. When her symptoms became intrusive after the accident, she had taken steps to inform herself and made the causal connection between the accident and the hitherto unknown disorder. I could motivate her to cooperate using common arguments. The decreasing symptoms after performing our homework exercises strengthened her conviction that she was on the right path and improved the working relationship. A typical psychiatric, psychotherapeutic setting could be built up and the patient given the necessary support to take control of her life on her own again. We did not work on or even talk about neurotic symptoms which appeared, intensified by the traumatisation, and subsided again after our work together.

This patient found meaning for herself in her survival and gratitude of being alive, which she expressed through the donation to the gallery. The psychotherapeutic model for trauma integration was effective. Today, almost two years after the accident, she is free of symptoms.

Intervention with a group of Bosnian refugees in Autumn/Winter 1995/1996

A trained eye watching television could see that the first official Bosnian refugees who were brought to Switzerland by the ICRC directly from the concentration camps in the Sum-

mer of 1994 were severely traumatised. It was not long until cries for help were heard from the centres which cared for them, as their suffering could not be overlooked. Yet it was extremely difficult to make it clear to the refugees that the suffering expressed in their bodies was not of somatic origin, and that they needed psychological help. A frequently heard comment was „... I'm suffering, but I'm not mad..." Under these conditions it was almost impossible to have any influence on the symptoms of PTSD directly through psychotherapy. So-called culturally adapted projects began to mushroom all over, but few managed to provide their clients with relief from their specific and non-specific symptoms of trauma. In response to the helplessness of the helpers a bi-cultural, Bosnian-Swiss project was set up to train multiplicators in mental health. A knowledge of German and the readiness to work with Bosnians towards their mental health between the training course sessions were the minimum requirements for participation.

The course was planned for twelve days, six two day sessions spread over eight months. The participants agreed to attend all units and to work as multiplicators for six months after the end of the course.

There were two levels to the goals of the project. On the one hand, the participants would have a chance, within a protected space, to come to terms with their own (hypothetical) traumatisation. On the other hand, - more or less as a support to their healing - they were to acquire sufficient knowledge and skills to pass on the experience, to relieve the Swiss helpers of some of the pressure on them and to support the Bosnians in a culturally appropriate way. The above goals were to be realised in the three parallel sections of the programme:

Knowledge about normal reactions to traumatic or life-threatening experiences, PTSD and resource-orientated methods (ANTONOVSKY 1988) were to be taught.

Working through and doing exercises in small groups - always with the explicit aim of acquiring more knowledge and skills - the participants' own traumatisation was to be reflected on, worked through and overcome.

Bi-cultural pairs would be set up systematically to work together as multiplicators between the courses. This would foster mutual understanding, respect and appreciation and develop greater tolerance.

The first day of the course could best be captured on film. Two groups turned up. The group of Bosnians, heads bowed, in a state somewhere between nervousness and hyperarousal. A group of concerned Swiss, some very anxious, but nevertheless calm, all involved with refugees in some way. Compulsively, the tense participants drank endless cups of coffee and smoked, increasingly during the sessions, and not only in the official breaks. The atmosphere was heavy, oppressive, and hopelessly sad. Originally I had planned to run the course based on a concept of child development. But on recognising the obvious mood of the participants, I decided to start providing information about trauma and how to work with it immediately. I wanted to work on psychological reactions and persecution, violence and uprooting, in order to introduce resources which they could learn to use straight away.

In one of the first exercises in which we worked on resources available in our own cultures on the second day, the participants were instructed to talk about festivities in small groups. The Bosnians protested that they were unable to do this, and some said that they didn't have any festivities at home. To resolve the deadlock I added an instruction that the Swiss, who said they did have festivities, should start with the sense-specific narrative (primarily cognitive, letting the emotions flow along). Less than half an hour later each group was trying to outdo the other as to who had the better festivities. They had to explain who did what how and describe the special dishes that were prepared, etc. For the first time there was laughter, faces cheered up, and the atmosphere relaxed.

Tensions came up continually, also between the two national groups, when discussing security for instance. How much security does one need in order to deal with the psychological consequences of traumatisation? Some of the Bosnians maintained there could only be security if they were allowed to stay in Switzerland for the next ten years (typical traumatic distortion of perceptions). They attacked the Swiss, blaming them for the situation. Thus clarity was required on issues such as *Who is responsible for refugee politics in Switzerland*? *What comprises minimal security*? *How are adaptation difficulties expressed on both sides?* and so forth. They learnt to recognise that aggression can also be a sign of hyperarousal. Relating what had been said to the present situation helped everyone in a big step towards mutual understanding and understanding the effects of traumatic reactions.

Debriefing techniques as a form of prevention were practised in various ways to bring some order into the chaos of traumatic experiences and to clarify emotions.

At the end of the twelve days of the course the dejected and frightened participants had been transformed into a group which was ready to go into the future with hope and courageously, to support those less fortunate than themselves in several different places. In short, the solidarity had worked for them. For the course leaders it is astounding

that many of the multiplicators continue to use what they have learned after the „end of the contract". Those who have returned home have taken what they have learned with them to Bosnia.

A new and different approach had been sought and found as a response to a desperate situation. The topics included information about how to act in and for a group. The strengthening of resources, by embedding them in the present context, and the mobilisation of self-help and taking responsibility for oneself were the main themes, and not individualised, personalised treatment from a therapist.

The Bosnians in our group did not experience their symptoms as problems „in their heads", as individual emotions, but saw them against the background of scenes of horror and persecution. They experienced the locus of control as outside, so it would have been meaningless, and a sign of a lack of respect and understanding of the horror they had been through, to act intrapsychically / psychotherapeutically.

Initially meaning could only be seen in relation to the malevolence of our fellow human beings, a „fate" that is against you and incomprehensible. Religion, which seeks meaning behind the incomprehensible, can sustain the belief in providence despite the helplessness experienced (Job). It is able to sharpen the perception of a new solidarity of other groups and give a new, as yet unknown, meaning in anticipation. But for most of the participants, who described themselves as atheists and Marxists, this path was not open.

My basic assumption as a course leader is that survivors have enough resources available to lead a further good life free of symptoms. My aim was to bring about changes in those traumatised to help them towards better coping. So it was clear from the beginning that the course should be future-oriented, mobilise resources and be a process of finding some peace. The idea of learning something new to pass on to people in need, i.e. the appeal to solidarity, proved to be fundamental and effective in the unexpected, much longer-lasting multiplication process. It is important to note that this process, besides the learning, consciously included not only cognition, dealing with traumatisation and migration, but also confrontation with one's own resources and coping abilities. It was planned and carried out as a process of change in the integrative, healing sense. Thus it could only be implemented by someone well versed in (psycho)therapeutic practices and working with groups.

Intervention in the transcultural context, a combination of techniques from different cultures

A doctor from Rwanda who had sought asylum from the atrocities there learnt about the concept of traumatic reactions while training under me. Below is her report on an intervention:

A 10 year old Rwandan girl, in Switzerland with her mother, can no longer sleep after watching a programme on television with some sort of bogeyman. She becomes frightened and starts clinging to her mother anew. The latter seeks the help of the Rwandan doctor.

While talking to the girl it became clear from what she said that new flashbacks and nightmares had emerged which were linked to the murder of her father, an incident which the child had witnessed. The doctor asked the child what she needed to be at peace again, i.e. she looked for possible resources together with the child. With the help of hypnotic techniques they worked on various resources, both Swiss and Rwandan. These were consolidated for the child (through other, lighter children's programmes such as Tom and Jerry, as well as through security, trust and ties to the living mother) until the child felt better. Nevertheless she still did not feel completely secure. After various attempts at solving the problem, my colleague realised that the child came from a very religious Christian family, and so she asked about Jesus. As a last resort they talked about Jesus' love and forgiveness. With the support of her beliefs the child was able to get rid of the nightmares, the flashbacks and her fear of sleeping. She felt secure again. Since then she has slept peacefully and is back to normal again during the day.

Traditionally important ways of dealing with trauma

All survivors of violence and disasters need social rituals to be able to acknowledge what has happened.

The Vietnam veterans struggled for years to get a memorial in Washington with the names of the dead. Today similar memorials have been erected in many other towns in the USA. The Yad Vashem memorial in Jerusalem for the victims of the Holocaust and many other memorials throughout the world help to ritualise remembrance.

Only after the unveiling of the memorial to the dead in a new park, following the mine disaster in the German town of Borken did peace return to the bi-cultural Turkish-German community (Stolzenbachhilfe working group 1992).

The Nuremberg trial after the Second World War and the trials of generals from the Latin American dictatorships, whether in Argentina or Chile, have had and still have an important function in the acknowledgement of severe travesties of justice. The Truth and Reconciliation Commission in South Africa and the War Tribunal for Yugoslavia in the Hague, and for Rwanda in Arusha, have the same function. All these judicial procedures facilitate the denunciation of what has happened, i.e. they enable cognitive structuring. Thereafter people can speak out about the damage and the

emotions of the victims. Charges can be laid and misdeeds condemned and punished. In the process demands for reparations can be made, opening the way towards peace. What is not punished or forgiven cannot be overcome and will always leave behind feelings of injustice, resentment and bitterness.

Justice is an aspect which is often unable to achieve much on an individual level legally. And yet, in working through crimes ritually and giving them meaning, it is a precondition to the forgiveness necessary for peace and a new beginning.

Structural similarities in the interventions between cultures

The assumption that all human brain structures are alike, and therefore react in a similar way to violence, is based on the observation that somatic reactions throughout the world are perceived to be similar when the same model of perception is used. Thus intervention models which are effective in dealing with the psychological and psychosocial consequences of violent experiences can repeatedly use similar structural procedures. The contents themselves, however, vary according to society's interpretation of what has happened, the assumptions of the culture in question and, of course, the specific personality of the person affected. The following factors are important elements in this procedure:

1. Security is the primary precondition for a process of change. There must be a framework with a minimum of basic security, differing according to geographic and cultural understanding. The security of being accepted and supported by the community or the therapist and a minimum ability to make social contacts are essential. People who have been traumatised often have an exaggerated need for security as if, after the experience of having no control, only total control - by which they mean «total and everlasting» security - is acceptable.

2. The listeners must be able to keep calm, not to let themselves be overwhelmed, even when the reports are terrible. They must keep on noticing and mentioning the resources of the victims, reminding them that they have survived. This salutogenetic behaviour is necessary, though obviously one never loses sight of how much the victim has suffered. The optimism that as long as people live there are possibilities for changes for the better is paramount.

3. In the case of ASR, a normal reaction to experiences beyond the norm, understanding support is structurally all one needs for the experience to be integrated into one's life and for a personal continuity to be rediscovered, either «in spite of» or «because of» the experience. This support enables one to carry on living even after assumptions about the goodness of the world and our power to have control have been shattered, when helplessness and being overwhelmed by intense negative emotions hamper attempts to deal with the situation cognitively, and when those affected appear not to be able to get any further. In all cultures ASR is dealt with in a similar fashion. Because traumatic experiences are always caused by the failure of the society to provide the protection one expects from it, the function of the group is important, this time with other, «better» representatives of the society. The event can be gone through again, reinterpreted and denounced with the support of the new group. Solidarity and reparations in some form or other can be introduced. This is a form of ritual in which what has happened can be introduced, discussed, shared and acknowledged in the society in which the affected people live.

4. Cognitive confrontation with what has happened occurs through talking about the event once more. Whether this happens on an informal or a formal level is immaterial, but it almost always takes place in a group, be it with friends, comrades, family, the clan, or other people who have been affected.

5. Expressing the emotions and support from the community are an integral part of the above.

6. Calming down the physical hyperarousal is achieved through explanations and actions which are prescribed, encouraged or found on one's own.

7. Rituals can help in conquering the problems. Shattered assumptions can be rebuilt in a different way to open up the future. In short, the experience contains a new meaning different from the traumatised one. It is reconstructed.

Similar structures can also be found in dealing with PTSD:

1. Cognitive confrontation with what has happened also takes place here. The same story is told in a changed setting, either in individual therapy or in a group, with another undertone, i.e. it is put into words, or represented in an artistic form, for in-

stance. A central theme is found to link the events and a narrative is constructed. Order is brought to the experience of chaos, and with it the precondition for the next steps is established.

2. Emotions and the associated convictions or assumptions are clarified.

3. Various techniques are used to calm down the client on a physical as well as an emotional level. Ideally, this is achieved rapidly.

4. Society's acknowledgement that something terrible has happened appears to be central to healing the mental wounds. Not only war, killing, destruction, persecution on the societal level, but also criminal, sexual and family (MADANES 1997) violence are unacceptable and must be rectified. The laying of charges, condemnation, sentencing, punishment, atonement and reparations are important steps, no less so in a western world with secular values.

In order for cognitive confrontation with the traumatic events to be reached, without unleashing a flood of feelings, various types of sensory overload are used. Looking on while watching lead being poured and hearing prayers from the Koran, the back and forth movement of the eyes following a moving finger, listening to the commentaries of the therapist in EMDR, the physical stimulation of both sides of the body accompanied by commentaries in TFT and the movement of the head from left to right accompanied by breathing in and out during a Toltec fright ritual are all ways which enable survivors, protected from an overabundance of emotions, to establish cognitive order. The same effect is achieved in the hypnotic techniques through so-called multiple dissociation accompanied by simultaneous instructions to mobilise resources on a physical level. Interestingly, it is not important whether everything happens on a clear conscious level or on a preconscious, «hazy» one (PERREN-KLINGLER, in press).

With almost all techniques mentioned a neurological stimulation of both body sides or respective halves of the brain takes place. And in some rituals, as well as in EMDR, TFT and hypnotic trauma techniques, horizontal eye movements from left to right and the other way round can be induced. This is an interesting observation and should be followed up in the future.

The culture-bound concept of time has a further role to play in the integration of what has been experienced and deserves an investigation in its own right.

Summary

The concept of PTSD led to a boom of various, therapeutic interventions, mostly designed for individuals in the eighties. The nineties have brought us back to many traditionally available methods, due to the large numbers of non European victims and their unwillingness for, or lack of understanding of, psychotherapeutic interventions.

Simple interventions can help in the long term when they take place early enough and are as well anchored as possible in the culture in question, ideally, when they are introduced by representatives of the culture.

The discovery of rituals for traumatic or fright experiences and the efficiency of these rituals in the respective cultures has taught us to develop respect and curiosity and to look for a structural common denominator with our own interventions. We have learnt to be humble about our „new“ techniques in the face of age old wisdom in different traditions. That our modern culture, which is often impoverished when it comes to traditions, should also make use of sound, western psychological techniques goes without saying. Where other methods are available, we should have the courage and respect to examine them, so that these methods can also be used.

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