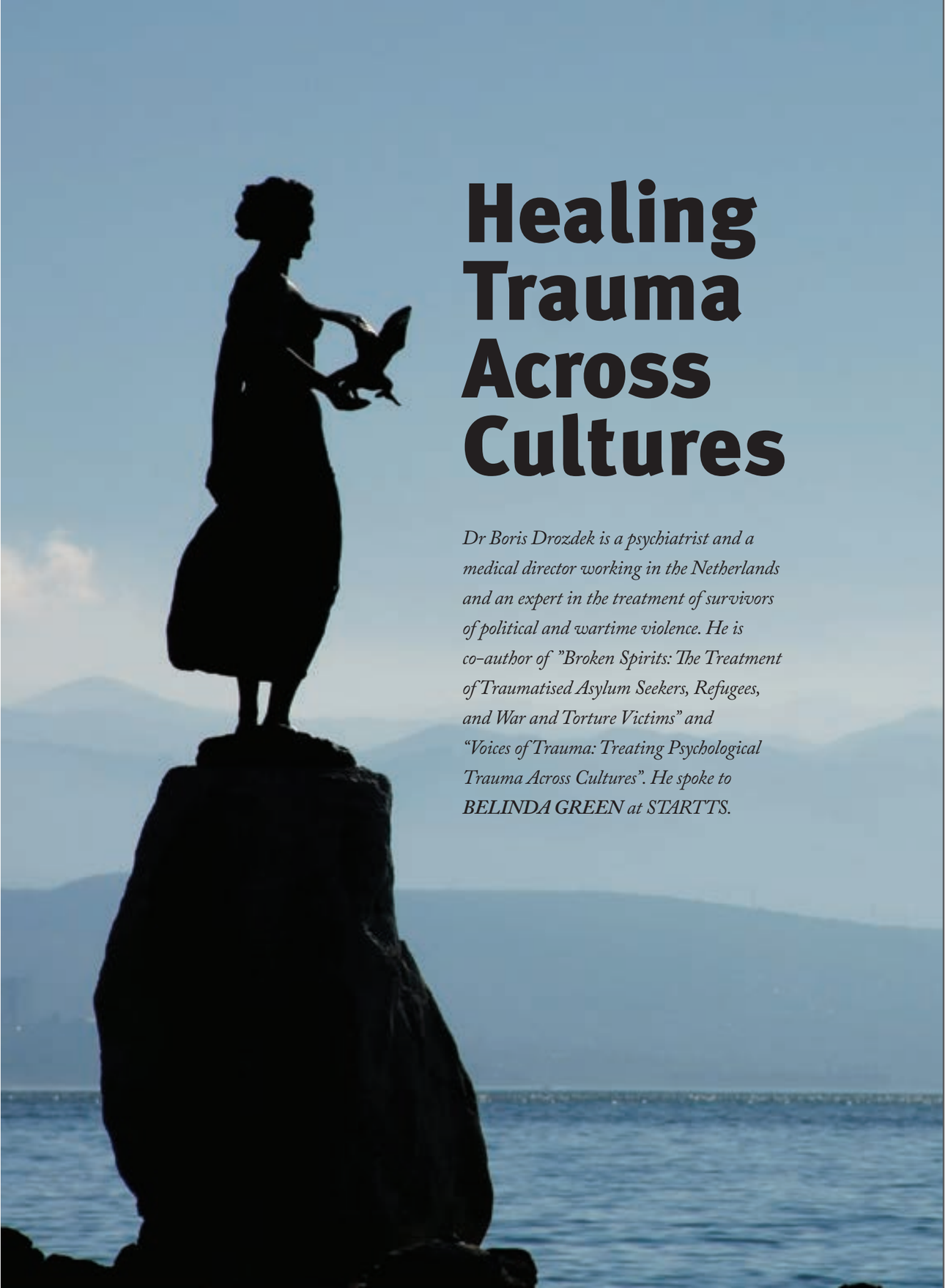

Healing Trauma Across Cultures

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You were born in Croatia and lived through the Balkan War. Tell us about your background.
Yes I was about to finish my residency as a psychiatrist when the war erupted in 1991. At the time the teaching of trauma treatment was not part of the psychiatric curriculum in Croatia and I guess it was the same elsewhere in Europe. But when the war started I was suddenly confronted by the overwhelming presence of violence and imminent danger.

I started assisting war prisoners, but the workload increased as a result of the influx of refugees.

We screened thousands of people for psychological assistance. I read many books in an attempt to find out how I could better help them because I felt I didn't have adequate knowledge. In the 1990s you could only find literature that had been written in the 1980s mostly it was about Vietnam War veterans in the US and the Holocaust survivors. I soon realised that what we could learn from those papers could not be indiscriminately applied to the type of clients we were working with. The question was: What was the point of differentiation between the two groups of clients? The Vietnam veterans and the victims of the Balkan War. The prevailing philosophy at the time was that you couldn't really treat a traumatised client while the trauma was still going on. Also, it was believed that survivors had to have enough basic safety to undergo trauma. But 'basic safety' as a concept was not well defined.

So many clients came to us for assistance and they talked to us a lot. They felt an urge to share their experiences. Then we realised that nothing happened to them if we allowed them to talk. We learned that sometimes we had to limit how much they talked and shared.

Later I was invited to the Netherlands to work at a number of asylum-seeker centres assisting refugees from the former Yugoslavia. I provided psychotherapy. Since I had no clearly defined parameters of what I had to do, I had the freedom to explore options and use my creativity.

At the time in the 1990s we were much more medically oriented and less culturally sensitive than we are now. But we developed treatment models. We started to become more aware of the role that culture plays in patients, and started to understand more as time went by.

In 2004, I met John Wilson and a few doors opened for me. This is how the Contextual Development Model was created and started to take shape. Wilson is a trauma guru and one of the founders of the Vietnam War Veteran Services in the US. He was enthusiastic about our work and came up with the idea of writing a book. The act of writing helped me to process my knowledge, and be precise in my descriptions as you are pushed to find the right words.

The Contextual Development Model that we created is similar to the STARTTS model in the sense that it also originates from a systemic tradition and it is not reductionist.

Let's talk about the systemic idea behind this notion, of the ecological environment in assisting refugees.
It is based on the idea that trauma happens in a certain environment and so does the healing. I believe that everyone is nestled in their own web of relationships and networks, and the longer I do this work the more aware I become of how important these relationships are for everyone. If change occurs in people's lives it will have a ripple effect on them because change transforms lives. Through my work I try to make people aware of the nuances that change brings to life.

What are these nuances that determine people's behaviours when change happens? Could you expand on that?
To illustrate this I will tell you about the work of psychologist Bronfenbrenner. He uses circles to represent what we call "the ecological environment". So he draws an inner circle that represents the inter-psychic dimension of the client, the next circle represents his primary relationships. The next circle is about his participation in society, etc. This is a complex model that includes the client's culture, subculture, religious beliefs, etc.

We then add to these components the developmental perspective, in which the therapist must analyse how the changes transform a client at the different levels of the ecological environment throughout someone's life span, and find out what the causes of stress are and where they source resilience.

What we see in a client at a particular moment in time is just a snapshot of his life. You can focus on the snapshot but you need to see the client over time in order to understand his life and put it in a broader context.

I believe the developmental perspective is important. As a therapist, you always ask yourself: "What protected this client before the trauma happened and problems developed?" I used to see refugees who were clearly uncomfortable and appeared to suffer from classical borderline personality disorder, then after a while and once their lives were stabilised their symptoms clearly disappeared.

There is always a search for a balance between damage and resilience and that means that one can become unbalanced and present symptoms in the snapshot that are something else other than a diagnosis of a mental

illness. The key to understand what keeps people balanced or unbalanced is in the developmental perspective which is added to the ecological environment I just described.

So what you are saying is that there is a danger in over-pathologising people and that this may be problematic?
Indeed. If you define this in a simple way you can see how sustainable those results are, why people do it, how useful it is to diagnose. I personally would not like to be diagnosed with something that comes from the medical technology and it is imposed on me. I would prefer to understand why I feel the way I feel.

So what do you do with clients is look at resilience and steer away from pathologising?
I also think this approach generates hope because there is something in you that keeps you balanced and in fact has kept you balanced for a long time. This something is always present. When you are unbalanced you feel the pain. But there is a source of resilience that may be empowered in order to deal with the pain.

What would you do if someone is displaying symptoms of psychosis?
A colleague of mine in Holland has done a PhD on what he calls "Posttraumatic Psychotic States". People can be misdiagnosed with psychosis. They are then stigmatised and become chronic patients with an "incurable" illness.

Of course that is not to say that everyone we see can be cured. In some cases people's wounds cannot be healed, but for the majority of clients it is possible to heal themselves, even though they present the same psychotic features that usually stem from trauma. In these cases clients experience similar psychotic phenomena such as hallucinations that have something to do with the past and with the traumatic exposure.

At a certain point traumatic experiences' pressure on the ego is so strong that boundaries become very permeable and then something that used to be experienced as a nightmare becomes a hallucination. What you do then is prescribe antipsychotic medication, but only to lower the anxiety levels, to glue the ego and then work on the traumas that have caused this posttraumatic psychotic state. If you treat that well, symptoms tend to progressively disappear. It is not incurable.

Can we talk about the notion of cultural assessment that you mentioned in the seminar? You spoke about a continuum, about the relational aspects of the survivor, and the incorporation of cultural aspects, etc. What are some of these components and how far should a therapist go to understand the cultural nuances of their clients?
Part of the therapeutical relationship with your client is to encourage him or her to be your cultural informer and offer that knowledge to you. But how far should therapists go to understand those nuances of culture is an interesting question.

It is important to be culturally sensitive from the moment you feel that the therapeutical process doesn't unfold the way you are used to, one then needs to ask oneself, what is preventing my efforts to help this client? Then you realise culture could be interfering. However, it would be rather preposterous to prescribe that you should over emphasise culture, since there are also universal aspects to being a survivor of trauma and torture that are common to everyone.

You tend to improve cross-cultural skills the longer you work in this field. The idea that talking helps people is a Western concept. It is not common to all cultures. If you realise that, you may negotiate differently the terms of the therapy with your client.

The fact that clients are silent may be due to many reasons. In some cultures when someone has been raped, the reparation manual within that culture may consist of killing the victim, or killing the perpetrator, expelling the victim from the community, or even scapegoating her.

If this is the reparation manual, if these are the solutions to these problems for that society whose member we are dealing with, the client will not open up to his therapist. He will keep certain things to himself.

In the Netherlands and in Australia we say talking about experiences does help recovery. These clients may say: "Convince me of that and protect me from all the risks I expect to encounter when sharing my experiences and feelings".

How do you go about convincing a client? You explain to them that there are certain therapeutic interventions available to them and this is one of the options available for their rehabilitation.

The key to deal with such clients is to be respectful to them. You as a therapist already have some knowledge of the reasons that are preventing your client from verbalising and sharing experiences and feelings. As far as I know, in some cultures the actual sharing of the experiences people have endured is very different from how it is done during the therapeutic process.

For example, if you are treating a survivor of sexual violence with the reparation environment we mentioned earlier, which is rooted in their culture, you will need to negotiate with the client about how to share this

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experience during therapy and also how to protect the client and make him or her feel safe, and ensure confidentiality.

There is also a stigma attached to going to therapy among some refugee communities where individuals tend to watch one another. They know who is going to see the psychiatrist, who is going where, and many don't like the idea of being perceived by others as needing psychological assistance.

In these cases a process of negotiation is needed rather than normalisation. In other words, I know what I have to offer and try to convince my clients that I may be of help to them. Sometimes I succeed, other times I fail. But most of the times I do succeed in convincing them.

What do you say to them in order to motivate them?
I listen to their priorities. They want to be acknowledged, validated and they want to reveal their lives' experiences and you play on that card much more than on the diagnosing of symptoms or the disorder. What I ask is: "What do you want from your life? Let's see how I can help you."

I normally deal with the practical issues. I remember one client that finished his therapy and had to leave the Netherlands, he said to me. "I am still living illegally in this country and I am sleeping in a church, but I have learned to take care of myself and this is what I am taking with me." If you can achieve this as a therapist, it is great.

Could you comment more on the nuances of working with asylum seekers particularly about working with men and the loss they experience associated with their understanding of masculinity and then a more general appraisal of the subtleties involved in your therapeutic relationship with clients.
I say to my male clients that by coming into a new country their position in society and their position within the family, has changed. Their loss of identity, their loss of their role as head of their families is something that needs to be dealt with. Normally men tend to complain that their wives don't listen to them anymore and don't like their children associating with other children outside their culture. Men tend to lose control of their milieu.

In terms of your other question, I believe that as a therapist when you see that you are not making progress, there is something that you have missed. It could be secrets a client won't reveal, or something you have overlooked. Your intuition will tell you where you need to search for it. There is always a door that will open if you listen to everything being said by the client.
I particularly pay attention, take notice and react to those things that I am being told that are not logical, that don't make sense.

You have to examine those things being said by the client that do not match your expectations. That is where the clues lie. They normally open the door to another level of understanding.

Trust between therapist and client is crucial. Sometimes it can be difficult to engage with them. The fact is that when clients have been persecuted and terrorised the likelihood that they will seek assistance is small. In that case, how can one encourage them to put their trust in a public institution?

You have talked about culturally-informed understandings of trauma. What is your view on Post Traumatic Stress Disorder (PTSD) and the prevalence of universal aspects of trauma?
The PTSD symptoms are more or less universal: having nightmares, being irritable, having aggressive outbursts, etc. PTSD is defined in terms of symptoms but the definition does not capture the human complexity, and culture does come into the picture, when you are searching for explanatory models.

People have different explanations about why they suffer, be it from PTSD symptoms or from other causes. Some people refuse to talk about what happened to them because they believe that when they talk it triggers the ancient spirits to become awake and angry. That can happen with some African clients. So what would you say to a client that has concerns about ancestors and ghosts?

I normally introduce the idea that this is our culture, that therapy is the way we look and treat problems. I say: "I can help you with this and that. Maybe we can combine some other ancient ritual to the therapy. Is there a ritual in your culture that may help you to keep the evil spirits away and the souls of the deceased at peace? If it does not work you can always come back to me." Then most clients will say: "if you think so let's give it a go."
Therapy is about respect and building an alliance at a very human level. It is about the therapist and the client believing in what they are doing. Then you come back to the universal values. ꟷ