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Dealing with the Consequences of Organised Violence in Trauma Work

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1. Introduction

War and persecution cause not only material harm but also produce extreme psychological suffering for those who must both live and survive under such circumstances. This statement is self-evident to the point that one is always surprised by the fact that up until recently it was not an issue in humanitarian help and in development cooperation. Until recently help has always focused on material goods and general economic development. What people feel within the context of political and social destruction seemed to be of little interest: at best, it was an issue for religion; at worst, it was a luxury to be dealt with once the ‚real' problems had been solved. Although this has changed somewhat in recent years (and nowadays we find trauma programs in most crisis regions of the world), the basic attitude of international agencies is still quite ambiguous. Professional opinions vary widely about both what trauma work is and what it should do.

This chapter does not pretend to offer a simple introduction to trauma therapy, nor is it a basic guideline on how to heal trauma throughout the world. Trauma can only be understood and addressed with reference to the specific contexts in which it occurs. Any attempt towards a ‚globalized' presentation and discussion of trauma is therefore useless. The basic aim within this chapter is to offer information about the concepts currently under discussion in trauma work and to share a certain amount of practical experience as an invitation to the reader to reflect on his or her own experiences. I have worked for many years as part of the team of the Latin-American Institute for Mental Health and Human Rights (ILAS) in Santiago de Chile, which aims to help victims of political persecution. My opinion has been constituted by this experience, as well as by consultative work with similar institutions in Central America, Angola and the former Yugoslavia.

Section 2 will provide an overview, definitions and finally a review of existing trauma theories. Keilson's concept of sequential traumatisation is considered to be the most useful conceptual framework we have to date. One of the main events that drew light upon the limitations of both trauma concepts and terminology was the attempt to address the consequences of the Holocaust. In response to this inadequacy, the resulting concepts are outlined with reference to the ‚extreme traumatisation' experienced by the victims. It will be argued that trauma concepts need to be continually reinvented and always contextualized within the specific social reality in which the traumatisation occurs. The third section will examine both the potentials and limitations of psychotherapy. These are explored through three questions: „How does it feel like to be traumatised and is it possible to understand these feelings?", „How do we relate to a traumatised person or group?" and „What is the basic aim of treatment with reference to trauma?" The fourth section focuses upon three central attitudes that can be employed in trauma work. After this, the wider application of trauma work, which lies beyond therapy, is illustrated through case studies. Special emphasis is given to an interdisciplinary approach that integrates aspects of psychology, economics and education. The penultimate section draws attention to the difficulties, needs and hazards that trauma workers themselves face and potential ways in dealing with this vulnerability.

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2. Trauma theorie

The word ‚trauma' originally comes from the Greek language where it means wound. Its analogous utilization in psychology and psychiatry began at the end of the nineteenth century as part of the effort to explain certain mental disorders. Trauma, thus, was the cause of these illnesses and understood as a psychological breakdown caused by external events that exceeded the capacity of the psychological structure to respond to them adequately.

By the end of World War I, the military had become interested in the problem when they realized that condition of ‚shell-shock' needed to be addressed and explained, and could not be reduced to simple cowardice. It was during the Vietnam War that the United States finally established a set of identifiable symptoms, the so-called „Post Traumatic Stress Disorder" (PTSD) which was included in the Diagnostical and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Society. This resulted in the recognition of trauma by mainstream psychiatry. The negative impact, which occurred from the mainstreaming, was the categorisation of trauma as one more mental illness amongst many.

Box 1: Different conflict contexts or settings

In trauma theory, we need to distinguish between the traumatic situation, the trauma and the symptoms resulting from trauma. A traumatic situation is defined as an event or several events of extreme violence that occur within a social context: exemplified by war. Such a traumatic situation is a necessary but not a sufficient condition for trauma to occur. While trauma implies the destruction of individual and/or collective structures, it does not always follow that such destruction causes immediate symptoms. PTSD is the best known classification of symptoms that persist with the victim of a traumatic situation. This may cover accidental events such as natural disasters or instigated events such as combat, crime, rape, kidnapping and imprisonment.

Currently, trauma is conceptualised in three different ways:

- Trauma as a medical concept, e.g. PTSD, where the aim is to establish a more or less complete catalogue of symptoms.
- Trauma triggers highly complicated psychological processes (intra-psychic) that need to be analysed. This can be exemplified by the therapeutic work with victims of the Holocaust that was carried out primarily by psychoanalysts (*see* Bergmann and Jucovy 1982 and Bettelheim, 1943.
- Trauma as a social and political process: recent work in Latin America has established that traumatisation is not only an individual process but also a social process that refers to the society as a whole. These studies have also shown that trauma can only be understood within a specific cultural and political context.

Concerning PTSD analysis, it is important to outline several important limitations. As mentioned above, PTSD diagnosis focuses on the symptoms without reference to the cause of these symptoms. The traumatic situation itself is either ignored or not addressed which allows the analysis to cluster what are in essence different situations in the same category (‚stressor'), such as heart attacks, erupting volcanoes or human rights abuses. The shortcomings of PTSD diagnosis can be summarized as follows:

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- Family diagnosis is impossible within PTSD categories. A torture victim, for example, can have PTSD but his wife and children can‘t, even if their symptoms can only be understood in the context of the destruction of the victim.
- PTSD provides a list of frequently occurring symptoms; however, it ignores many others. While one can say that if PTSD symptoms are present, then trauma has occurred, there is no guarantee that trauma has not happened if these symptoms do not appear. Somatic and psychosomatic symptoms in particular, as well as social behaviour indicative of trauma, are not included in the definitions provided by PTSD.
- PTSD works within a rigid definition of time. Consequently, this may lead to an incorrect diagnosis if symptoms do not occur within a certain time span (for example six months). This time limit contradicts everything we know about trauma symptoms with reference to man-made disasters. For example, the symptoms of Holocaust survivors can appear ten, twenty and up to fifty years after the original traumatic event. This same experience has been confirmed with survivors of political persecution in Latin America. There is considerable data to confirm that trauma can be transmitted trans-generationally from parents to their children. PTSD diagnosis does not deal with this phenomenon (for a more detailed critique of the PTSD concept, *see* Becker 1995).

In contrast to PTSD, a parallel and different development occurred with reference to trauma in psychoanalysis, especially amongst those working with survivors of the Holocaust. In 1943, Bruno Bettelheim wrote about his time in a concentration camp and justified the need for a new term to describe the experiences he and his fellow prisoners had suffered: „What characterized it most was its inescapability; its uncertain duration, but potentiality for life; the fact that nothing about it was predictable; that one‘s very life was in jeopardy at every moment and that one could do nothing about it“ (Bettelheim 1943, 418). Thus Bettelheim suggested the term „extreme situation“ to describe his experiences. He was the first to clearly illustrate that traumatisation resulting from a man-made disaster could not be categorized in the usual psychiatric or psychoanalytical language. New terminology was required to describe this type of trauma. In the years following the Holocaust (referred to as post-Shoah), the term „extreme traumatisation“ was developed. The word ‚extreme‘ conveyed the special nature of the trauma, which neither in its way of happening, nor in its short and long term consequences, nor in its symptomatology, nor in its socio-political implications could be compared to other traumatic events such as accidents, an earthquake or a heart attack.

Freud provided the idea that trauma can also be a product of several experiences (Laplanche and Pontalis 1977). This was further developed by Khan and led to his concept of „cumulative trauma“ (Khan 1977), through which the dimensions of time and relationship are introduced into the discussion of trauma. According to Khan, trauma can be a product of a series of individually non-traumatic experiences, which develop and accumulate within an interactive framework and finally lead to a breakdown. These ideas are highly important because, although initially limited to the mother-child relationship, they transfer the emphasis from the trauma to the traumatic situation. This converts the event into a process and, without denying the intra-psychic wound, focuses on the importance of the interactive framework.

Both Bettelheim‘s and Khan‘s ideas were later developed by Hans Keilson in his concept of „sequential traumatization“ (Keilson 1992, first published in German in 1977). In his important follow-up study of Jewish war orphans in the Netherlands, he identifies three traumatic sequences:

1. „Enemy occupation of the Netherlands and the beginning of terror“ (Keilson 1992) against the Jewish minority. This implies attacks on the social and psychological integrity of Jewish families.
2. „The period of direct persecution“ (Keilson 1992), which was the deportation of parents and

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children, the separation of mother and child, the hiding of children in foster families and the direct experience within the concentration camps.
3. „The postwar period during which the main issue was that of the appointment of guardians" (Keilson 1992). The alternatives were to leave the children with their Dutch foster families or return them to their original Jewish environment.

Keilson's concept implies a radical change in the understanding of trauma. Instead of an event that has consequences, we are now looking at a process in which the description of the changing traumatic situation is the framework that organizes our understanding of trauma. Keilson demonstrates, for example, that a severe second traumatic sequence and a ‚good' third traumatic sequence implies better long-term health perspectives for the victim than a ‚not-so-terrible' second traumatic sequence and a ‚bad' third traumatic sequence. This is extremely important in explaining why trauma continues, even when the active persecution has stopped. We are thus able to understand not only why patients might develop symptoms immediately after the original traumatic event, but also why they might do so twenty, thirty or forty years later. Finally, Keilson's concept illustrates that, since there is no ‚post' in trauma but only a continuing traumatic process, the helpers (the people who deal with the victims) are also always part of the traumatic situation and do not operate outside of it.

One of the advantages of Keilson's concept is that it can easily be used in different cultural and political settings. Unlike PTSD, it does not define a fixed set of symptoms or situations but actually only invites one to look closely at a specific historical process; it allows the quality and the quantity of the traumatic sequences to be very different in various contexts. One sequential change that seems to be relevant in most parts of the world is the change between active war and persecution and the period that follows. In many cases, this ‚afterwards' needs to be divided into different sequences. For example, the war in Angola has continued for the last thirty years, being interrupted by small periods of supposed peace; in the former Yugoslavia there is now a condition that is different to war while not actually being peace.

Not being able to use PTSD with reference to our own patients and finding Bettelheim, Khan and Keilson extremely useful, we have adopted the term „extreme traumatization" (Becker and Castillo 1990; Becker 1992) for the situation in Chile and defined it as follows:

Extreme traumatisation is an individual and collective process that refers to and is dependent on a given social context; a process that is marked by its intensity, its extremely long duration and the interdependency between the social and the psychological dimensions. It exceeds the capacity of the individual and of social structures to respond adequately to this process. Its aim is the destruction of the individual, of his sense of belonging to society and of his social activities. Extreme traumatisation is characterized by a structure of power within the society that is based on the elimination of some of its members by other members of the same society. The process of extreme traumatisation is not limited in time and develops sequentially.

It is possible to see in our ‚Chilean' definition that we incorporated many of the ideas described above, but placed greater emphasis on the collective aspect of trauma. This was an attempt to transcend the individual level (without denying it) and include the social reality. I am uncertain whether our definition is really better than the others I have described. Nevertheless, the definition at least acknowledges a basic difficulty, inherent to all trauma theories: on one hand, they must deal with individual intra-psychic processes; while on the other, they have to deal with society. Conceptually, it is very difficult to do justice to both at the same time. This results in either the individual or the collective aspect of trauma becoming overstated or understated. Nevertheless, I believe that our definition is contextually important. In Latin America, and especially in South America, the issue of the long fight against dictatorship was central. Many people know nothing about Chile, but nearly everybody has

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heard of its dictatorship and its central symbol, Augusto Pinochet. In this context, a very ‚political‘ definition of trauma is therefore appropriate. In other regions of the world it might be different.

A good example of the relevance of contextualising our trauma definitions was an experience I had during a small workshop in a refugee camp in Bosnia. I asked my colleagues to forget everything they knew about psychological and psychiatric diagnosis, and to write down, in everyday language, what they thought constituted the refugees‘ trauma. This is what they wrote:

> *The destruction caused by the war, the grenades, the living in tents, the cold, the lack of food, the insecurity of when or whether they can return, the economic situation, the legal problems, the loss of family members, the memories of torture and concentration camps, the inexistence of privacy, the rejection by the local community...*

In fact, the list was a lot longer and included more details than can be written here. Although it was not a clinical definition, and did not fit into any standardised way of dealing with trauma, did not even differentiate well between the traumatic situation and the trauma, to my mind, it is one of the best definitions of trauma I have ever met. In terms of concrete information about the specific characteristics of the suffering of these refugees in Bosnia, it was excellent. It permitted us to start doing useful work because a good diagnosis is half the treatment. With this description in mind, it was possible to understand that ‚treatment‘ in this case had little to do with typical ‚therapy‘, but much more concerned with improving living conditions, initiating community work and facilitating collective grief processes.

In summary, I am suggesting that in each different social context people should create their own definitions of trauma within a framework, in which the basic focus is not so much on the symptoms of a person but on the sequential development of the traumatic situation. Whereas it will always be important to register the specific symptoms of a patient (mainly because of the metaphoric message that symptoms convey about the illness), our primary approach must focus on the repressive experiences. Thus, we would differentiate between a person who has experienced torture in Chile, a Bosnian refugee or a Vietnam veteran much more than between depressive, hysteric or obsessive symptoms. We would not hold that psychosis is a typical consequence of torture, but if we treat a psychotic patient and learn that he was tortured, our treatment strategy and our way of understanding his psychosis would change. In general, our diagnosis must include the specific social context in which the illness appears. Respecting the fact that political traumatisation is always tied to the context obliges us to understand that a Turkish, a Chilean or a Vietnamese refugee might present similar symptoms, might even have some comparable experiences, like torture, but each one of them, in effect, suffers originally from a different illness. What might constitute their similarity is that they are all refugees coming from the same country and therefore undergoing the same traumatic sequence.

Box 2: Different conflict contexts or settings

The basic framework for trauma when dealing with the consequences of organized violence can be defined as follows:

1. Trauma implies a notion of tearing, of rupture, of structural breakdown.
2. Trauma can only be defined and understood with reference to a specific context, which must be described in detail.
3. Trauma is a process, which develops sequentially.
4. Trauma contains both an individual intra-psychic dimension and a collective, macro-social dimension that are interwoven.

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3. Potential and limits of psychotherapy

The ‚treatment' of extremely traumatised persons neither begins nor ends in a therapist's room. Nevertheless, therapy may become the first social space in which victims might begin to overcome their difficulties. The relative intimacy of therapy permits us to learn, in a more implicit way, about a number of key issues of trauma that are also always present in other contexts. These issues can be formulated as questions:

1. What does it feel like to be traumatized and is it possible to understand these feelings?
2. How do we relate to a traumatized person or group?
3. What is the basic aim of treatment with reference to trauma?

Sandor Ferenczi noted in his clinical diary on February 21, 1932 that fragmentation might be a useful defence in surviving a traumatic situation. Confronted with unbearable aggression, a child might ‚give up his soul', mentally ‚dying', while physically surviving death. Afterwards, the pre-traumatic personality structure will be partially re-established, but a part of the person will have ceased to exist, will go on being dead or lost in the agonies of fear. The task of analysis would be to overcome this process of splitting. It is at this point where the dilemma arises. If the traumatic experience is reconstructed through a cognitive process, then the splitting between the destroyed part and the part that is looking at the destruction is maintained, thereby denying any real access to the traumatic experience. However, if the patient makes a ‚cathartic regression' to the stage of the traumatic experience, he feels, once again, his suffering, but cannot think anymore, and does not understand what happens to him. Once awake, the evidence immediately disappears and the trauma is again only perceived from the exterior, without the corresponding feelings (Ferenczi 1988). In short, it seems that neither approach can be successful.

Ferenczi here offers short and precise answers to some of the questions stated above. For him, trauma at its core would feel like extreme agonies of fear that lead to the psychological experience of death, which means that a basic split has to happen. This, Ferenczi shows, is helpful in order to survive trauma, although in the aftermath it implies sustained fragmentation; part of the person stays dead, while another part begins to function again. To overcome trauma, fragmentation would need to be overcome, but that is nearly impossible, because, ‚within' the traumatic experience, there are only agonies, no words, and no capacity for reflexive thinking. ‚Outside' of the trauma, thinking works and words exist, but without being totally connected to the traumatic experiences. So when dealing with traumatized persons, we always confront a double reality, on one side there is a person that can talk about, think about, and even tell us about what happened to them. On the other side, we have a person lost in the experience of death and of terror, for whom there are no words to explain their experience.

From Balint (1965), Winnicott (1965) and Bion (1990, first published 1962) amongst others, we have learned that the Ferenczi dilemma can only be solved through the ability of the therapist to connect with the ‚agony of fear', to contain it and to offer an authentic but sufficiently secure space for the patient to begin the process of reintegration. The therapist needs to allow the appearance of his or her own potential for fragmentation while at the same time maintaining his or her disposition of containment. This aids the patient to recognize themselves in those fragmented parts, which implies the beginning of integration. This is more easily said than done. How does one connect to terror, how can one feel empathy towards something that is so unbearable, that the person who experienced it is, with good reason, dissociating? Can anybody wish to recognize themselves in images of destruction?

Clearly, nobody wishes to recognize themselves in images of destruction, but traumatized persons have no choice. They can try to forget, but this never works. The terror is part of them. So

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the question is not does the person want to look at the terror, but how will a person look at this terror? Will he or she do so alone? In nightmares? Or will there be a space of sharing, of interaction with others, where death can become part of a living relationship?

It is useful at this point to consider the ideas developed by the psychoanalysts Cohen and Kinston. Although they use a complex psychoanalytical language, they nevertheless have developed some crucial ideas:

We accepted Freud‘s view that meeting a need leads to mental representation in the form of a wish and argued that a failure in need mediation would result in a persistent absence of associated wishes (internal self/object relations) and thus a gap in emotional understanding (psychological structure). Such a failure was held to be the essence of trauma and the basis of mental illness; and the resultant absence was primal repression (Kinston and Cohen 1986, 337).

They then go on to distinguish between being frustrated and being traumatised. They refer to Winnicott (1954; 1960) who argued with reference to treatment that ‚id wishes‘ could and should be frustrated while ‚ego needs‘ should be fulfilled. In accordance with him, they say „wishes often need to be frustrated and this is not traumatic; but frustration of needs, better termed failure of the environment to meet needs, is to be avoided. Such failure is traumatic and results, metaphorically, in a persistent wound or hole in the psyche“ (Kinston and Cohen 1986, 337).

Box 3: Defining Primary Object and Primary Relatedness

The consequences that the task of frustrating wishes and containing (meeting) needs has for the therapeutic process can be understood more clearly by two additional concepts introduced by the authors: „primary object“ and „primary relatedness“. To broaden an original concept, Kingston and Cohen state:

Primary object: „The primary object originally includes the uterus-placenta, the childhood environment and later some amalgam of personal relationships, works, possessions, physical environment, social status and religious or secular faith. The primary object generates possessiveness and embodies hope; its alteration or loss, in whole or part, is resisted strenuously and may lead to illness and death. The analyst can and must become part of the analysand‘s primary object. However, for growth to occur, the analyst must make direct contact with the patient in a state of primal repression. This seems to be possible only in the presence of a specialized form of relationship, which we call primary relatedness.“

Primary Relatedness: „Primary relatedness is the term we will use for the direct valuing, nurturing, confiding and reflecting relationship with others, which each person absolutely and objectively needs. It is characterized by intense mutual attachment and deep empathic communication. It is an environmental complement to the individual and so cannot be internalised. When no active form of primary relatedness exists, then the individual lives in a state of psychological death with the primary object.“

Source: Kinston and Cohen 1986, 343

Kinston and Cohen help us to solve the dilemma described by Sandor Ferenczi. They apparently perceive psychological structure throughout life as the product of a mediating process with the environment. Primal repression, i.e. trauma, can happen at any point in life and although the defence mechanisms will vary, the final effect is always terrible: a hole in the psyche. The trauma begins to form part of the primary object of the person. Where there is no wish, there can be no representation and no symbolisation; there is only a hole. The therapeutic task thus consists of

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adequately selecting and differentiating the moments to interpret wishes from those to satisfy needs. The latter implies becoming part of the primary object of the patient and thus facilitating an environment, a space in which the patient can grow.

Years ago, while offering therapeutic help to victims during the dictatorship in Chile, we spoke about a „bond of commitment" („vinculo comprometido", Becker and Castillo 1990), referring to something that seems closely connected to the concept of primary relatedness. We then wanted to express our conscious non-neutrality towards the victims, validate our own experience in the dictatorship and indicate our disposition to connect ourselves with a kind of suffering that, at that time, still did not receive any kind of public social recognition. I believe we learned then the importance of relating to our patients from an active position, breaking the silence and calling the atrocities the regime was committing by the name they deserved. We also learned then that the psychological death experienced by the people we were trying to help could only be integrated into a perspective of life if we, ourselves, were willing to recognize that death. We had to look at its causes and make it a part of a lively relationship, thus reconfirming the life of the patients. In this sense, to cure means not so much to repair destruction, rather it emphasizes a willingness to share it. Obviously, we also committed many errors. Doing the same work today we can appreciate the difficulties we have had in being able to recognize and frustrate wishes and we are conscious of our tendency to have only recognized and met the needs. This learning process has also permitted us to understand that primary relatedness, committed bond, containment and meeting needs does not only mean sharing the sense of destruction but also accepting and confronting the destruction within and between each other.

It is possible to summarise and formulate lessons from the original three questions we asked: what does it feel like to be traumatized and is it possible to understand these feelings?, how do we relate to a traumatized person or group? and, what is the basic aim of treatment with reference to trauma? The first lesson is that trauma implies the feeling of death, of extreme fear. Secondly the consequence of trauma is fragmentation. Thirdly an interpersonal space is needed to overcome trauma. This must consist of sufficient primary relatedness or (in our Chilean language) a good bond of commitment, in which some kind of symbolisation can slowly develop. Symbolisation implies that, instead of re-experiencing terror, a psychological level or space is found and created, which, because it is symbolic, loses its ‚de-structuring' capacities and makes it possible for the past to really become the past and to establish a convincing difference between extra-psychological and intra-psychological reality.

4. Beyond the framework of therapy: the importance of truth, justice, respect and empathy

Although the psychological processes and dynamics described here appear to correlate with specific psychotherapeutic settings and theories, this does not mean that they only appear in psychotherapy. I strongly believe that the issues of primary relatedness, of the possibilities of symbolisation etc. are not limited to the psychotherapeutic setting. In fact, although it is much more difficult to find adequate words to describe it, I think that all of this also happens in the social and political space. Truth commissions and justice, for example, tend to re-establish some of the ‚primary objects' of a society (see also the contribution of Gunnar Theissen in this Handbook). They also help symbolisation to occur and to find adequate words. This results in a good ‚anti-traumatic' effect. Nevertheless, it would be wrong to expect only positive reactions to them, even in countries where these commissions act from a comfortable position of power, as in South Africa.

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Quite the contrary, if they work, they have to produce contradictions, and discussions, and all types of feelings. They have to facilitate a process where a new and different confrontation can occur with reference to the terror that happened. In that sense, those who expect silence to emerge from these commissions will always be frustrated. But those who understand the basic issues involved in the healing of trauma will be able to celebrate the new difficulties and discussions that arise with and through these commissions. As we saw before, at the beginning of trauma work there are only needs. Wishes can only appear after some integration has occurred and fragmentation, albeit in part, has been overcome. Instead of the repetition of trauma, we will find feelings and relationships. Many of these will be of an aggressive nature that can be addressed in new and different ways within an emerging dialogue.

On a more individual level, we can deduce certain basic attitudes in trauma work from the ideas discussed above that should be valid for everybody working in the context of war and persecution. These basic attitudes can be summed as respect, comprehension and relationship. These three attitudes are something that should be present in every kind of relationship, but they are especially important in the context of trauma. In addition, there is a little more to it than may be obvious. Although other attitudes towards suffering seem very human, they actually may hinder rather than help the process of recovery. Victims, for example, hate compassion in so far as they often correctly fear that compassion is a disguised form of rejection. The receptor of compassion is further victimized while the giver reconfirms his or her own situation of not needing compassion. This does not mean that what victims long for is somebody who doesn‘t feel at all, but there can be no doubt that somebody openly un-empathetic is often experienced as less destructive than somebody who pretends feeling but in reality only insists on his or her status of not being a victim. The same can be applied to grief.

4.1 Respect

Most of us have learned early in our lives that when you see someone who is sad, you should help them to be happy again. In short, if someone cries you should try to make him or her stop. In the context of trauma and terrible loss, this can be exactly the wrong thing to do. If somebody has suffered a terrible loss, wouldn‘t it be more appropriate to cry rather than not to cry? In that sense, respect would mean letting a person express her or his distress and grief, without immediately insisting on calming her or him. Many years ago in Chile, I dealt with a family (a mother and her daughter) whose fourteen-year-old son had been killed during a public protest by the police. One of the difficulties of the case was that well-meaning friends of the family had said to the daughter that she shouldn‘t cry so much because that would wet the wings of her brother flying to heaven and thereby make his journey more difficult. Now this had meant for the little girl, alongside her terrible grief, accumulating feelings of guilt that evidently didn‘t help her much. In fact, she and her mother did not eat anything for days after the incident occurred. Only after we (the therapists) had confirmed two essential points could they slowly begin a more normal life, although their grieving obviously continued for a long time after. These points were: (a) the police, and not themselves, were responsible for the death of the son; and (b) crying was good and normal and, if anything, could only help the son‘s journey to heaven because it showed that his family loved him.

Thus, respect means a lot of things, of which the most important are not to further victimize the people with whom we are dealing, respecting their grief and destruction as well as their capacities for surviving and continuing through life. It means being interested in their history and respectful of their own way of expressing themselves without pretending to know everything about them. Respect means not running away once the people really start talking to us.

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4.2 Comprehension

The second attitude, comprehension, is equally important. Comprehension of the dynamics of trauma is central when dealing with victims, although it does not necessarily mean that one should always act on what one understands. For example, certain issues like mistrust, insecurity, passivity and exaggerated fear can be understood in the context of trauma. Additionally, the fact that somebody is able to talk, communicate and even able to work, while at the same time feeling extreme inner terror, does not surprise us much, when we have a greater understanding of trauma. Clearly, comprehension is not something we can obtain a priori. It always depends on how well we know the context and how our concrete relationships develop. We can, at least, be willing to learn and thereby develop our comprehension, and, in a general way, we can have hunches about the best direction to take.

If, for example, trauma has all the destructive force we have postulated, and also develops sequentially, then we know that traumatized persons are involved in the very difficult struggle of reconstructing their personality. We would understand, for example, that an eleven-year old, ex-child-soldier in El Salvador, whose parents were killed at the beginning of the war, and who for years was a good and responsible soldier, would now, in a time of peace and back at school, begin to manifest serious problems. His parents are dead, the power and social importance he had as a soldier have disappeared, he is now only a schoolboy who does not read and write very well. We would understand that only now will he begin a grief process regarding the loss of his parents and his childhood, and also that, for him, it is possibly less fun being a ‚stupid student‘ than a ‚good soldier‘. If we want to help him, we have to accept this specific part of his history. This would mean acknowledging both him and his past. It is necessary to take him seriously and to look for the possibility that his past can be valued, while at the same time making room for the needed educational process. This could happen, for example, by letting him also be a teacher, giving him the task of organizing and participating together with other young men in the educational work and teaching others to read and write.

4.3 Relationship

The third attitude, relationship, sums up the first two, but also goes beyond them. For psychotherapists it is quite obvious that they should never forget one of the basic laws of communication which states that communication always has two aspects: one referring to the relationship established between the persons communicating, and another referring to the content of the message that is being communicated. The relationship aspect is always more powerful and important than the aspect referring to the content. This implies, for example, that a teacher of mathematics, while teaching the subject to a group of students, might be talking about math on one side (content), but on the other side always establishes the specific teacher-student relationship, and that she and her students cannot communicate outside of this relationship. Moreover, the quantity of math that her students learn does not depend so much on the information she gives, but rather on the relationship she establishes with her students. One often wonders why the knowledge of this law should be limited to psychologists. Would it not make a lot more sense for everybody to know about this? This is especially true for teachers and technicians; that is, persons who hope to transmit information but who often forget that this implies a relationship, which in turn determines if the information they want to transmit really reaches the other person.

In the context of trauma work, this is a central issue. Finally, it should be understood that help, which is offered in crisis regions and in situations of catastrophe, is never only a question of

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what people need, but also a question of how the required help is put into effect. People might need food and shelter, but it makes an enormous difference if they participate actively in this or if they are just passive recipients of help. In the latter case it should not surprise anybody if these persons afterward stay passive and do not develop much energy to reconstruct an independent form of living. Building and developing relationships is thus a key activity in trauma work. The aim is always to respect and understand others and to build a framework in which change might occur. A relationship in this sense also implies trusting the traumatized persons; trusting that they have the energy and creativity of their own that they can use to help themselves. The ideology of ‚help, in order to facilitate self-help‘ is not new in the cooperation for development. But not all actors seem to take it very seriously. In short, self-help can and will occur, even in the most terrible situations, if the helpers are willing to offer a kind of relationship that is committed and respectful; i.e. a framework of trust and protection in which new initiatives can develop.

4.4 Psychosocial work as a method for dealing with individuals and their social context

Everybody working in a crisis region should be aware that trauma work is not something that should be limited to specialists of psychology. There are a number of relevant psychological issues involved, but these should be shared in a clearly interdisciplinary approach to our work. It is quite sad to observe how in different places in the world the same error is repeated over and over again; trauma work is considered a mental health issue, absolutely independent of educational activities and economic reconstruction. Psychosocial work should never be an aim in itself. It should be understood as a method that obliges us to deal with individuals and their histories, as well as with their social context and the economic realities that are present. Thus, depending on the specific situation, trauma work can be therapy, but it can also be the reconstruction of houses in the community by the community itself, or even school work.

Case Study 1: Community Center, Bosnia

In Sanski Most, a small town in Bosnia, there exists a project in which women, who were traumatised during the war (most of them lost their husbands), take care of old people who live alone. Through this activity they are able to make a little money and, at the same time, they are offering a basic health and social service, one that is much cheaper than what the state could offer. In addition, through their work, they overcome their own isolation and form groups, in which they talk about the problems of the elderly people as well as themselves. They are being supervised by a group of local women activists that have organized this work as a kind of community centre with the help of Swiss development agencies. This project is a real self-help project. Despite the trauma of the participants, they still persist in inventing perspectives for change amongst themselves. In Bosnia, the relationship towards one‘s parents is culturally very deeply rooted and highly valued. Helping the old is also a way of not forgetting the past: the pre-war past. In short, we are looking at an integrated project that provides a social service, generates income, implies working through trauma and is being carried out by laypersons doing an excellent job.

Case Study 2: Grameen Bank, Bangladesh

A further example is the Grameen Bank in Bangladesh, the so-called bank for the poor. I don‘t think its founders ever thought about their work in terms of trauma. But when one reads about their work, how they build trust and relationships with the people, how they help

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them to organize themselves in groups, how they respect cultural traditions and how within this framework they develop economic perspectives, one cannot help feeling that what they are doing is excellent trauma therapy, although what they are known for is micro-credits, very small loans, that usually do not exceed U$ 200. So many economic projects have failed, simply because they are interested more in the money than in the people who deal with this money. The Grameen Bank works the other way around. Their first interest is the people, their histories and their needs. They then develop perspectives together with the people, while understanding that the problems people have and the possibility of autonomy and self-help are not a contradiction but a complementary function of the same issue. Furthermore, Grameen offers a group structure that facilitates containment in the most direct therapeutic sense. Thus, at the end they achieve a very respectable economic result, but they also achieve the result that the most exploited and traumatised persons begin to trust themselves and their capacities and begin to construct a more dignified life.

5. The danger of traumatisation of the trauma worker: burn out prevention and supervision

Finally, I would like to comment on the persons trying to help in the context of trauma. When one is trying to help others, one often tends to forget that nobody is invincible and that helpers also have needs. When dealing with extreme suffering, it appears to be a luxury to think about one‘s own well-being. Nevertheless, it is quite well known now that people working in extreme situations need to be very attentive to their own psychological processes. Quite frequently people overestimate their capacities to resist terrible situations and underestimate their need of receiving respect and validation through others. The consequence of not really dealing with oneself is known as ‚burn-out‘. What is meant by this is an absolute lack of distance towards one‘s work, a permanently exaggerated use of one‘s own capacities till the point of total fatigue is reached. At this point one works poorly, gets ill and begins to hate the people one previously wanted to help. The problem is recognized all over the world but is only very rarely dealt with in an adequate fashion. In fact agencies usually don‘t like to pay for supervision, training workshops and time-outs for trauma workers. Trauma workers themselves also tend to ignore the difficulties and frustrations in their work, and continue to the point where they fall ill.

If we really want to avoid these errors, we have to assume that working in a traumatic situation implies that the helpers, in one way or another, can become traumatised and that they need time to work through their own traumatisation. This must happen through regular external supervision. In this context, supervision is meant not as a further means of control, but rather as a space in which the trauma worker can talk about problems at work within a framework of trust and respect. If local supervision is not possible, then external supervisors from other countries need to be brought in, until a suitable local structure is in place. One should always encourage trauma workers to write and communicate about their work. This is a way of working through one‘s own experience and making sure that it does not convert itself into a private traumatic event, but becomes part of a public process again. Also vacations and trips to other places are necessary. Some of these can be official working trips, but it is also important to understand the legitimacy and importance of not working or taking a break.

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Trauma teams all over the world have had severe crises because this issue was not addressed appropriately. In fact, most teams I have encountered, at some point in their development, have broken up because of these problems. Trauma always has to do with extreme aggression. If we do not learn to consciously deal with this aggression we will be condemned to repeat it amongst ourselves, at the least destroying our work, and, at worst, destroying ourselves through illnesses.

6. Conclusions

At first sight, it would seem a positive development that psychological dimensions are finally being considered with reference to the consequences of organized violence. However, this quickly becomes doubtful when trauma is understood and dealt with as a typical medical illness, like malaria or chicken pox. In this framework trauma work is just one more smoke screen of political propaganda that is used to give people the illusion of help. The basic issues of power and social conflict are not only ignored but, worse, are conceptually redefined as part of an individual psychological illness, thereby further hindering a person's capacity to act upon the situation. Exaggerating a little, one could say that first we have war and destruction, and then we offer individual therapy instead of social change.

When dealing with human suffering as a consequence of man-made disaster, we are confronting two problems. First, we have to try to understand the basic psychological dimensions involved and enhance the recognition of the importance of these dimensions. Second, we have to avoid a cheap psychologisation of political problems and make sure that the sociopolitical aspects are not ignored, but are actively recognized and integrated into our work. In other words, when confronting trauma arising out of man-made disasters, we have to deal with the individual and the society, with the material and the spiritual aspects of life, with politics and economics, justice and psychology.

Consequently, it is understandable why trauma is such a complex topic. However, this should not lead to the erroneous conclusion that only highly-trained professional therapists can do trauma work. We have recently seen not only a high number of trauma projects being set up in the crisis regions of the world, but also an army of trauma experts (usually from the rich industrialized nations) teaching the locals the techniques of trauma therapy. Most of these techniques fit well into the individualized culture of rich western countries and their corresponding structure of mental health care. Nevertheless, they are often quite beside the point in a crisis region, where trauma is a collective reality and the cultural context is different. Approximately 80% of trauma work in crisis regions is being carried out by lay persons. Some do therapy, but many conduct activities similar to community education, human rights work and economic reconstruction. Training in the field of trauma can only be worthwhile if it is understood that there cannot be either one model or one way of doing things. In different contexts, trauma work must be continually reinvented without being restricted to the activity of individual therapy.

Trauma work can be an important factor in helping individuals confront the consequences of organized violence throughout the world, if it is carried out in a responsible way and developed with reference to the specific cultural context. Trauma work needs to be part of an integrated approach that includes the dimensions of education and economics. Furthermore, it should always address both the individual and the collective aspects. To be carried out effectively support structures are needed on a national and international level. In that sense, we should try to avoid turning trauma work into an international business, but rather defend the possibility of international solidarity.

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