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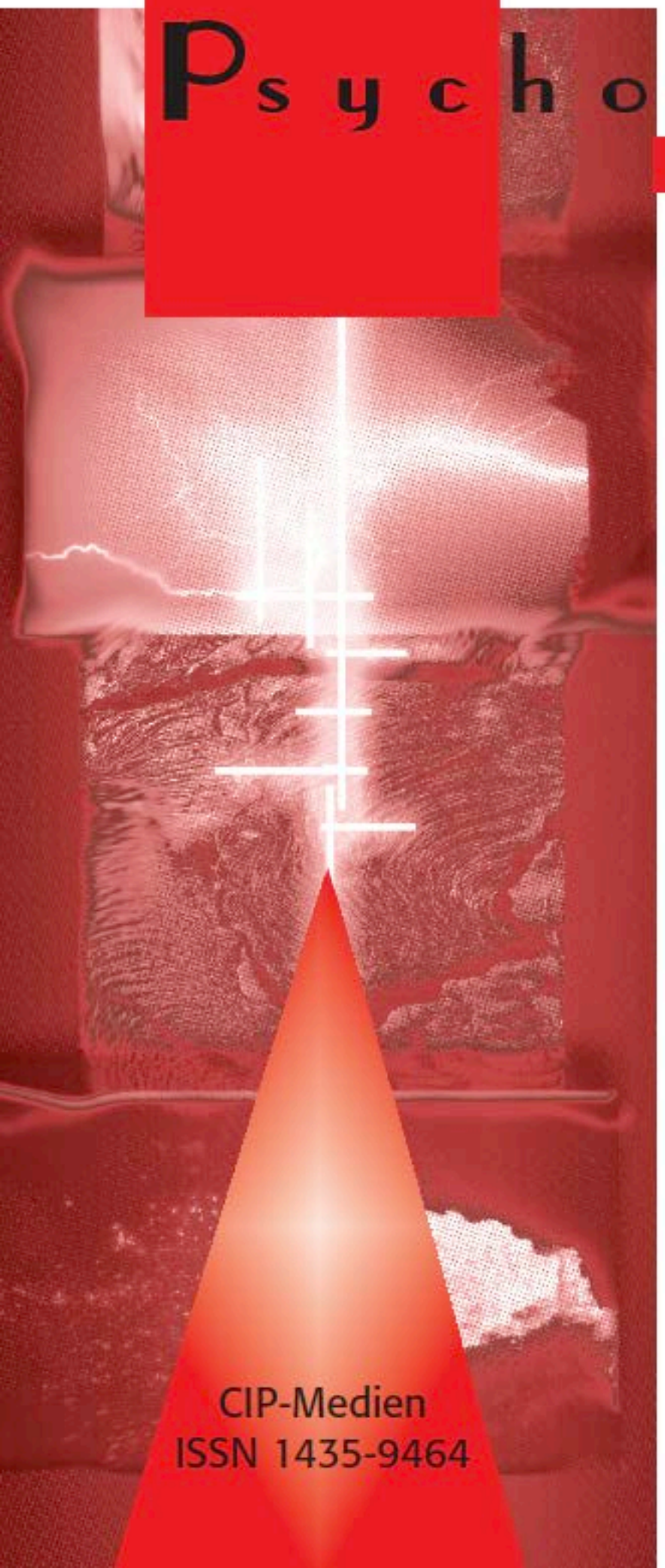

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SPECIAL TOPIC

Willi Butollo and Coworker

Posttraumatic Stress Disorder

CLINICAL EXPERIENCE

CONTENTS

Dear Readers,
Last year we presented the remarkable approach of the intensive psychodynamic short term therapy Davanloos. It is the expression of longstanding scientific development as well as the founder's particular personality.
Just as exceptional is Willi Butollos trauma therapy which he developed in the treatment of trauma after effect during the war years on the Balkan and in the postwar era. Here, the contemporary historical course of events and psychological development connect. Some essays and a therapy manual offer a comprehensive description of this humanitary and psychotherapeutically significant work. We are very glad to be able to place these publications at the european psychotherapist public's disposal. We can take valuable suggestions from Butollos and his team's statements on the increasingly important becoming work with traumatized people, so that we can incorporate the therapy of trauma victims more courageously.

In addition, Rolf Sandell reports about the current state of therapy process research against a backdrop of the large swedish study in two papers.

Both subject areas mark the present state of psychotherapy in Europe which give cause for optimism and point towards positive future perspectives.

As always, original in-depth papers and essays will be available on the internet at **http://www.cip-medien.com/europsych.htm**, right after recommendation by two reviewers. Date of publication is the month of endorsement. This secures fastest possible publication for the authors. Once a year, the printed version will be printed and published, in which all the published papers within 12 months can be found. Access to the internet version is free of charge, which multiplies the number of readers of an article.

We wish our readers an exciting read and much joy with the psychotherapeutic work.
the editors

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IMPRESSUM

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Varieties of Psychotherapeutic Experience

Abstract

Meta-analytic studies have concluded that level of psychotherapeutic experience, whether measured in years of professional practice or in terms of level of training, has at most a weak relation to treatment outcome. It is suggested that this is due to the failure to distinguish between different aspects of therapeutic experience. Assuming a less simplistic view on therapeutic experience, we studied the relations among a number of experience indicators in a random national sample of 227 licensed psychotherapists Sweden. On the basis of a cluster analysis of the experience indicators, four kinds of therapist experience were identified. One, *seniority,* may be considered a core variety of experience in terms of number of post-license years, supervisor training and activity, and training in several varieties of psychotherapy. Another variety of experience that emerged in the analysis, called *psychodynamic repute,* had psychoanalytic training and long personal therapy as its principal indicators (linked to seniority by way of long private practice). A third experience cluster was *long and faithful service,* indicated by long experience of psychotherapy in psychiatric practice, inpatient or outpatient, as well as age and number of pre-license years. A fourth variety was associated with a large accumulated *case-load,* particularly linked to cognitive-behavioural orientation and practice. It is suggested that, in judging qualification of applicants for training, jobs, or teaching positions, it may be important to differentiate among these kinds of experience.

Introduction

Most people would agree that professional experience is a good thing in general, and when it is not, we prefer to use other names for it, like routine, or burnout. Thus, being experienced as a psychotherapist is generally a quality contributing to one's credibility – possibly also to one's quality. Therefore, it becomes a bit confusing and disturbing when research is reported to the

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effect that therapeutic experience, or clinical experience in general, does not seem to pay off for the clients. A classic example are the findings of Strupp and Hadley (1979) of no outcome differences between professional therapists and relations-skilled university teachers. Although Strupp (1996) himself has de-emphasized it, Dawes (1994), Jacobson (1995), and others, have contended the interpretation that clinical training and experience are irrelevant or that psychotherapy as such is more based on faith than on learning and knowledge.

Several research reviews on the value of experience of psychotherapists have also arrived at negative conclusions (Auerbach & Johnson, 1977; Berman & Norton, 1985; Beutler, Machado & Neufeldt, 1994; Hattie, Sharpley & Rogers, 1984; and for children and adolescents, Weisz, Weiss, Alicke & Klotz, 1987). Stein and Lambert (1984, 1995) appear to have treated the issue in the most systematic and sophisticated manner, in two meta-analyses. In their first meta-analysis, they found the average effect size equal to 0, meaning no difference between more and less experienced therapists. In their second meta-analysis, Stein and Lambert (1995) focussed on training and concluded that "a variety of outcome sources are associated with modest effect sizes favoring more trained therapists" (p. 182). "Modest effect sizes" in this case refer to *d* values between 0.2 and 0.3, which are conventionally called "small effects" (Cohen, 1988). These results are probably counter-intuitive to most of us. Among others, Rönnestad, Orlinsky, Parks, Davis et al. (1997) have noted that the null findings might have been due to the fact that the allegedly experienced therapists have indeed not been very experienced, which has led to restriction of range and thereby weaker relations between therapist experience and patient outcome. Another – so far unexplored – reason for the unexpected meta-analytic findings may be that experience has been taken as a unitary phenomenon, which it may not be. Stein and Lambert commented, 1995 as well as 1984, that researchers usually had confounded training level, training quality, duration of clinical practice, case-load, and age, and suggested that difficulties in the definition of therapeutic experience had hampered research integration in the area. Even such sophisticated studies as those of Orlinsky, Rönnestad et al. (1999) and Rönnestad et al. equated therapeutic experience with "duration in professional practice [of psychotherapy] (answered in months and years)" (1997, p. 194). It is likely that experience is somewhat more complicated than that. The purpose of this paper was to consider, theoretically and empirically, the various aspects of psychotherapeutic experience. The importance of this issue is highlighted in situations where the qualifications of therapists, therapy students, or applicants for therapy training have to be judged and compared, typically based on various parameters of experience.

First, to avoid confusion, it should be understood that *psychotherapeutic experience* in this particular context refers to the level of professional experience of the therapist, not to his or her individual experiences as a therapist. Second and more specifically, *psychotherapeutic experience* should be understood to refer to parameters or indicators of the level of professional

experience of the therapist, as distinct from his or her stage of development as a therapist. Whereas a number of models of development as a clinician or a psychotherapist attempt to capture internal processes of adaptation, socialization, or maturation in the therapeutic profession (Hogan, 1964; Skovholt & Rönnestad, 1992a, b; Stoltenberg & Delworth, 1987), therapeutic experience in this paper refers to external variables that may be assumed to influence these processes.

Given these qualifications, at least two components seem to be implied in the concept of therapeutic experience, basically, length of practice and level of training, but various qualifications and interactions of these variables generate multiple variables of each kind. Surely, most would hold a therapist as experienced if she/he has had a long practice in the profession, where experience may be easily measured in terms of number of years. However, these years may have been spent in different settings, in psychiatry, for instance, or in private practice, and these settings are probably rather different in terms of types of patients and types of services. There is a risk, also, that one may neglect the therapist's degree of activity during these years, whatever the setting. Thus, it might be more appropriate to measure experience in terms of case-load, the accumulated number of clients treated. One may also distinguish between different levels of qualification or training. Some studies have accordingly compared students at different stages of training or compared licensed therapists or trained therapists with people without any such training (professionals v. paraprofessionals). Of course, length of experience at different levels of training is a complicating interaction between these two basic dimensions. Another aspect of therapeutic training, which Stein and Lambert suggested is seldom considered in research, is the quality of training. Operationally, they proposed to measure the number of theoretical courses and/or the number of hours of supervision. Formal training as supervisor, if available, may be another parameter of training quality. Also, one might consider the therapist's possible activity as a psychotherapy teacher, as supervisor, or in other training capacities. Still another component of experience, really a part of professional training that is considered indispensable in psychodynamic circles, is the therapist's personal therapy, or training analysis, as it is called among psychoanalysts (Macran & Shapiro, 1998). It should be kept in mind, however, that the value and meaning of these various components or indicators of experience may depend on the specific school of psychotherapy. Just as personal therapy might make many behavioural therapists appear less experienced, case-load would necessarily cast doubts about the experience of many psychoanalysts.

In view of this diversity of indicators and their modifications and interactions it is no wonder that consistent findings on the associations between therapist experience and patient outcome have not been found. Is it possible that the meta-analytic null findings (Stein & Lambert, 1984, 1995; Beutler, Machado & Neufeldt, 1994) are a consequence of the amalgamation of diverse variables of which some have positive and some negative associations with outcome?

An attempt exploratory to chart the terrain of therapeutic experience in order to discover its dimensions or components seems never to have been undertaken, however.

On the hypothesis that therapeutic experience is multidimensional, the purpose of this study was, therefore, to analyze the associations among various parameters of therapeutic experience in order to identify its specific components or aspects. In the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP) we have data to submit the associations between various aspects of psychotherapist experience to a rather fine-grained analysis. The STOPPP consists of a number of data collections on patients in long-term psychotherapy and psychoanalysis and their therapists, as well as on various comparison samples. For this particular study we have used a survey in a random national sample of psychotherapists in Sweden that was undertaken for standardization purposes in the STOPPP.

Method

Respondents

The study is a survey in a random sample of licensed psychotherapists in Sweden. In 1996 a mail questionnaire, Therapeutic Identity (THID), was distributed to 325 psychotherapists throughout Sweden. These were a random sample from the population of all psychotherapists licensed at that time by the National Board of Social Welfare. After four reminders 227 of the therapists had responded (70%). The only systematic difference found between responders and non-responders was that therapists in the higher age categories were under-represented in the former category, claiming to have retired from active work.

The questionnaire

The THID[1] has about 150 questions and/or items, divided in six sections, (a) demographics, academic and professional training (age; gender; graduate education [M.D., psychologist, social worker, etc.]; psychotherapeutic training for licensing purposes; auxiliary psychotherapeutic training more than one year; formal supervisory training; academic training or professional training outside psychology or psychotherapy; membership in professional associations), (b) professional experience (duration of psychotherapy practice before and after licensing); psychotherapy practice in different contexts [outpatient or inpatient psychiatry, private practice, etc.]); accumulated case-load in different categorizations (types of therapy, durations and frequencies, age and diagnostic groups of patients, etc.); supervision taken and/or given past 12 months, (c) personal therapy or training analysis (rounds; kinds; frequencies; durations). The

[1] There is now an English, a German, and a Spanish translation of the original Swedish version. All versions are available through the first author.

items were designed specifically for the project or adopted from the questionnaire used in the Society for Psychotherapy Research (SPR) network (Orlinsky, Ambühl et al., 1999). The most important information culled from these sections is summarized in Table 1. Section (d) is a set of six scales to rate one's allegiance to each of some major schools of psychotherapy. Sections (e) to (f) of the THID has three sets of items to chart the therapists therapeutical orientation (Blomberg & Sandell, in press). Items from sections (d) to (f) were not used in this study.

Results

Table 1 presents percentage distributions of the sample on various background and experience variables taken from sections (a) to (c) in the THID. The majority of the therapists were female, between 50 and 54 years of age, and psychologists. If we consider the training that was the basis for the therapist' license, the vast majority (almost 70%) graduated from one of several training institutes with a psychodynamic orientation, either in a university setting or at extra-university training sites. About 10 of these almost 70% were trained at an institute specializing in psychotherapy with children and adolescents. More than 10% had family therapy training, irrespective of theoretical orientation, and 5% psychoanalytic training at either of the two institutes in Sweden. Not more than 2% had training in behavioural or cognitive-behavioural therapy, and only another 2% cognitive therapy training, and these varieties of training will be collapsed into a single CT/CBT training variable in the following analyses. More than 50% had additional training in more specific psychotherapeutic modalities after their licensing, and more than 40% had formal training as supervisors. Almost 30% had an academic or professional training outside psychotherapy or related areas.

Where on-the-job experience is concerned, the average length of experience was as high as 17 years, longer before licensing (10.7) than after (6.6). The mean number of years providing psychotherapy in outpatient psychiatry was almost nine years, in inpatient psychiatry almost three, and in private practice more than five. The average number of patients treated was over 80. More than 50% had taken regular supervision during the past 12 months, and more than 50% had supervised colleagues regularly last year. The average therapist had been in personal therapy (which is obligatory for licensing) more than two rounds, for a total of almost eight years, most frequently in individual psychodynamic psychotherapy.

Fifteen variables were selected to explore the structure of psychotherapeutic experience, and these are indicated by bold-face in Table 1. The selection was intended to cover a broad range of experience-related variables. In view of the different metrics of the variables (and the crude metrics of some of them), correlations among the variables were computed using the PRELIS 2.30 program (Jöreskog & Sörbom, 1994, 1999), which estimates product-moment, polyserial, or polychoric correlations in accordance with the scale levels of the variables. These correlations were then subjected to a cluster analysis of the variables, according to a simple and effi-

Table 1: **Distributions (%, unless otherwise specified) on Selected Background and Experience-Related Variables among Therapists in a Random National Swedish Sample (N = 227)**

Gender	
female	68
male	32
Age	
– 44	14
45-49	23
50-54	39
55-60	16
61+	8
M (SD)	51.4 (6.5)
Basic academic training	
MD	11
psychologist	62
social worker	16
other	11
Psychotherapy training taken as a basis for licensing	
psychoanalytic	5
psychodynamic therapy, university training	19
psychodynamic therapy, extra-university training sites	41
child and adolescent psychotherapy	9
behavioural/cognitive-behavioural therapy	2
cognitive therapy	2
family therapy	12
group therapy	2
unspecified	8
Auxiliary psychotherapy-related training	
(›1 yr course(s) in the psychology or psychotherapy area)	55
Formal training as supervisor	43
Academic training or professional training beside the above	28
No. yrs in psychotherapy practice	
before licensing; *M (SD)*	10.7 (6.5)
after licensing; *M (SD)*	6.6 (4.2)
No. yrs doing psychotherapy in	
outpatient psychiatric practice; *M (SD)*	8.9 (7.8)
inpatient psychiatric practice; *M (SD)*	2.6 (5.1)
private practice; *M (SD)*	5.5 (6.5)

Accumulated no. patients in individual psychotherapy ("case-load")	
1-9	7
10-24	15
25-49	21
50-99	25
100-199	21
200+	11
M (SD)	82.9 (125.8)
Been in supervision last 12 mos.	
regularly	54
occasionally, as needed	27
not at all	19
Has supervised colleagues last 12 mos.	
regularly	53
occasionally, on request	27
not at all	20
Number of personal therapies; *M (SD)*	2.3 (1.0)
Total duration (in years) of personal therapy; *M (SD)*	7.9 (3.6)
Total number of sessions of personal therapy (dose); *M (SD)*	566.7 (454.7)
Main kind of training therapy (in terms of duration)	
psychoanalysis	21
individual psychotherapy, generally psychodynamic	61
group therapy	11
behavioural/CBT/cognitive	1
unspecified	6

Note. **Boldface** indicates that the variable has been included in the subsequent cluster analyses.

cient, although little known, manual procedure suggested by Kamen (1970). The clustering technique is based only on the ordinal information about the correlations, again making the original metrics of the variables less important. The procedure is to determine, for each variable, its closest connection to another variable (or variables, in case of ties), according to some measure of association, in the present case, the correlations. Only positive associations are considered; thus, the clustering disregards the contrast implied by negative associations. The strongest connection of each variable is then considered a link to the other variable, and the link is graphically indicated by an arrow. In case of ties, two or more links/arrows are entered, and mutual links are indicated by two-headed arrows. In order to obtain a more nuanced structure, these strongest links may be complemented by all other links representing correlations

higher than, say, .30. Such links may indicate between-clusters connections. In all its simplicity, Kamen's method often produces a robust solution that agrees remarkably well with those of more technically advanced multivariate methods, like component analysis of factor analysis. Because of missing values – 40 of the cases had one observation missing, seven had two and four had three – two correlation matrices were computed, one with missing observations (effective sample size = 176) and one with the missing observations imputed (effective sample size = 227). The cluster analysis solutions were very similar and the few differences will be commented upon. The correlation matrix based on the imputed data is displayed in Table 2, and the corresponding cluster solution is presented in Figure 1. In this figure, the strongest link of each variable is indicated as an arrow, whereas all other links stronger than .3 are indicated by lines without arrowheads. The thickness of each line indicates the approximate strength of the link.

Table 2: **PRELIS-Computed Correlations among Experience-Related Variables (after Imputation of Missing Values) in a Random National Sample of Swedish Therapists (N = 227)**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age														
2. Psychoanalytic training	-.22													
3. Cognitive/cognitive-behavioural training	-.10	-.76												
4. Auxiliary therapy training	.23	-.27	-.05											
5. Academic training	.08	-.18	-.04	-.10										
6. Supervisor training	.21	.20	-.06	.16	-.12									
7. Pre-license therapy	**.35**	-.09	.14	.16	-.04	.00								
8. Post-license therapy	*.33*	.19	.02	**.31**	-.01	**.67**	-.18							
9. Case-load	.04	.05	**.41**	.26	-.08	*.33*	.20	.21						
10. Outpatient psychiatry	.13	-.10	.05	.13	-.22	**.28**	**.28**	.24	.21					
11. Inpatient psychiatry	.14	-.16	.14	.22	-.06	.11	**.23**	.09	.02	.14				
12. Private practice	.22	**.45**	-.14	.29	**.09**	.22	.01	*.37*	.16	-.24	-.09			
13. Been in supervision	-.12	-.00	-.37	.03	-.13	-.19	-.11	-.17	-.04	-.06	.00	-.13		
14. Supervised colleagues	-.02	.06	.04	.18	-.18	**.64**	.08	*.33*	*.32*	.21	.07	.17	**.17**	
15. Length of personal therapy	.05	**.50**	-.32	.19	.00	.14	-.02	.18	.15	.06	-.03	.16	**.17**	.17

Note. **Boldface** figures indicate strongest correlation for each variable. *Italics* identify correlations >.30.

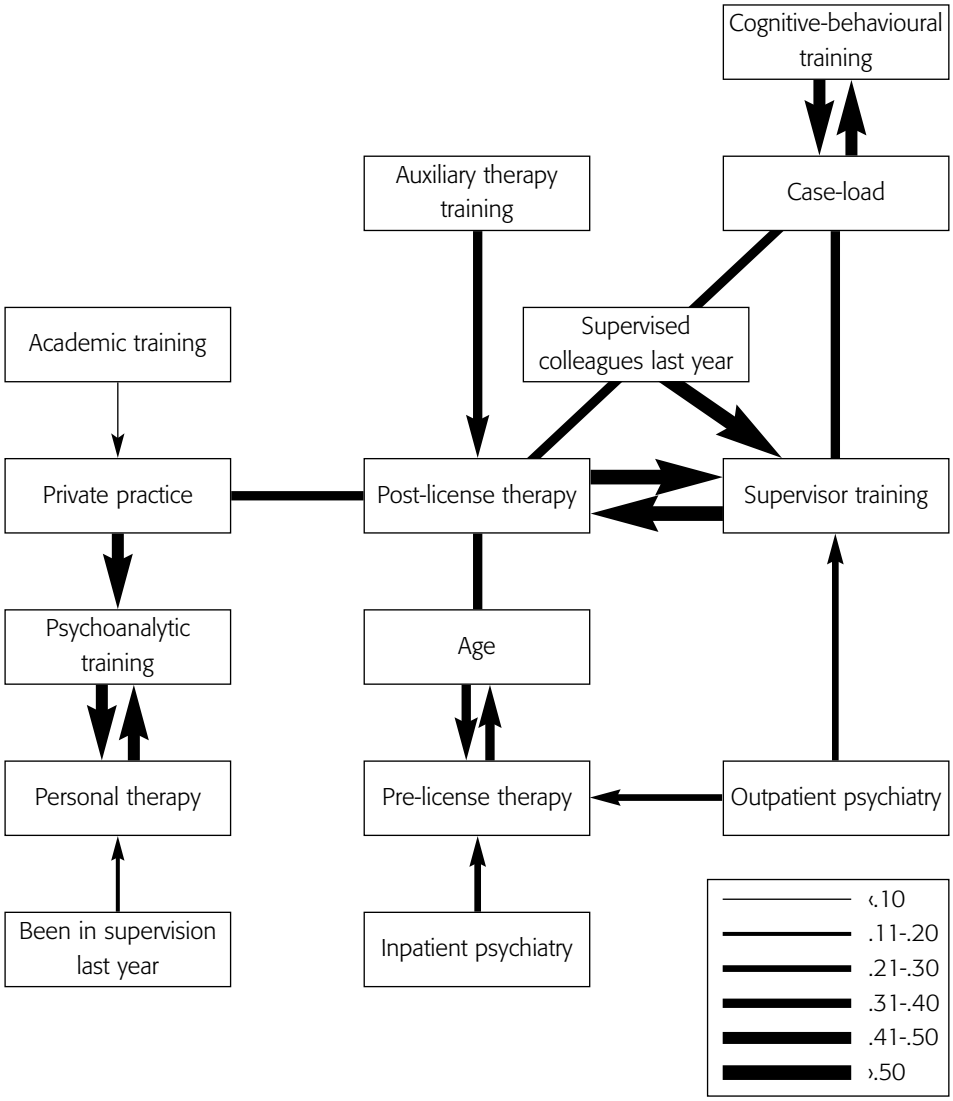

Figure 1. Links between experience indicators based on PRELIS-estimated correlations. An arrow indicates the strongest link (maximal correlation) from each variable, and its approximate strength is indicated by the thickness of the corresponding line. Links without arrowheads indicate submaximal correlations > .3.

A reasonable way to determine the number of clusters in Kamen's technique is, simply, to take only the strongest links of each variable into account. If one follows that principle, one will see that there were four distinct clusters of experience variables.

The core cluster, according to Kamen's technique, should be defined by the single strongest link in the correlation matrix. It is shown in the center right in Figure 1. The central variables were having formal *training as supervisor* and number of *years working as a therapist after licensing,* with a strong mutual link (.67). Also, current or recent *activity as supervisor* was strongly related to both, most strongly to supervisor training (.64). Further, training in additional varieties of therapy besides the one being the basis for one's licensing (*auxiliary therapy training*) had its strongest link to number of years after licensing (.31).

The second cluster, to the left in the figure, had, as its main variables, having a *psychoanalytic training* and duration of *personal therapy* (training analysis), which correlated .50. The hub in the cluster seems to be psychoanalytic training, which received the strongest link from number of years in *private practice* as a psychotherapist (.45). When missing observations were not imputed, *auxiliary therapy training* had its strongest link (.32) to private practice, so its primary connection is somewhat ambiguous, as it was most strongly connected to the first cluster when correlations were based on imputed data. Having been in *supervision during the past 12 months* was most strongly related (albeit only weakly in absolute measures) to this cluster, by way of length of personal therapy (.17). It was in fact as strongly related to recent activity as a supervisor, but that relation was weaker (.12) when missing observations were not imputed. Finally, having *academic training* (besides one's psychotherapy training) was only weakly (.09) related to this cluster and should in fact rather be considered an isolated variable, as this was its strongest connection.

The third cluster, in the top right corner of Figure 1, consisted of only two variables, having a large accumulated *case-load* and *CT/CBT training,* with a fairly strong mutual link (.41).

The fourth cluster, in the lower right corner of the figure, is a rather loose one, judging from the generally weak correlations among its members. The main members were *age* and number of years *working with psychotherapy before licensing* (.35). In turn, the latter variable was linked to number of years working with *outpatient psychotherapy* (.28) and *inpatient psychotherapy* (.23). Outpatient experience had an equally strong link to supervisory training (but had not when missing values were not imputed).

Discussion

Although these findings are based on a sample from the outskirts of the therapeutic community, we believe that at least one conclusion is generalisable to non-Swedish, non-homogeneous therapist samples: Therapeutic experience is not a unitary phenomenon, not simply number of years in the profession, as has been the customary indicator. Some equally reasonable parameters of experience are only weakly related among themselves and order them-

selves in four clusters. The reader should realise that the clusters of indicators identified in this study should not be looked upon as dimensions in the sense given by factor or principal components analyses but simply as "kinds of experience."

Although there are interconnections or overlap between the variable clusters, three, or possibly four, such kinds of experience seem to be supported by the analyses. The core variable cluster may be considered as the essence of what most people would intuitively regard as therapeutic experience and probably what makes a therapist most obviously eligible as a teacher or trainer. A therapist high on these variables has been a licensed therapist for a long time. She/he has a formal training as a supervisor and is in fact active supervising colleagues and students. Finally, she or he tends to have formal training in several modalities of psychotherapy, not just the one in which he or she was trained and licensed. Through connections to other clusters, she or he is also more experienced in terms of accumulated case-load, she or he is older, and she or he is more likely in private practice. That there is a rather strong relation between number of years in practice and supervisory activity has been reported before by Rönnestad et al. (1997), who also found that receiving supervision is unrelated to these variables, just as in this study. A proper name for this major kind of therapeutic experience may be *seniority* (Orlinsky, Rönnestad et al., 1999). This is meant to allude less to the age aspect than to the status differential of higher rank and longer service, implying a stroke of wisdom and elder statesmanship.

But there are other aspects of therapeutic experience as well. Consider the therapist who is high on the variables making up the second cluster. She or he is in private practice and may have a psychoanalytic training, which in turn involves long and/or repeated training analysis. Additionally, he or she is likely to be in supervision, and there is also a slightly higher probability of academic training besides that in psychotherapy. The core variables in the cluster are psychoanalytic training and length of personal therapy (or training analysis), but therapists with psychoanalytic training proper are indeed in the minority in the therapist community. However, in Sweden there is a large number of psychotherapists in private practice with strong psychoanalytical or so-called psychodynamic persuasions, with long personal therapies in psychoanalysis and often with continuous or intermittent supervision with psychoanalysts. In those circles, having a psychoanalytic training and being oneself in psychoanalysis are highly regarded and quite effective in gambits of therapeutic one-upmanship (Potter, 1952). These are prestige indicators of quite different, superficial import than those indicating seniority, and we propose to refer to this kind of experience as *psychodynamic repute.* The value of this kind of psychoanalytically inclined experience for psychotherapy, especially of non-psychodynamic kinds, is of course doubtful and is probably also so considered by non-psychodynamic therapists.

The third variable cluster is primarily a matter of case-load, and its strong relation to experience with cognitive or cognitive/behavioural therapies is only natural in view of the relative brevity

of such treatments, generally. Therefore, insofar as the varieties of psychotherapy are typically or systematically different in duration, number of years in practice and number of patients seen will necessarily become rather independent experience parameters. At this point, one may only speculate on their differences in terms of consequences for the development of the therapists and for the benefit of their patients, and it is still probably more a matter of opinion than knowledge which pays off best. Some would believe that brief treatments with a high number of patients (preferably of different types) provide higher-quality experience than working long-term in depth with a small number. We shall consider this cluster a provisional one and simply refer to it as *case-load.*

The therapist with high values on the variables assigned to the fourth cluster is relatively older and has long experience of doing psychotherapy *before* licensing. The results suggest that it may be important to distinguish between pre-training and post-training practice from an experience perspective. These periods are obviously independent in terms of duration, but are they differentially important? As Skovholt and Rönnestad (1992a, b) have suggested, "Post-training years are critical for optimal development" (1992a, p. 114). In this study, it is not altogether clear to what extent pre-*training* and pre-*license* years coincide, because in Sweden the licensing system, under the National Board of Social Welfare, was introduced in 1985, although several psychotherapy training institutes, with different orientations, had been active long before that. Therefore, older therapists are likely to have been in psychotherapy practice long *before* licensing but *after* training – and some in the very oldest generation even *without* any formal training at all. Instead, they often had on-the-job-training in psychiatric institutions rather than the national standard type of training of later days. It is also significant that in the early days the psychiatric institution was the natural habitat for psychotherapists, and that some remained loyal to public health care, eventually being only part-time in private practice. This is a honourable career but surely not the most prestigious one in the therapeutic community. We suggest that the variables in this cluster, taken together, indicate *long and faithful service* rather than an enterprising career in the therapeutic profession.

When characterizing a psychotherapist as "experienced," or when evaluating applicants for training or for therapeutic jobs or teaching positions, it may turn out to be an important practical difference in which of these four ways he or she is indeed experienced. Here, it remains to be seen how these varieties of therapeutic experience relate to therapeutic development. Skovholt and Rönnestad (1992a, b) describe the core developmental process as one of "continuous professional reflection" (1992a, p. 114). This means to think about, and learn from, one's experiences in professional and personal relationships. It is in the interactions with clients, supervisors, teachers, and peers that the conceptual and theoretical knowledge of the therapist come to exert its impact. The question is, now, to what extent the experience variables may produce, facilitate, or permit the development of a reflective stance. Whereas formal training,

working with clients, supervision, and personal therapy themselves may produce experiences to reflect on, the mere passage of time in the profession produces nothing of itself, of course. The important thing is in what ways time is spent, doing what how, whether pre- or post-training, whether in private or psychiatric practice, or merely by growing older. It is conceivable that different professional contexts or environments offer better or worse opportunities for fertile continuous professional reflection on one's experiences. And it is reasonable to consider the benefits to the patients as the ultimate criterion of fertility. Our continuing study will now turn to the associations between the different varieties or indicators of therapeutic experience and therapeutic success. It is our hypothesis that disaggregating them will reveal that some have positive relations and some no relations – and that some may even have negative relations – to patient benefit, thus proving the omnibus non-association incorrect.

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Varieties of Therapeutic Experience and their Associations with Patient Outcome

Abstract

Therapist experience has been reported to be only weakly related to patient outcome in psychotherapy. The purpose of the present study was to explore the relations between patient outcome in treatment and therapists' level of experience. More than 400 patients in long-term psychotherapy provided the long-term outcome data, and these were linked to the level of experience of their therapists, numbering more than 200. Seven indicators of different varieties of therapeutic experience yielded mixed results, which was expected in consideration of the fact that therapeutic experience is not a unitary phenomenon. Accordingly, some indicators (such as number of years of post-license practice) were significantly and positively associated with patient outcome, some (such as duration of personal therapy) significantly and negatively related to outcome, and some (e.g., number of years in pre-license practice) only weakly or not at all. Alternative interpretations of the findings are discussed.

Introduction

Several research reviews on the value of the level of experience of psychotherapists have concluded that it is at most weakly related to the treatment outcomes of his or her patients (Auerbach & Johnson, 1977; Berman & Norton, 1985; Beutler, Machado & Neufeldt, 1994; Hattie, Sharpley & Rogers, 1984; and for children and adolescents, Weisz, Weiss, Alicke & Klotz, 1987).

Stein and Lambert (1984, 1995) appear to have treated the issue in the most systematic and sophisticated manner, in two meta-analyses. In their first meta-analysis, they found the average

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effect size equal to 0, that is, no difference between more and less experienced therapists. Although there were more studies with positive than negative results, about half of the studies did not show any difference whatsoever. An obvious but important conclusion of the authors was that experience effects were more evident where the variation in the therapists' experience was larger. This points to limitations in research on experience in relatively range-restricted groups of therapists: when therapists' levels of experience do not differ, outcome differences cannot depend on level of experience. Another important conclusion was that effects of experience were also more evident in more complicated forms of psychotherapy (in comparison with, for instance, simple forms of counseling or the routine application of specific behavioural techniques). This observation may be linked to a conclusion by Strupp and Hadley (1979), that low experience is a drawback especially in the therapists' work with long-standing and long-range problems.

In their second meta-analysis, Stein and Lambert (1995) reported somewhat more positive findings. They now focussed on training and concluded that "a variety of outcome sources are associated with modest effect sizes favoring more trained therapists" (p. 182). "Modest effect sizes" referred to d values between 0.2 and 0.3, but these are conventionally considered small effects (Cohen, 1988). The association with training was stronger for various measures of patient satisfaction and pre-post differences on psychological tests. An interesting observation, indirectly supporting one of the conclusions in Stein and Lambert's first review, was that less experienced therapists tended to have more dropouts among their patients. This was particularly obvious in longer and more complex forms of psychotherapy; the authors suggest so-called insight-oriented family therapy (in contrast to acute or crisis-oriented family counseling) as an example. Unless intention-to-treat is considered, by ignoring the drop-outs in estimating mean outcome, such dropout may make the less experienced therapists' cases appear more successful than they actually are.

These results are probably counter-intuitive to most of us and have not gone unchallenged. Several researchers (e.g., Rönnestad, Orlinsky, Parks, Davis et al., 1997, and Stein & Lambert, 1984, themselves) have noted that the null findings might have been due to the fact that the allegedly experienced therapists have indeed not been very experienced; if so, there was in fact too little variation in therapist experience level to make much difference in patient outcome, a mechanism called restriction of range. Another reason for the unexpected findings may be that experience has been taken as a unitary phenomenon, which it probably is not. Stein and Lambert commented, in 1995 as well as 1984, that researchers usually had confounded training level, training quality, duration of clinical practice, case-load, and age, and suggested that difficulties in the definition of therapeutic experience had hampered research integration in the area. In general, however, therapeutic experience has been operationalized as number of years in practice or in terms of level of training.

It is likely that experience is somewhat more complicated than that. Sandell et al. (2002a) applied a manual cluster analysis procedure to a set of experience-related variables and found four clusters of variables in a national random sample of Swedish therapists. Besides a central variety of experience, which they called *seniority,* three more specific clusters were suggested. *Psychodynamic repute* had psychoanalytic training and long personal therapy as its principal indicators (linked to seniority by way of long private practice). A third experience cluster was *long and faithful service,* indicated by age and number of pre-license years (and long experience of psychotherapy in psychiatric practice, inpatient or outpatient). A fourth variety was associated with a large accumulated *caseload,* particularly linked to cognitive or cognitive-behavioural training and practice. The authors suggested that these factors might be related to success with patients in different ways, some positively, some not at all, and some even negatively.

The purpose of this study was to explore these relations between patient outcome and various parameters of therapist experience on the basis of data from the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP). The STOPPP consists of a number of data collections on patients in long-term psychotherapy and psychoanalysis and their therapists, as well as on various comparison samples.

Method

Design and procedure

The design was quasi-experimental, partly cross-sectional, partly longitudinal, based on a three-wave panel survey under "Caucus-race" conditions[1] (Carroll, 1865). This means that the panel members' treatment status in each panel wave was uncontrolled, some patients being in treatment, some waiting to start, and some having already terminated. In analyzing the observations in the panel, we unfolded, so-to-speak, the panel along a time scale, distributing the panel members on the time scale in accordance with their treatment status each wave, thus creating what we call an "unfolded panel design" or what Bell (1953) has referred to as an "accelerated longitudinal design." As we have noticed that our design is not easily understood, we shall

[1] During her adventures in Wonderland Alice had wept violently, creating a pool of tears, crowded with birds and animals that had fallen into it. The Dodo then suggested a Caucus-race to get them dry and declared that the best way to explain it was to do it: "First it marked out a race-course, in a sort of circle (the exact shape doesn't matter, it said), and then all the party were placed along the course, here and there. There was no 'one, two, three, and away,' but they began running when they liked, and left off when they liked, so that it was not easy to know when the race was over. However, when they had been running half an hour or so, and were quite dry again, the Dodo suddenly called out 'The race is over!' and they all crowded round it, panting, and asking 'But who has won?'" (Caroll, 1865/1982, p. 33). The Dodo's answer is familiar to every psychotherapy researcher.

describe it in terms of the following six steps (see also the account by Sandell et al., 2000, 2001).

(1) A sample of 756 persons was selected so as to ensure that it consisted of people who had terminated their treatments as well as people who were in the midst of it and people who had not yet started. Thus, we selected all patients whose treatments had been subsidized by the County Council for the periods 1991-93 and 1992-94. These were 202, some having terminated and some being still in treatment. Additionally, we selected the first 554 persons on the waiting list for subsidization, because we anticipated that a number of these were not yet in treatment.

(2) A questionnaire was distributed to these 756 persons in 1994, and in 1995 and 1996 to all who had responded the previous year, each year with four reminders. After returns from 78%, 86% and 89%, respectively, for each year, this produced a panel of 446 persons, which was 59% of the initial sample of 756. An analysis of the attrition showed that patients with higher educational level and higher current level of functioning tended to respond significantly more often. However, the pattern of attrition did not differ between patients in different modalities of treatment.

(3) The "unfolding of the panel" is visualized in Figure 1. The 446 persons were divided in seven subgroups on the basis of their treatment status each panel wave. Thus, we had one group of 12 persons who had not commenced treatment in any of the three waves. This group was henceforth discarded altogether and is not shown in Figure 1. The remaining six groups are ordered vertically in the left-most column of the figure. Thus, among the remaining 434 persons, we had one group of 20 who had not started treatment in the first panel wave 1994 or in the second 1995 but were in treatment in the third wave 1996. We had another group of 31 persons who had not started treatment in 1994 but had so in 1995 and were still in treatment 1996. Following the same reasoning we had four other groups in later phases of the treatment process, up to, and including, a group of 156 patients who had already finished their treatment when they were in the first panel wave. For natural reasons, we considered this last group as having reached a later stage of treatment than the rest of the groups, and similarly considered the first-mentioned group as being at an earlier stage of treatment than the others. Correspondingly, we could order the six subgroups along an ordinal or relative time scale, defined by the relations "before" and "after" or "earlier than" and "later than" such that each position on the scale is later than or after all positions to the left and earlier than or before all positions to the right.

(4) We then aligned the three panel waves in each of these subgroups, such that we assumed, for example, that the last wave before treatment was at the same time, relative to treatment,

whether it was the first or second panel wave, and that the first wave in treatment was at the same time, relative to treatment, whether it was the first, second, or third wave, and correspondingly through all waves in all groups. So, we were able to produce a sub-grouping of all (434 x 3 =) 1302 observations. This grouping is shown in the lowest row in Figure 1. Thus, for example, the 20 patients in group 1 in the third panel wave, the 31 in group 2 in their second panel wave, and the 151 in group 3 in their first panel wave were all in their first year of treatment and were therefore grouped together in the "early ongoing" treatment group, which

Treatment in relation to questionnaire waves:

Groups				WbQ 1994	WbQ 1995	WbQ 1996		
1						Treatment		
2					Treatment			
3				Treatment				
4			Treatment					
5		Treatment						
6	Treatment							

Questionnaire waves in relation to treatment:

Groups	Early before	Late before	Early ongoing	Ongoing	Late ongoing	Early after	After	Late after
1 $n = 20$	1994	1995	1996					
2 $n = 31$		1994	1995	1996				
3 $n = 151$			1994	1995	1996			
4 $n = 25$				1994	1995	1996		
5 $n = 51$					1994	1995	1996	
6 $n = 156$						1994	1995	1996
$N = 434$ $N = 1302$	$n = 20$	$n = 51$	$n = 202$	$n = 207$	$n = 227$	$n = 232$	$n = 207$	$n = 156$

Figure 1. Unfolding the three-wave panel. Groups of cases at different stages of treatment, in relation to waves of administration of the Well-being Questionnaire (WbQ) (upper panel), and in analysis design (lower panel).

thus consisted of 20 + 31 + 151 = 202 patients or observations. Thus, by pooling observations from different groups in different waves who were in the same relative phase of treatment, that is, relative to earlier and later phases, we had the observations distributed along eight steps on a *relative* time scale. The variation across time was partly within-subjects and partly between-subjects. Scattered missing data reduced the effective number of observations to between 1281 (for the SOCS) and 1287 (for the SCL-90 and the SAS), spread out across the eight-step time scale, from (about two years) before treatment to late (about three years) after treatment termination.
Having tested the correlations of our time scale with more than 30 different variables (patient and therapist characteristics), we have concluded that the distribution of the observations along the time scale is independent of obvious confounds.

(5) In order to compare different types of treatments, the observations in each step of the time scale were quasi-experimentally split in subgroups. Thus, of the 434 persons in the panel, 345 had long-term psychotherapy as their treatment or – in case they had been in more than one – their main treatment, in terms of number of sessions. They generated 1035 (3 waves x 345 persons) observations spread over different phases of psychotherapy. Correspondingly, we had 76 persons with psychoanalysis as their treatment (thus 228 observations) and 13 persons with various kinds of so-called low-dose treatments (39 observations in low-frequency individual therapy, group therapy, family therapy, etc.). When the treatment modalities, specifically, were being compared, we excluded the small low-dose treatment group.

(6) Correspondingly, in order to compare treatments with therapists with different levels of experience, the observations in each step of the time scale were divided in subgroups based on the therapists' level of experience according to different indicators. This required a linking of data from the patients with data from their respective therapists, so missing data from the therapists were naturally added to non-response from the patients, which naturally resulted in a smaller number of observations than the 1302 observations available from the patients alone. The results of the linking will be further detailed in the Treatment section, below.

Assessment Procedures

Patients' pretreatment status. Various diagnostic and assessment procedures were applied to the patients' referrals. These pre-treatment assessments will not be specified here (but see Blomberg, Lazar & Sandell, 2001).

Patient outcome measures. The Well-being Questionnaire (henceforth the WbQ), was designed to explore the patients' symptoms, social relations, and morale. The following standard self-rating scales were included:
• The Symptom Check List (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) contains

90 items representing various psychological and somatic signs of distress. The task is for the patient to rate the extent to which he or she has been troubled with each of the 90 items during the last seven days. The scales are five steps, from 0 (not at all) to 4 (very much). The ratings are scored in various combinations. In this study we used the General Symptom Index (GSI), which is calculated as the mean rating across all 90 items. Reliability estimates in the three waves varied between .83 and .96.

- The Sense of Coherence Scale (SOCS; Antonovsky, 1987) is a 29-item self-rating instrument, designed to measure sense of coherence, the feeling of confidence that life is manageable, comprehensible, and meaningful. The items are questions or phrases about life experiences, and the rating scales are seven-step bipolar scales, the poles of which are contrasting, alternative responses to the item. Following Antonovsky's recommendations, a general score was calculated as the mean across all items. Reliability estimates in the three waves varied between .81 and .92.
- The Social Adjustment Scale (SAS; Weissman & Bothwell, 1976; Weissman, Prusoff, Thompson, Harding & Myers, 1978) contains 39 items, divided in six sections (Work, Friends and leisure time, Extended family, Partner, Children, Family [partner and children]). The original items were translated and revised to suit Swedish users in the 90's. The task is to rate to what extent, during the last two weeks, various kinds of contacts have been satisfying or unsatisfying. One of the important revisions was to introduce the same five-point rating scale for all items, ranging from *every or almost every day* (or *every or almost every time*) to *not one day* (or *never/not once*). A general score was computed as the mean across all items. Reliability estimates in the three waves varied between .74 and .80.

Besides these instruments, the WbQ contained the following sections, with standard items/questions on (a) demography and socio-economy, familial, vocational, and financial situation; (b) ongoing psychotherapy; (c) previous treatments, including psychotherapy, for psychological distress; (d) current health status and health care utilization past 12 months; (e) current and prior severity of psychological problems; (f) occupational activities (including studies) past 12 months.

Therapists

There were 294 therapists and analysts involved in treatment with the patients in this sample. These were all licensed by the National Board of Health and Social Welfare. Some were fully trained psychoanalysts, members of any of the two psychoanalytic societies in Sweden. In the fall 1995 a postal questionnaire, Therapeutic Identity (THID) was distributed to all. After four reminders, 209 (71%) had returned their questionnaires. Analyses of the attrition showed no systematic sources of dropout. This sample will henceforth be called the treatment provider sample (or *provider sample*, for short).

The THID has about 150 questions and/or items, divided in six sections, (a) demographics, academic and professional training (age; gender; graduate education [M.D., psychologist, social worker, etc.]); psychotherapeutic training for licensing purposes; auxiliary psychotherapeutic training more than one year; formal supervisory training; academic training or professional training outside psychology or psychotherapy; membership in professional associations), (b) professional experience (duration of psychotherapy practice before and after licensing; psychotherapy practice in different contexts [outpatient or inpatient psychiatry, private practice, etc.]; accumulated case-load in different categorizations [types of therapy, durations and frequencies, age and diagnostic groups of patients, etc.]; supervision taken and/or given past 12 months), (c) personal therapy or training analysis (rounds; kinds; frequencies; durations). The items were designed specifically for the project or adopted from the questionnaire used in the Society for Psychotherapy Research (SPR) network (Orlinsky, Ambühl et al., 1999). The most important information culled from these sections is summarized in Table 1. Section (d) is a set of six scales to rate one's allegiance to each of some major schools of psychotherapy. Sections (e) to (f) of the THID are three sets of items to chart the therapists therapeutical orientation (Blomberg & Sandell, in press). Items from sections (d) to (f) were not used in this study.

The THID had been standardized on a random sample of 325 licensed psychotherapists throughout Sweden, of which 227 had responded (70%) (Sandell et al., 2002). This sample will be called *the national sample.* There was significant non-response from therapists in the higher age categories who claimed that they had retired from work.

The treatments

In the referrals psychotherapy was defined as once- or twice-a-week treatment with a licensed psychotherapist, and psychoanalysis as three- to -five-times-a-week treatment with a fully trained psychoanalyst. Of the 434 cases with complete data from the patients, there were 337 with data from the treatment provider as well. Of these 274 were psychotherapy cases, 55 psychoanalysis cases, and 8 cases in low-dose therapies, spread across the eight-step time scale, yielding a total of 1011 observations of patient outcomes. (Due to missing data in the therapists' questionnaires the following analyses had to be based on smaller numbers of observations, different with different experience indicators.)

The treatments were not manualized or standardized with respect to duration, session frequency, technique etc. Without a protocol, further specification of the treatments has to be *ex post facto,* in terms of provider characteristics, on the basis of information in the THID. Thus, all therapists in the provider sample claimed to have a psychoanalytic or psychodynamic theoretical orientation. The majority (75%) were women and their mean age was 51.4 years. Mean number of years in the psychotherapeutic profession after licensing was 9.6 years and before

licensing 10.7 years. Further details on the treatment providers (and the national sample) are given in Table 1.

Patient Characteristics

The typical patient was a woman, single, divorced, or unmarried, with children. The majority (87%) had at least some university education and typically worked in the health-care, education, or social sector. The mean age was 36.4 (SD = 8.1).

When patients in psychotherapy and psychoanalysis were compared, there were relatively more men in the psychoanalysis group. Analysands were also somewhat older, had higher education and were more often married or divorced. There were no differences between the two groups with respect to DSM-diagnoses. However, in terms of previous experience of psychiatric treatments, more of the analysands had prior psychotherapeutic experiences, whereas psychotherapy patients had more often been hospitalized. Further details on the patient sample are given by Blomberg et al., (2001).

Norm Groups

To establish a standard for evaluating patient outcome in relation to "normality," the WbQ was also distributed in two non-clinical groups, (a) a random community sample of 400 persons between 20 and 69 years of age in Stockholm County; (b) a sample of 250 psychology students, demographically very similar to the clinical sample, according to pilot analyses of the referrals. The norm groups took the questionnaire only once, in May 1994. Without any reminders, the response rates in the two groups were 37% and 79%, respectively. The responders in the two groups had almost identical mean values on the self-rating scales, and they were therefore collapsed into one group.

Results

The therapist variables were selected on the basis of the cluster analysis of Sandell et al. (2002), which involved 15 different experience indicators. The cluster solution identified four clusters. For this study we have selected one pair of variables in each cluster that correlated more strongly with each other than with any other variables in the entire variable set. Whereas there was a natural division in subgroups on some of the experience variables (e.g., supervision training and psychoanalytic training have two natural categories, training and no training), subgroups on other experience variables were formed by splitting the distributions in three groups of cases as equal in size as possible, using the SPSS Categorize variables routine.

Table 1: **Distributions (%, unless otherwise specified) on Selected Background and Experience-Related Variables among Therapists in a Random National Swedish Sample (N = 227) and in the Treatment Provider Sample (N = 209)**

	National sample	Provider sample
Gender		
female	68	76
male	32	24
Age, in years		
– 44	14	4
45-49	23	19
50-54	39	38
55-60	16	23
61+	8	16
M (SD)	51.4 (6.5)	54.1 (6.6)
Basic academic training		
MD	11	2
psychologist	62	74
social worker	16	12
other	11	12
Psychotherapy training taken as a basis for licensing		
psychoanalytic	5	26
psychodynamic therapy, university training	19	21
psychodynamic therapy, extra-university training sites	41	47
child and adolescent psychotherapy	9	6
behavioural/cognitive-behavioural therapy	2	0
cognitive therapy	2	0
family therapy	12	0
group therapy	2	0
unspecified	8	0
Auxiliary psychotherapy-related training		
(>1 yr course(s) in the psychology or psychotherapy area)	55	69
Formal training as supervisor	43	60
Academic training or professional training beside the above	28	34
No. yrs in psychotherapy practice		
before licensing; *M (SD)*	10.7 (6.5)	10.7 (4.4)
after licensing; *M (SD)*	6.6 (4.2)	9.6 (4.1)

No. yrs doing psychotherapy in		
outpatient psychiatric practice; *M (SD)*	8.9 (7.8)	7.2 (7.7)
inpatient psychiatric practice; *M (SD)*	2.6 (5.1)	1.6 (3.9)
private practice; *M (SD)*	5.5 (6.5)	11.6 (7.0)
Accumulated no. patients in individual psychotherapy ("case-load")		
1-9	7	2
10-24	15	7
25-49	21	29
50-99	25	34
100-199	21	19
200+	11	10
M (SD)	82.9 (125.8)	89.0 (126.3)
Been in supervision last 12 mos.		
regularly	54	49
occasionally, as needed	27	37
not at all	19	14
Has supervised colleagues last 12 mos.		
regularly	53	64
occasionally, on request	27	24
not at all	20	12
Number of personal therapies; *M (SD)*	2.3 (1.0)	2.6 (1.0)
Total duration (in years) of personal therapy; *M (SD)*	7.9 (3.6)	10.3 (4.1)
Total number of sessions of personal therapy (dose); *M (SD)*	566.7 (454.7)	1007.8 (580.6)
Main kind of training therapy (in terms of duration)		
psychoanalysis	21	46
individual psychotherapy, generally psychodynamic	61	43
group therapy	11	6
behavioural/CBT/cognitive	1	1
unspecified	6	5

Note. **Boldface** indicates that the variable has been analyzed as a moderator variable in this study..

In the following analyses only the GSI, the mean ratings across all items on the SCL-90, was used, as this proved to be the most sensitive of the instruments used. We have analyzed how the patients developed from before treatment until after, in the following way. To obtain estimates of change rate (how much patients changed each stage, at an average, during and after treatment) for patients within each therapist subgroup, the GSI was related to the relative time scale in lin-

ear regression analyses. The mean change rate in each therapist subgroup was then estimated by the linear trend (unstandardised *b*). The regression procedure also produced an estimate of mean baseline or initial level (before treatment), the intercept (*a*). For the sake of convenience we have assumed that our time scale was equidistant (that each step on the scale was equally long) and that patients' change was linear (that they changed an equal amount each step).

Table 2: SCL-90 GSI as a Function of Time in Treatment (Intercepts: a; Slopes: b), in Groups of Cases with varying Therapist Experience

	All treatments		Psychotherapy		Psychoanalysis	
Therapist experience	*a*	*b*	*a*	*b*	*a*	*b*
Post-license experience, years						
3-8	0.97	-0.016	0.99	-0.017	0.33	+0.066
9-10	1.07	-0.082***	1.11	-0.087***	0.88	-0.075(*)
11-35	1.08	-0.104***	1.07	-0.102***	1.15	-0.128***
Supervisor training						
yes	1.11	-0.085***	1.12	-0.081***	1.06	-0.109***
no	0.94	-0.039*	0.97	-0.046*	0.68	-0.045
Psychoanalytic training						
yes	0.99	-0.069***	0.98	-0.048	1.04	-0.104***
no	1.06	-0.066***	1.07	-0.070***	--	--
Personal therapy, no. sessions						
125-720	1.19	-0.105***	1.23	-0.115***	0.60	-0.058
725-1240	1.01	-0.061***	1.03	-0.063**	0.99	-0.094
1250-2500	0.90	-0.030	0.80	+0.007	1.08	-0.109***
Age, years						
41-50	1.08	-0.039	1.10	-0.038	1.04	-0.079
51-56	1.02	-0.073***	1.04	-0.074***	0.89	-0.067
57-80	1.05	-0.096***	1.05	-0.096***	1.14	-0.156***
Pre-license experience, years						
0-8	0.96	-0.042(*)	0.98	-0.039	0.99	-0.107**
9-11	1.19	-0.076***	1.20	-0.079***	1.21	-0.121
11.5-25	1.00	-0.087***	1.02	-0.090***	0.89	-0.071
Accumulated number of patients in individual therapy						
1-49	0.91	-0.035	0.89	-0.022	1.05	-0.100*
50-109	1.05	-0.074***	1.01	-0.057**	1.23	-0.151**
110-200	1.16	-0.092***	1.28	-0.121***	0.71	-0.053

Note. *** $p < .001$; ** $p < .01$; * $p < .025$; (*) $p < .05$. All intercepts were > 0 ($p < .01$).

The regression parameters are all displayed in Table 2 and one example will be detailed in order to guide the reader. The first rows in the table body concern the first of the *seniority* indicators, number of years in psychotherapy practice after licensing. This variable was split in three groups, of roughly equal size (more than 300 observations in each group). When cases in different types of treatments were pooled, in the left-most column, the initial level of symptom distress (*a*) was higher the longer the post-license experience, from 0.97 over 1.07 to 1.08. These differences were not significantly different from 0. When change was concerned (*b*), the cases with the least experienced therapists (with 3-8 years of post-license experience) changed at a low rate, -0.016. (It should be noted that the minus sign indicates a desirable *decrease* in symptom distress.) This was not significantly different from 0. As the therapists' experience increased, so did the change rate, over –0.082 to –0.104 in the most experienced group (more than 11 years). The two most experienced groups differed significantly from the least experienced group, $t\ (\infty) > 2.30$, $p < .05$. How the patients' self-ratings changed across time

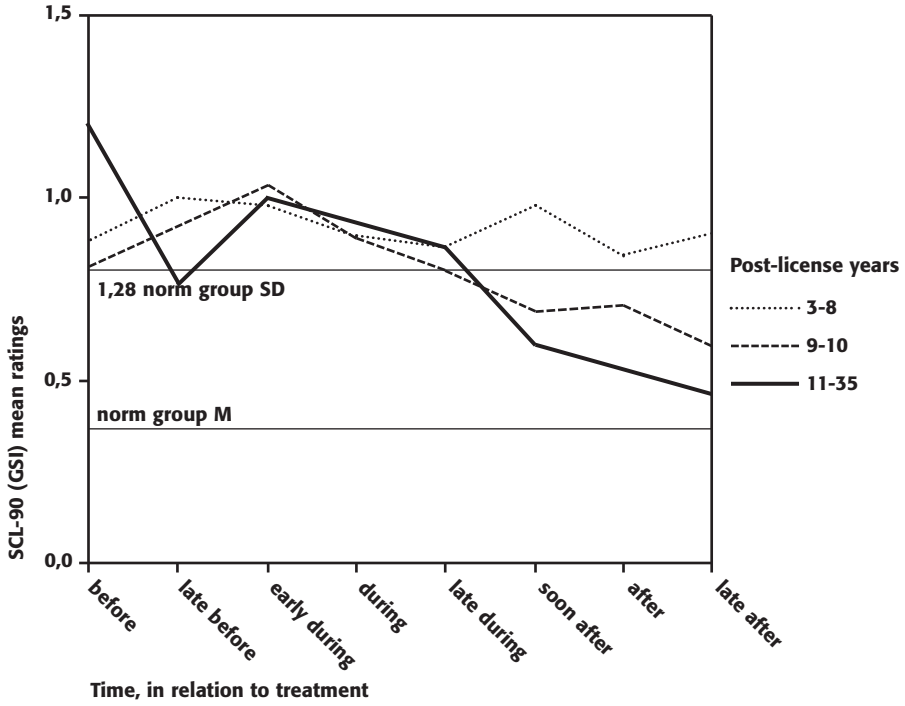

Figure 2. Mean trajectories across stages in treatment for patients with therapists with different amounts of post-license experience. (Reference lines refer to normal mean M and caseness criterion [Derogatis & Lazarus, 1994].)

in treatment, in the three groups, is shown in Figure 2.[2] Two reference lines are inserted in the figure, one indicating the mean in a normal population and one dividing the 10% highest-scoring persons in the normal population (1.28 *SD* above the mean). This has been suggested by Derogatis and Lazarus (1994) as best discriminating between persons who are or will become psychiatric patients and those who will not ("the caseness criterion").

When cases were divided in psychotherapy and psychoanalysis cases, the picture remained largely the same, as may be seen in the columns to the right in the table. In the psychoanalysis group the differences between the experience subgroups in change rate were more pronounced, and the patients of the least experienced analysts had indeed a trend towards *more* symptom distress (indicated by positive *b*). One may notice, however, that subdivision of the psychoanalysis cases created subgroups with large mean errors, because the subgroups became rather small. Therefore, slopes and slope differences of sizes that were significant in the larger psychotherapy subgroups failed to reach significance in the smaller psychoanalysis subgroups.

Turning, now, to the second seniority indicator, supervisor training, there was a slight but significant superiority for cases with therapists *with* such training, $t\ (\infty) = 2.02$, $p < .05$, which again was somewhat more pronounced among the psychoanalysis cases.

The second cluster of experience variables was labeled *psychodynamic repute*, because psychoanalytic training and being or having been in long personal therapy, particularly if a psychoanalysis, are high-prestige indicators among psychodynamic therapists in Sweden. As may be seen in Table 2, there was no difference between those with and those without psychoanalytic training in the undivided group, except that the patients of those without it started from a slightly, non-significantly, higher level. In the psychotherapy group the psychotherapists (those without psychoanalytic training) had patients with a significant decline in symptom distress, whereas the change among the cases of the therapists *with* psychoanalytic training did not differ from 0. A direct comparison between the two groups of cases did not reach significance, however.

When personal therapy is concerned, there is a very clear negative trend in the total group with increasing experience; from -.105 in the group with least personal therapy, over -.061, to -.030

[2] The regression parameters in Table 2 are estimated on the exact size of each subgroup on the time scale, whereas the figure shows the means in each subgroup across the time scale, irrespective of the sizes of the subgroups. Especially, it should be noted that there were only 20 persons in total at the very first step of the time scale, which means, of course, that the subgroup means at this step are quite unstable. This is taken account of in the regression analyses (each step is weighed, so-to-speak, in relation to the number of observations on it), but not in the figures (all steps appear equally important).

in the group with most. The difference between the extreme groups is significant, t (∞) = 2.65, p <.01. Obviously, however, there is a difference between the psychotherapy and the psychoanalysis cases here, because among the latter there is an opposite (though nonsignificant) trend.

The *long-and-faithful-service* cluster is indicated by therapist's age and number of years in psychotherapy practice *before* licensing. When therapists were divided in three equal age subgroups, the change parameter increased with increasing age. The difference between the cases of the youngest and the oldest therapists was not really significant, however, t (∞) = 1.94, p >.05 (two-tailed test).

Pre-license experience, in contrast to post-license experience, seemed to make little difference, as may be seen in Figure 3. The differences between the subgroups were not significant, whether in the total group or in any of the two treatments.

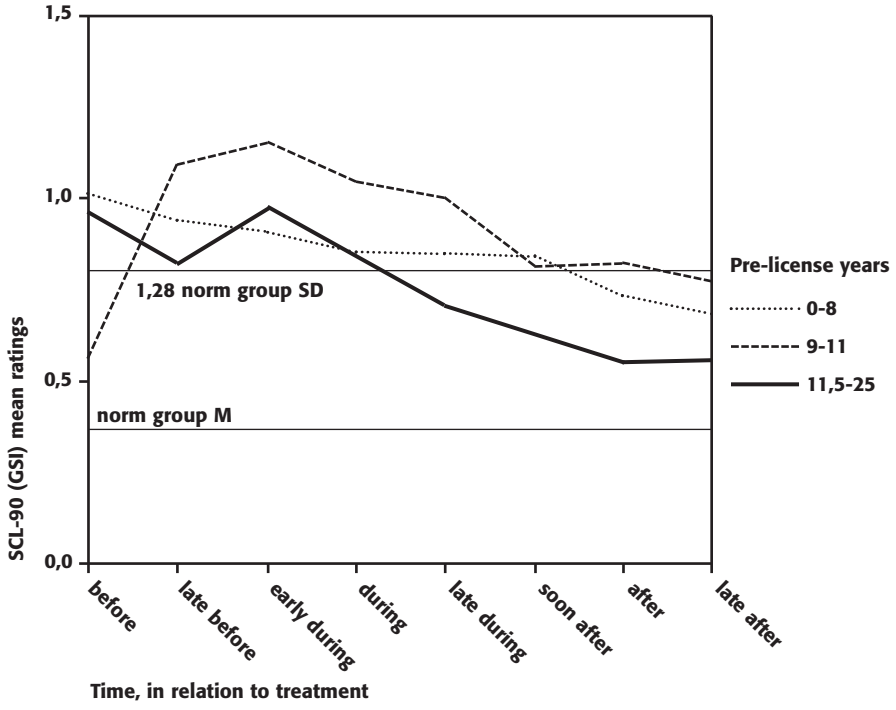

Figure 3. Mean trajectories across stages in treatment for patients with therapists with different amounts of pre-license experience. (Reference lines refer to normal mean M and caseness criterion [Derogatis & Lazarus, 1994].)

As there were no therapists with CBT or CT training in the sample, the fourth cluster, *case-load*, had only case-load, the accumulated number of patients in individual therapy, as an indicator. The change among patients with the most experienced therapists did not differ significantly from those of the least experienced ones. There was an interaction with treatment, however, such that, in the psychotherapy group, the difference between the extreme groups was strongly significant, $t\ (\infty) = 3.39$, $p < .01$, whereas, in the psychoanalysis group, there was a difference in the opposite direction, albeit not significant.

Discussion

Obviously, different experience indicators were associated in different ways with patient outcome. Although not shown, the findings were essentially replicated with the SOCS and the SAS, albeit somewhat less pronounced, so the associations are not specific to symptom distress. Whereas the seniority indicators (post-license years; supervisor training) were positively, and significantly, associated with patient outcome, the association between psychodynamic repute was negative, when personal therapy was concerned, and nil, when psychoanalytic training was concerned (among the psychotherapy cases). The variables in the long-and-faithful-service cluster seemed to matter little (age) or not at all (pre-license years), and the association between outcome and case-load was opposite among the psychotherapy and the psychoanalysis cases. No wonder, then, that *generic* experience level has not shown any strong relation to patient outcome.

Some of these findings are indeed quite interesting. For instance, pre-license and post-license experience seem to have different impact. The critical variable here is probably the difference before and after formal psychotherapy training. One may speculate that on the job experience *before* formal training lacks the theoretical underpinning that makes increasing on-the-job experience *after* formal training more and more useful to the patients. There may be reasons to question the value of "lay psychotherapy," that is, therapy offered by persons without formal training, even if they are in supervision.

Another intriguing finding concerns the variables in the psychodynamic repute cluster. Whereas the value of long training analysis seems fairly clear among the psychoanalysis cases, there is a direct and even clearer negative relation between length of personal therapy and outcome of psychotherapy. On this variable research has hitherto offered mixed findings (Macran & Shapiro, 1998). As has been reported elsewhere (Sandell et al., 2002b), this negative value of long personal therapy is even more specifically linked to cases where the psychotherapist has been in particularly long personal psychoanalysis. Our interpretation of the findings on both personal therapy and psychoanalytic training is that the tricks of the psychoanalytic trade are irrelevant in psychotherapy (when the therapist has psychoanalytic training) or even detrimen-

tal (when the therapist has learned them by identification with his or her own analyst). If this is the case, the consequences for training in psychodynamic psychotherapy are far-reaching, when qualifications among applicants are rated, when teachers are recruited, and when techniques and approaches taught are concerned. It appears that the transfer value of psychoanalysis to psychotherapy has been overrated. Also, it would appear that persons contemplating a dynamic psychotherapy should carefully consider whether the therapist may be "too psychoanalytical."

However, when the importance and influence of different experience indicators are discussed, one had better consider carefully how the relations should be interpreted. Basically, there are three different possibilities. The interpretation that one might prefer is that the associations are *direct treatment effects,* for instance, that therapists become more skillful the longer they have been professionally active post-license. One alternative interpretation is that the associations are due to *selection with increasing experience.* Such selection means that the therapists who are more skillful tend to become more experienced. This may sound paradoxical but is not, really. Thus, for instance, more skillful therapists might continue to work as therapists, whereas less skillful ones might change to other specialties than psychotherapy. This attrition would be expected to accumulate with increasing years in the profession and with increasing age. The same mechanism might cause the more skillful therapists to train as supervisors. Considering the negative association with personal therapy, it might be the less skillful (and therefore less secure) therapists who seek to improve their performance by continuing personal therapy longer than more skillful ones. There is practically no way to control for this mechanism as long as one cannot randomize experience on therapists – and whereas that might be possible with training, in principle, it is certainly not with "number-of-years-type" of variables

A second alternative type of interpretation is *patient selection,* indeed of two kinds. The first is that more experienced therapists learn to select patients with better prognosis. Whereas there is no tendency for patients of more experienced therapists to commence their treatments on lower levels of symptom distress, there may be more subtle qualities with the patient which indicates how promising the case is, qualities that the more experienced therapist may be more sensitive to. The second kind of patient selection may be less reasonable but not totally unreasonable, that "the good patient" manages to spot the more experienced therapist. For instance, "good patients" may keep themselves better informed about therapists' qualifications or be more sensitive to skill and non-skill with the presumptive therapist during initial interviews and shun the less experienced ones on these bases. Patient selection is more easily controlled, simply by randomized assignment of therapists and patients to each other. The preconditions of this study precluded this control.

Whatever the mechanism, direct causality, selection with increasing experience, or patient selection, patients with therapists who have more of some (not all) kinds of experience show greater change – although this is not necessarily *because of* the therapists' experience. Some way, some aspects of therapist experience do matter. In this respect there are practical conclusions to be drawn from this study with respect to the selection of applicants for psychodynamic therapy training or therapist positions – and the selection of psychodynamic therapists by patients – and for training in psychodynamic therapy. Whether the findings would be replicated in the context of other types of therapy than the psychodynamic one remains to be researched.

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Willi Butollo

War Traumatization

Foreword

The political changes in Europe at the end of the eighties, peacefully accomplished in most of the countries, lead to a disastrous, extremely violent series of battles in Yugoslavia. As psychologists and psychotherapists we found us confronted with questions on how we could support people in this area, after psychology, quite well developed in Yugoslavia then, obviously failed to contribute to the societies' attempts in preventing the disaster.

Certainly, increasing psychological knowledge and competence among those people seemed to be a reasonable task, which many organisations indeed realised. But what kind of psychology and which skills do you teach, to whom and in which setting?

Keeping in mind the fact that war is the ultimate collapse of dialogue, and furthermore that traumatic experiences, among other aspects, severely damage peoples abilities to re-enter dialogues, it seems obvious that any training curriculum should heavily concentrate on communication skills and aim at improvement of the dialog-ability of people.

At the end of 1992 a concept for training psychologicial and therapeutic skills with doctors, psychologists, social workers, but also teachers and nurses was proposed and eventually sponsored by UNICEF to be applied in the Bosnian war areas. A training manual, which in its first form was developed then, was the basis for continuous trainings offered mainly to members of governmental and non-governmental institutions. Experience over the years lead to several revisions and as a result this manual fills now the main part of this volume.

To introduce the reader into our dialogical frame of thought it is preceded by a more theoretical paper which outlines a theory of the traumatised self. After the war we stayed present in the region, first by establishing a stable cooperation between the departments of psychology of the University of Munich and the University of Sarajevo, generously supported by DAAD and Volkswagen Stiftung. This cooperation was later followed by contracts with the universities of

Banja Luka, Novi Sad, Belgrade and Prishtina. Members of the psychology department of Munich University regularly travelled – and still do – to those cities to teach clinical psychology and psychotherapy for students and post graduates. Psychologists were so the first to really establish a constant dialog between colleagues of former war parties. Student exchange with Munich but also between the local universities was organised, financially supported by DAAD and lead to CLIPSEE-program ("Clinical Psychology for South East Europe"), which entertains regular meetings of lecturers from the universities not only of the former conflict parties within Bosnia, but also includes the universities of Zagreb, Split, Ljubljana, Novi Sad, Belgrade, Tirana, Prishtina and Skopje.
Of course our first moves in South East Europe were not directed towards research since our main topic was the improvement in teaching psychology. But as a natural consequence a rich pattern of research activities developed in cooperation with the colleagues from those countries, so that a series of absolutely unique studies rose from those activities over the years. Only a short glimpse into it can be given at the end of the theoretical paper in this volume. For more information the reader is recommended to visit the projects home page
www.psih.org/docs/flightpaths.zip

or read

- Powell, S., Rosner, R., & Butollo, W. (2000). Flight Paths: Report to the Office of the (German) Federal Government Commissioner for the Return of Refugees, Reintegration and related Reconstruction in Bosnia and Herzegovina. Sarajevo: GTZ-Büro. (published in English, German and Bosnian).

or

- Rosner, R., Powell, S. & Butollo, W. (in press): Posttraumatic Stress Disorder three years after the Siege of Sarajevo. Journal of Clinical Psychology.

At the end of this volume an empirical paper is added specially looking at the accessability of therapeutic and psychological services for multiple traumatized people and the efficacy of those services.

Our presence in South East Europe lived from the willingness of my colleagues in Munich to help in a thousand ways, but of course also from the great engagement of our colleagues in the local universities, especially Sarajevo. To all of them I express my warmest thanks.
But out of the many people I owe deepest gratitude I just have to name three:
Irena Bezic, psychologist and therapist from Zagreb, then UNICEF assistant, who helped to establish the first contacts to be able to start the project. She also took the risk to accompany us into the war areas several times.
Roswitha Berkau, psychologist from Munich, who prepared our first training seminars in Bosnia by travelling into Bosnian cities during war activities to select trainees,

and, of course,
Steve Powell, psychologist from Munich, who took the burden to really live in post-war Sarajevo as our representative, constantly working on so many levels, like to improve contacts between psychologists in the region, organising teaching and research and monitoring all our various activities in the region.
The whole volume, however, is dedicated to the memory of *Prof. Ibrahim Tepic*, former dean of the philosophical faculty at Sarajevo University. He supported our presence from the first days, in a then war ridden faculty building, with great devotion and skill. Unfortunately, he died far too early, far too young, in a sense as a "post war victim". With warm gratitude we shall keep him alive in our memories.

Munich, Sept. 2002 Willi Butollo

Willi Butollo

War Traumatization – A Social Interaction Model

Introduction

In the past two decades our approach of integrating psychotherapy stressed careful analyses of pathology generating processes in the clients, as well as designing appropriate measures to meet the needs of the clients in different phases of their recovery. Empirical testing is not so much concerned with outcome but with the diagnosis of the changing needs of the clients throughout the therapy process and their response to the therapeutic interventions, devised to improve their condition from phase to phase. Therefore, phase dependent interventions, which were also stressed by Prochaska, Di Clemente and Norcross (1992) became focus in our studies, applying integrative therapy to different problems of anxiety disorders (Butollo & Höfling, 1984, Butollo, 1995, 1996a, Butollo, Rosner & Wentzel, 1999). This approach has been applied also to devise appropriate treatment for the very complex situation of post-traumatic stress disorders. With these disorders, the phases of therapy have to be adapted to the different stages of development which seem to occur after a traumatic experience.

Our treatment approach has been applied to clients with single traumatic experiences of civilians, like accidents or exposure to violence and sexual assault. But it was also applied to war traumatization in Bosnia during 1993-1995 and in the post war period as well. Joint projects with the colleagues from the University of Sarajevo include diagnosis of posttraumatic development, empirical treatment studies and therapy process studies. (For further details see Butollo, 1996b, 1997a, b,c, Butollo, Krüsmann & Hagl, 1998, Butollo, Hagl & Krüsmann, 1999, Butollo & Gavranidou, 1999, Powell, Rosner & Butollo, 2000, Rosner, Powell & Butollo, in press).

In this paper, from the many aspects and facets that ougth to be dealt with in studying the therapy of traumatized people, I want to stress one highly important aspect. It is the role of conceptualizing *self processes as a representation of social interaction and the violation/distortion of these self processes by the experience of a traumatic incident*. This model strengthens the argument for a more dialogical approach in the treatment of posttraumatic stress disorders.

If our self processes *are* representations of interactions, a distorted form of interaction as it is obviously the case in most traumatic incidents, should dramatically influence these self processes. If this is the case, then therapy must deal with interactional experiences in the first place.

One can guess this is true for any war, but in South East Europe war activities were to an extremely high extent aiming against civilians with unbelievable cruelty. As a consequence traumatizations following such experiences should not only be due to physical injury, life threat

or social consequences due to expulsion, but perhaps in the first place due to loss of interpersonal trust.

The social interaction model

Throughout our life we develop models of the "world" in which we live, of other human beings with whom we have our contact experiences. Of course our expectations about future experiences and behaviors are influenced by those constantly revised models. As time moves on, new experiences might change them, sometimes more, sometimes less, with a gradually stabilizing set of reality-models out of which we somehow "create" our being in the world. The complexity of these models depends on many factors, among them the availability of a complex cognitive processing system, its selection, memory and retrieval functions and perhaps a few other factors. Similar to the representations of our perceptions of the "physical" world, the configuration of our self-processes is determined by the *experience of interaction* between the acting person and its world. In a smooth development the novelty of incoming information will be not so discrepant from our expectations and therefore it will be possible to revise more or less gradually our models of the world, of ourself and their interaction.

Traumatic experiences, however, are by definition far beyond of what one would expect in so called normal life situations. Therefore in the case of trauma, special attention has to be paid to cognitive and emotional functions which operate in order to restore the kind of congruency between our models of the world, our self and the actual experiences to be integrated. And there is evidence to assume that cognitive and emotional attempts to integrate traumatic experiences have to run through different phases and levels in which the coping processes are of different complexity and directed towards different goals. What might be helpful soon after a traumatic incident might be counterproductive or even toxic later and vice versa.

Phases of Posttraumatic Adaptation

The attempts to cope during the acute phase of trauma reactions might be directed towards a general reduction of stress and they might make use, among others, of strategies like "inner" and "outer" (cognitive and behavioral) attempts to *escape* or *avoid*. Coping strategies in later steps of posttraumatic adaptation, as Horowitz (1993) pointed out, might focus on *denial* either of the experience as a whole or of some aspects of it – as not to loose even the last sense of competence and coherence somehow left over from posttraumatic self. This might be inevitable, if no skills had yet been developed to cope with the traumatic experience in its full scope. And in an even later period of coping people might feel attracted to deal emotionally and cognitively with the memories of the traumatic events again. If they feel relatively safe, strong and well integrated in their ongoing relationships and if they feel competent in dealing with everyday issues again, maybe they become interested to approach their sealed memories step by step, of what was unbearable in its full extent then, though they might reenter the stresses of living through the traumatic incident now again.

Early models of phase dependent coping after trauma (e.g. Horowitz 1993) have influenced later concepts of therapeutic measures, even though the empirical evidence for these phases of non-specific reactions to trauma is still to be proven.

One of the basic problems in posttraumatic adaptation across different types of traumatic incidents seems to be: how can people integrate outrageous experiences in a way that their old models of the world are not completely shattered and replaced totally by the implications of the traumatic experience and, on the other side, that they do not in a rigid way just attempt to restore the old models and ignore or deny the impact of the traumatic incident.

Research about therapeutic measures in the work with traumatized people seems predominantly occupied with developing specific techniques to reduce trauma related symptoms or behavioral cognitive problems. Most attempts focus on skills to calm overwhelming uncontrollable affects or to eliminate intrusive thoughts or imaginations. Others stress on the restoration of functions not directly affected by the traumatic event, and, by doing so, even support avoidance tendencies as long as the support system of the client is too fragile to deal with the traumatic experience itself.

And there are also the attempts to "work through" the traumatic experience by some way of re-experiencing emotionally and cognitively the impact of such incidents with the focus to integrate them. That might lead to a sense of new competence in dealing with them.

Unfortunately, many of these therapeutic approaches seem to omit a phase-dependent indication of therapeutic measures. They also seem to focus only on non-specific trauma reactions, like arousal control, avoidance patterns, and intrusive or dissociative processes. One can assume, however, that specific processes due to the type of the traumatic incident are activated as well. We have seen in empirical research, that traumatic events like natural catastrophes in average seem to have lower impact on the symptom production than more interpersonal kinds of traumatization (violence, sexual assault, life threat, etc.).

Our "Internal Safety Generator"

Obviously our "safety generator", a cognitive emotional process that leads to a kind of safety monitoring in different life situations is much more affected by traumatic incidents caused by other people than by natural disaster. So, it seems to be necessary to deal with specific processes due to the *interpersonal meaning or message*, that is conveyed by the traumatic incident. And these kind of messages might not only be transmitted on a verbal level and stored or represented in a verbal-cognitive system, but maybe even more in a *preverbal* representation of the relationships a person has in her social environment. In this sense self formation, which has been built over the years from childhood till adulthood might be shattered. And, while this happens, a person might function on a quasi child like state of dependency, with fear and panic. That implies that through such an experience the early basis of emotional reactions and the representation of social interactions is affected and might not be touched in a later phase of restoration by more adult like, cognitive ways of coping. Deep feelings of

insecurity and dependency might persist and remain emotionally active even though a more rational, adult like view of the situation might come to a conclusion of safety and competence. That, among other aspects, makes it necessary to look at a social interaction model of self formation and its implication for the understanding of success or the failures in coping with traumatic experiences.

Social Interaction and the Formation of a Traumatized Self – A Model

Self, according to the conceptualizations given by Polster (1995), is an ongoing configuration *process* which is triggered by a present contact situation and activates stored experiences about a person's role in former contact events. Contact events are created by the mobilization of contact functions, one of them being memory of past interaction experiences. Such a notion of self as an ongoing formation process exceeds that of a *self-concept* as it has been an object of studies in social psychology. Self concept is the way how a person – more or less – consciously sees, imagines or conceptualizes herself, whereas the *self* is the activation or mobilization of those functions as experiences in ongoing contact episodes. Such a notion of self, which has been stressed also *within* the earlier theoreticians of Gestalt therapy, implies that *self processes are always of an interactional nature*.

Therefore self-processes imply an ongoing inner and/or outer relationship, which leads to explicit or *implicit messages to and about* the person, who enters contact with others. These messages can be divided into the messages of the world about itself, the messages of the world (or the others) about the person, whose self is activated, and the message which is created in the *response of the person* towards the world. In that sense self is not only a kind of mirror reflecting messages but it configures, selects and tailors messages according to past experiences and according to its own self creating processes. The person in its social interaction is not only responding to the world but also reaching out towards the world in a contact process. Depending on a somehow aggregated collection of experiences, new contact and new interactions will be designed. The self, activated in a specific contact episode, is therefore a kind of selective activation of inner and outer processes, representing symbolically both the acts of the world (objects, person, etc.) towards an individual and the acting individual being in contact with this field. From this view it becomes obvious that self processes are constructions of the world and its interaction with the contacting person. Self processes lead to a certain preparedness for specific actions or responses of a person in their interactional behavior and a preparedness for certain self-related evaluations, like "being good, competent, weak, suffering", etc. This preparedness might sometimes provide a perfect anticipation of coming events and necessary action but it might sometimes be inadequate in some aspects of new situations. Therefore constant revision by ongoing experience of discrepancies is needed, between the preparedness for certain expectations on one side and actual experiences during contact on the other side.

Emotional weighting of self messages

The basic issue, however, is that self processes are interactional representations and in some way "self" **is** always some kind of aggregation of interactional experience in the moments of ongoing contact. It is necessary to note that certain self related messages can be of different emotional weighting within the integration of experiences into the self system. This "emotional weighting of messages", in other words the importance or the impact of the message, might depend on many factors, one of them being intensity and quality of attachment to the person who delivers a self related message (with positive or negative value). "Emotional weighting of messages" might also depend on the intensity of *feelings* in a contact experience, with the tendency of stronger feelings, pain, or existential threat leading to more emotional weighting of message.

Traumatic experiences can be viewed as special cases of forming the impact of self processes. The messages about the person whose self is activated in the traumatic incident becomes much stronger if the incident is beyond expectation, outside of control and of high emotional intensity. As a consequence of this conceptualization *posttraumatic self formation is a process that starts **after** a traumatic experience*. The traumatic experience as such, exceeding all previously experienced contacts cannot be integrated in the former self system. Therefore the content of the self formation processes has to be changed in an attempt to merge the old model of "the world" with the recently perceived incident. This seems to be a kind of "cognitive-emotional work" which the traumatized person performs in the posttraumatic period.

As an example it can be assumed, that a traumatic experience, e.g. a violent attack, aiming at the destruction of a person can lead into posttraumatic processing of that incident which repeats the self destructive messages and eventually might cause self destructive results. In such an extreme case the person surrenders his/her own self processes to the perpetrator and identifies herself with the message of, and in a sense even becomes "one" with, the aggressor. We can understand this as a kind of confluent or symbiotic reflex as one of the basic and primitive/ regressive survival responses under life threat. The self-functions during such a trauma-caused symbioses carry a kind of introjection-destructive self messages (the perpetrators "voice") and are built into the self processes of a person: she might think of herself of being not worthy of living, having negative characteristics, being bad, feel shame and guilt etc. According to the emotional impact of the traumatic experience these messages seem to have a strong subjective validity, much stronger than the self-supporting messages conveyed by helping people or during a therapeutic process. We know from cognitive therapy, that, if patients are offered new ways to conceptualize themselves, they might be able to think or even speak in this way, but do they also *believe* in these self statements? Self related messages obviously need some congruency with the emotional impact of the event in which the self-message is created. This means, that if there are strong negative messages, maybe even transmitted on a preverbal level, the therapeutic processes need the activation of this preverbal mode of self-formation to provide effective counteractive messages.

Re-imprinting

In a way one could think of self formation in the posttraumatic period as a kind of *re-imprinting*. If the perpetrator is able to create a state of terror, disorganization and helplessnes, he thereby, on a psychological level, creates an experience in which new guidelines for survival are desperately looked for. If identification with the perpetrator is one of these guidelines on an almost reflectory level a kind of re-imprinting might happen. The perpetrator becomes emotionally important for the survivor, whose thoughts and fantasies of his victim are kind of obsessed with his behavior, his intentions, his background, his values. If we use the analogy of two territories in the representation of "self" and "other", who have a contact boundary between them, we can say that through traumatic experience the contact boundary is demolished, self territory invaded and overwhelmed by the characteristics of the perpetrator. This process which we earlier called a kind of psychological cannibalism (Butollo, 1997b), leads to complete *dependency* on the perpetrator, at least in the psychological sense.

Self action

In the healthy and not too grossly disturbed self processes the rhythm of self-other interaction creates a sense of *connectedness*. This sense of connectedness implies both a sense of a *coherent self* as well as the sense of being in *contact*. Sense of connectedness is characterized by several aspects among them being preverbal and verbal experience of self efficacy and the perception of self in a self-other interaction (Figure 1). It is now assumed that the process responsible for self formation *is the answer of the person towards the perceived action or message from the world*. This answer, or "self-action", can be of a confirming or rejecting kind. It implies, that the message of the "world" about the person becomes active in the self formation of a person only if her answer, her "self-action", *confirms* it. In other words, if the person identifies with the incoming message.

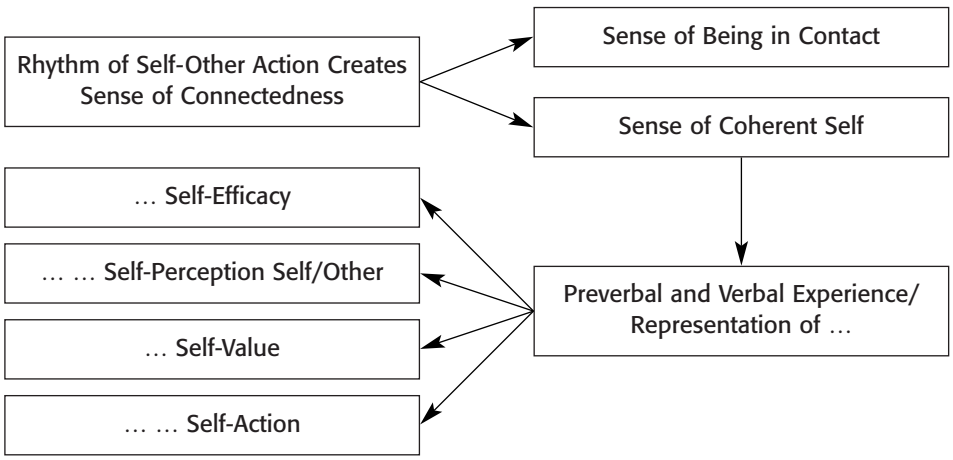

Figure 1. Self-processes and rhythm of self-other action

In the course of a traumatic experience the ability to defend one's self against self messages of destructive nature is weakened or completely exhausted. The "foreign" message cannot be warded off, it *becomes* the answer of the perceiving person: The destructive message is built into the self of the survivor. There is nothing left the survivor seems to be able to put against the intruding destructive message. In that case the perceiver somehow repeats, and thereby confirms, the destructive information about himself: He "answers" what he hears. Paradoxically survivors seem to feel safe as long as they agree with the destructive message of the perpetrator. It is much more difficult to kind of "step aside" in their mind and start to rebuild their self territory against the psychological invasion caused by the perpetrator. That leads to strong feelings of insecurity and people tend to avoid that in earlier stages of recovery from the traumatic experiences. This opinion holds even more, as long as physical and social security is not yet provided.
The ways how survivors respond to the message of a perpetrator, if they do not regress into a fatal identification or confluence reflex, might differ from person to person. The most risky and in many cases least successful way is direct attack, at least in imagination. Another one could be a dialogical attempt. That means to start an inner dialogue which conquers the destructive message about oneself. This can be done by activation of another message contrary to the destructive one. It is assumed that it should be still available in the memory system of past experiences of positive interaction which has lead to a respectful representation of one's self.

A third possibility is a kind of *"passive action"* which leads to avoidance or "incapsulation" of the traumatic experience, obviously aiming at an attempt to rescue those self aspects which seem to be not yet invaded by the traumatic incident. This "passive action" might even lead to quasi-autistic withdrawal of the person, generalizing the whole world of being potential aggressors and taking care of the rest of one's self by not communicating with the outside world at all anymore. These responses, no matter how pathological they might appear, must be understood as rescue and survival skills of the person. And the inability to distinguish new situations as being more or less threatening, might be due to the impact and the pain of the traumatic experience itself. These processes can be understood as connecting both verbal and preverbal levels of emotional processing and should at least partly follow even the old laws described in the context of classical conditioning of emotional responses. It is important to remind, that we are still speaking of interactions between *representations* of "real" events or people, i.e. the representation of the perpetrator, his actions, the self representation of the survivor, his actions and the interactions of both.

Implications for Therapy

Relationship oriented therapeutic goals

Different phases of posttraumatic recovery require different therapeutic moves depending on the needs of the client, his or her support system, pretraumatic abilities and therapeutic goals.

But having the social interaction model of self formation in mind, the therapist will always look for the characteristics and possible distortions in the *inner communication* which goes on in the client's representation system. How does the client conceptualize other people, does he or she distinguish between them with respect to safety or danger signals. How does the client react to possible, maybe even irrational danger signals? Does he tend to show overgeneralized confluence or identification reactions or does he seek refuge in phantasies of withdrawal or even thinks of inadequate attack, leading to self devaluation or idealization of the other? How can the client develop new experience, differentiate safe from unsafe relationships? How able or willing is the client to really register new and supporting experience? What happened to the old internalized relationships and interactional skills with significant other people in the pre-traumatic life period?

These and many other issues of the representation of social interaction, including one's own skills, lead to a list of non specific relationship oriented therapeutic goals beyond specific goals of direct symptom reduction – undoubtedly still of great importance.

Self territory rebuilding in contact

If the client lives in relatively good physical and social safety and if some stability of his basic functioning has been restored, work can try to focus on contact processes, their distortions and needs which have to be met to risk contact episodes. It seems obvious, that this should be done in role playing situations or real contact situations in the therapeutic context. Talking about these issues might be a guideline to give the client a frame to understand the meaning of these exercises but should not distract too far from experience. To regain self territory means that clients start to risk some kind of inner opposition towards the internalized distortion or invasion caused by the perpetrator. To regain self territory means to realize and support being different and separate from the perpetrator, and that this being different/separate can be verbalized and is valued in session. Awareness exercises of ones boundaries, as well as reactivation of memories of old contact experiences with respectful people help to conquer self-destructive messages after traumatic incidents. Especially to be aware of the change in feeling and self-respect after remembering supporting contacts proves to be a helpful step additionally to the ones mentioned before.

Social competence in perception and interaction

Posttraumatic defenses tend to distort social perception. To revisit this in therapy adds to reaffirmation of social competence: Awareness of ones distortions, readjustment and confirmation of social perception by means of a kind of tailoring of this perception should be helpful for the client and allow competent social behavior to be reestablished. In certain areas this might even exceed the pre-traumatic level of skills. Social competence will not only help to reestablish actual social networks but will also help the client to cope in difficult social situations where otherwise destructive feelings could take over again. The training methods here can be adapted from

social skills training or awareness exercises focused on social perception. If feelings of security can be increased by improving social competence this might feed back some further support towards the previous step in therapy ("self territory"), which can be revisited and extended beyond what has been reached before.

Awareness

Previous steps should not only lead to greater social efficacy itself, but also to the *representation* (self-concept) of increased social efficacy. People will be convinced again that they have good social skills and assertiveness. This seems to be an important aspect, since quite often one meets trauma survivors who tend to devaluate their competence with respect to social situations. They even tend to refuse to change their negative attitude towards their own skills, no matter how well they may be doing again. Negative self comments seem to resist posttraumatic efforts to increase optimism and cheerful expectation. The disaster, stored in their representational system, tends to survive more recent cases of relative success. The representation of social efficacy means that the people eventually regain certainty with respect to the range of their social behaviors and perceptions. This leads to a step by step improvement in self confidence which enables them greater stability in new contact ventures which again feeds back positively to increase their strength and risk taking in previously avoided social situations.

Processing of experience

Developmental psychology teaches us that the transfer from the non verbal to the verbal self sometimes leads to difficulties resulting in a split of social perception along this line (Stern, 1985, Downing, 1996). Severely traumatized people seem to regress, at least for a certain period, to non verbal self stages with perhaps a highly sensitized ability to perceive intuitively social situations in the here and now but with low skills to verbalize these perceptions or intuitions. Furthermore, a remarkably low ability can be found to *connect* this experience with past experiences or future expectations The time-link between past and future as an incidental task in ongoing cognitions appears to be disturbed.

The non verbally mediated experiences, if they are not dealt with therapeutically, are easily lost somehow in the process of regaining verbal abilities. This means that cognitive processes of a greater complexity, based on good verbal skills, might miss integration of the preverbal traumatic experience. Feelings of safety, as mediated by verbal messages, as it is usually offered in therapy, can lead to good functioning and a sense of security. But this holds only as long as certain triggers and reminders of the traumatic experience are not present. However, as soon as some early signs of their re-appearance are perceived a vast system of avoidance strategies can be triggered which may not even be conscious to the client. And if these avoidance tendencies fail he might be overwhelmed by the preverbal reactivation of the traumatic experience. Specific exercises in therapeutic sessions which connect nonverbal feeling, intuition and/or body sensations with the verbal representation system have shown to be helpful in

reducing this split, particularly in the case of trauma reminders. Thereby, the danger of being re-traumatized by flashback type of emotional flooding can also be reduced.

Empathy and internalized dialogical processing

The previous steps aim towards successful stabilization of a client's support system and his self processes. The client might be ready to risk first steps of empathy reactions again. Empathy reaction implies the ability to tentatively move into the position of another person without leaving his own sense of identity, self coherence and self constancy (Butollo, Krüsmann & Hagl, 1998; see also Bohart & Greenberg, 1997). In earlier stages of posttraumatic recovery this might be even a destructive move, but in later stages this seems to be necessary and helpful to reestablish good contact with the client's own feelings. To develop the ability to feel as if one would be in another persons position helps to move out of a confluent, symbiotic experience in which a person is confused with her own identity and self-boundaries. At first, of course, it is recommended to offer empathy exercises with PTSD cases using examples with more neutral kinds out of the client's relationships. Later on it is suggested to work using vicarious contact with a person who suffers from similar experiences as the client does, but to whom he otherwise has no close relationship. On the last stages one practices empathy maybe with a close relative and finally it might be even possible to make inner contact with the hypothetical feelings of a perpetrator who experiences similar situations.

All these steps are exploratory and awareness oriented, of course no specific quality or control of emotions is demanded from the client, as not to lead to a premature re-identification with the perpetrator. If that kind of exercises seem too scary to the client they should be avoided, of course. But as a final goal it remains to explore, how it might feel from inside, if one would be like the perpetrator. This can reduce the victimization tendencies on behalf of the trauma survivor and still lurking feelings of inferiority on his side. To feel stronger and ready to fight might under certain conditions also affect certain attitudes with respect to guilt, shame and dependency feelings.

Pre- and posttraumatic identity

To verbalize pre-traumatic identity and to confirm old skills and strengths should help to add greater stability and self support to posttraumatic identity. People might be hesitant to do this in therapy because initially this enhances their awareness of losses and changes, which could trigger mourning processes. If they are not yet ready for that, a sense of deterioration and collapse can be activated including another re-living of the traumatic experience with its feelings of sadness and despair. But working through this process of mourning, with stable self-support can lead to a new acceptance of posttraumatic *facts*, which paradoxically increases the ability to challenge over generalized self destructive attitudes. To remind oneself of old strengths and reactivating those in role playing or group interaction exercises might reestablish feelings of competence, connectedness and self support. As part of this we also work with guided fan-

tasies, specially focused on reestablishing confirming inner relationships. Good former contact with important people from the past – even the dead ones –, like grandparents, or parents, teachers and so on, reestablishes feelings of connectedness. The client will be encouraged to "visit" these people in fantasy or in a ritualized way, tell them everything that has happened to him, how he struggles now, ask them for support and comfort. This usually deeply moving steps lead to strong feelings of sadness but at the same time the clients feel connected with the pre-traumatic family and social system, even though it only is a system of representation. To feel accepted by systemically important people helps to integrate the destructive experience and to gain more mature feelings as a person, with a wider, though disillusioned, view on life events.

Out of such experiences people report feelings of increased strength, wholeness and self coherence. People might realize that their posttraumatic identity will never be like their pre-traumatic one, even though they would wish it could be so. The goal is to accept their posttraumatic identity without allowing the traumatic experience to destroy their pre-traumatic identity. It is intended to integrate both aspects instead to form new levels of a stable self. Thereby, they could reach a beautiful form of self that integrates an incredible range of human experience. Figures 2 and 3 show a list of therapeutic goals and measures which might function as a guideline for therapeutic steps mentioned in this section. They provide just an impression of how posttraumatic treatment along the social interaction model of self formation can be organized. With our studies on adaptive skills to overcome trauma in postwar Bosnia we hope to find some answers to those questions.

Figure 2

Therapeutic Measures

1. Self-support
a) Support interplay of self-awareness, other-awareness and rhythm of exchange
b) Connect modes and contents of verbal/preverbal processing
Approx: feeling/sensation and thinking about yourself, about other
c) Reactivate representations of pretraumatic bonding – in-vivo/ in imagination

2. Self-integration
a) Monitor gaps between ongoing experience and representation of it
b) Re-integrate traumatized self and non-traumatized self

3. Self in interaction
a) Provide dialogical experience in thought and action
b) Rebalance self-territory by differential contact-experience on preverbal and verbal level

Figure 3

Empirical Studies on War Traumatization

Children's stress after missing, loss or separation

Expelled, seeking shelter in foreign countries, children from war areas have to cope with multiple traumatic experiences, only one among others being the experience of loss of one's father killed or missed due to war activities.

In a study in the canton of Sarajevo we investigated 816 children, early adolescents (age 10 - 15). The main goal of the study was to look at the psychological effects of traumatic experiences caused by loss of fathers due to war activities (Zvizdic & Butollo, 2001).

Four groups were compared with respect to number of traumatic experiences during and after the war as well as depressive symptoms measured by Birlesons Depression Scale for Children - DSRS (Birleson et al., 1987).

The four groups were:

1. Missing fathers:

Children who lost contact with their fathers due to war activities and still did not receive any information about their fathers fate (N = 201, 106 boys, 95 girls).

2. Separation:

Children who were separated from their fathers during the war but could come together again after the war (N = 204, 104 boys, 100 girls).

3. Control:

No losses or separation of fathers, all other factors as in other groups (N = 203, 99 boys, 104 girls).

4. Killed fathers:
Children whose fathers were killed during the war and the children had full knowledge about fact and circumstances (N = 208, 105 boys, 103 girls).

Table 1 shows the average number of **other** traumatic experiences beyond the experience of loss of father. Besides the sad fact of very high numbers of incidents, the results are particularly amazing, since they show significantly higher scores for the group with missing fathers. We understand that the fact of having no information about a close relative could be a *conse-*

Table 1
a) Results of analysis of variance (4x2) of the variables war and postwar-related stressful/traumatic experiences

Source Of Variation	Stressful/traumatic experiences			
	ITRRN		INRR	
	F	p	F	p
Groups	87,86	,000	25,17	,000
Gender	,26	,610	,09	,754
2-Way Interactions Group x Gender	,43	,730	,46	,710

b)Means (M) on the Questionnaire for war-related traumatic events (ITRRN)

	MG	SG	CG	DG	
Boys	13,50	7,17	9,16	9,90	9,96
Girls	13,58	7,80	9,24	9,67	10,02
	13,54	7,48	9,20	9,78	9,99

MG = participants whose fathers disappeared during the war;
SG = participants who have been separated from their fathers during the war;
CG = the control group
DG = participants whose fathers have been killed during the war

c) Means (M) on the Questionnaire for postwar-related stressful/traumatic experiences (INRR)

	MG	SG	CG	DG	
Boys	2,98	1,69	1,66	2,12	2,12
Girls	2,83	1,90	1,73	2,13	2,13
	2,91	1,79	1,69	2,13	2,13

quence of the chaotic circumstances during so-called "ethnic cleansing", which led to higher trauma scores for those children.

As interesting as this result is, it could cause a confounding variable with respect to depressive symptoms. Therefore in order to correct the confounding effect of this co-variate on the variable "depression" an analysis of co-variance was done.

The main depression scores adjusted for co-variates are shown in Table 2a and 2b.

The still highly significant group differences showed highest depression scores in those children, with missing father, with almost as high scores in those children whose fathers were killed.

Of course, there are several factors involved in such a result, sad as it is. But it certainly calls attention to those cognitive processes, which are triggered in children after loosing a parent through violent acts and even more being left without any information concerning the whereabouts of their fathers.

Table 2

Depression and losses in children

a) Results of analysis of variance (4x2) on the variable of depressive reactions controlled for covariates of war and post-war stressors (from: Zvizdic & Butollo, 2001)

Source of variation	Depressive reactions F	p
Group	6,72	,000
Gender	67,90	,000
2-Way interactions Group x Gender	,72	,538

b) Means (M) on the scale of depressive reactions (DSRS) controlled for covariates

	MG	SG	CG	DG	
Boys	12,20	9,18	9,16	11,28	10,48
Girls	14,96	11,23	12,10	13,72	12,97
	13,50	10,19	10,67	12,49	11,71

MG = participants whose fathers disappeared during the war;
SG = participants who have been separated from their fathers during the war;
CG = the control group;
DG = participants whose fathers have been killed during the war

Uncertainty with respect of family systems, as we could show, was the strongest factor in childhood depression.

Traumatic and stressful events experienced by adults with different flight paths.
Another study investigated the question what kinds of stressful and traumatic events and situations were experienced by returnees, displaced people and "stayers" (Powell, Rosner & Butollo, 2000). A new checklist employed in this survey (the first section of the modified PSS) of about 130 different traumatic and stressful events during and after the war provides extensive information on important factors. For the purpose of gaining an overview over these 130 items, they are grouped here into the following event clusters and calculated separately for several subgroups of the total sample of 501, which included mainly displaced people, two subgroups from Sarajevo, two from Banja Luka and one from Prijedor.

Table 3: **War events and displacements** (from: Powell, Rosner & Butollo, 2000)

War events: self	Sarajevo: returnees from outside Former Yugoslavia. 104 persons.	Sarajevo: displaced (or former displaced). 97 persons.	Banja Luka: displaced. 100 persons.	Banja Luka: stayers. 100 persons.	Prijedor: displaced in collective centres. 100 persons.	Group mean
Total traumatic events in war zone: events which happen to the individual during the war such as being shot at, being wounded, being in a cellar for over three weeks, etc. Witnessing violence to others is also included. (number of events)	*8,98*	*12,76*	*12,28*	*7,47*	*10,04*	*10,68*
stressors: expulsion and flight (number of events)	*1,63*	*3,07*	*3,27*	*0,02*	*3,02*	*1,97*
other war-related stressors (material loss, ill health, displacement) (number of events)	*4,18*	*4,88*	*5,17*	*0,95*	*4,27*	*3,68*
length of time in war zone (years)	1,61	2,96	2,65	0,96	1,92	2,01
stressors: months in concentration camp	4,36	7,27	0,16	0,00	0,37	0,68
Displacement, flight, refuge						
stressors: months in collective centre	22,36	18,00	0,92	0,00	40,30	14,93
stressors: months in temporary accommodation	39,44	55,53	27,40	0,00	8,72	21,97
stressors: days with no accommodation at all	3,38	4,40	23,49	0,00	13,86	11,10
stress: refuge abroad (number of events)	1,18	0,83	0,02	0,00	0,01	0,31

One of the most important results here is that the Sarajevo returnees had about as much exposure to the war and war events as the two Republika Srpska displaced persons samples.
The returnees and displaced persons spent a great deal of time in temporary accommodation and collective centres.

Table 4: Vicarious traumatization and losses (from: Powell, Rosner & Butollo, 2000)

Loved ones	Sarajevo: returnees from outside Former Yugoslavia. 104 persons.	Sarajevo: displaced (or former displaced). 97 persons.	Banja Luka: displaced. 100 persons.	Banja Luka: stayers. 100 persons.	Prijedor: displaced in collective centres. 100 persons.	Group mean
losses of loved ones (number of people)	2,51	2,79	2,78	1,52	2,26	2,36
violence, threat and injury to loved ones (number of events)	5,29	5,75	5,74	4,00	3,76	4,78
total length of separations from family members. The total length of separation from each family member. (months)	67,28	45,94	30,13	18,77	25,48	37,14
total length of no information about family members (months)	23,29	23,39	12,14	8,33	17,40	16,32
Current stress						
stressors: unemployment since 1991 (number of months, plus number of months no-one in family was employed).	68,57	74,96	57,66	26,10	60,05	56,07
Current stressors: family members separated or missing (number of people)	1,89	1,85	2,03	1,15	1,71	1,73
current stressors: accommodation, health, unemployment etc (number of stressors)	*3,68*	*4,61*	*6,50*	*2,15*	*7,37*	*4,29*

Not surprisingly all the respondents experienced appalling losses.
The respondents in collective centres seem to be exposed to a particularly high level of current stress.

The overall result is that each of the samples have their own profile of traumatic events and other stressors. The Banja Luka stayers seem to be somewhat better off. It also seems that the Sarajevo samples had experienced in general more traumatic events and other stressors. One should not forget here that the samples did not exclude ex-soldiers.

Event groups having a significant correlation with current symptoms

More or less all of these events and event groups are correlated with current psychological distress; the more the respondents have experienced these events, the worse they feel. These symptoms were measured with the SCL-90-R; this records psychologically relevant symptoms such as headaches, anxiety, or hearing voices which are not there (Derogatis, 1986).

However the mere presence of a correlation between the occurrence of certain events and the presence of current symptoms does not mean there is a causal connection. For instance, it is possible that some groups of events have a high correlation with symptoms just because they occurred together with other events which themselves have a genuine causal connection with symptoms.

A regression analysis was used to try to determine the *unique* connection of each of these event groups on symptoms, independently of the influence of the other groups. The event groups shown in this analysis to have the strongest unique influence on psychological status are printed in *italics* in the table above.

In this case it seems that the most psychologically debilitating event groups are groups of war events which the respondent themselves personally suffered or witnessed, together with difficult present-day personal and social circumstances.

However this is only a preliminary analysis; much more work needs to be done, for instance to isolate as many as possible of the factors which predict particular psychological problems.

Psychological status

The information in the following analysis is intended to assist the identification of psychological needs and target groups for psychosocial intervention for each of the samples questioned. Psychological adjustment is important not just because it is an indication of the pain, optimism etc experienced by the citizens of Bosnia-Herzegovina but also because it has a major influence on the reconstruction of the country. For example depression is a major obstacle because it disables progress. Even the most talented or resourceful people achieve very little for themselves or others if they are depressed or hopeless.

Figure 4 and figure 5 show the scores on subscales of the clinical instrument used, the SCL-90-R. A higher score means more symptoms. It is not however yet completely clear if the elevated level of symptoms in comparison with the German normal sample is due solely to war and post-war stress or to what extent cultural differences are being reflected.

Three additional comparison samples have been added from research carried out by our Institute in Sarajevo in 1998: people in medical and psychological treatment and a random sample from the town, with N = 100 for each additional group.

In general it is clear that symptom levels are significantly raised in relation to the reference sample of German people without special psychological problems, but are not – thankfully – as high as would be expected in in-patient populations.

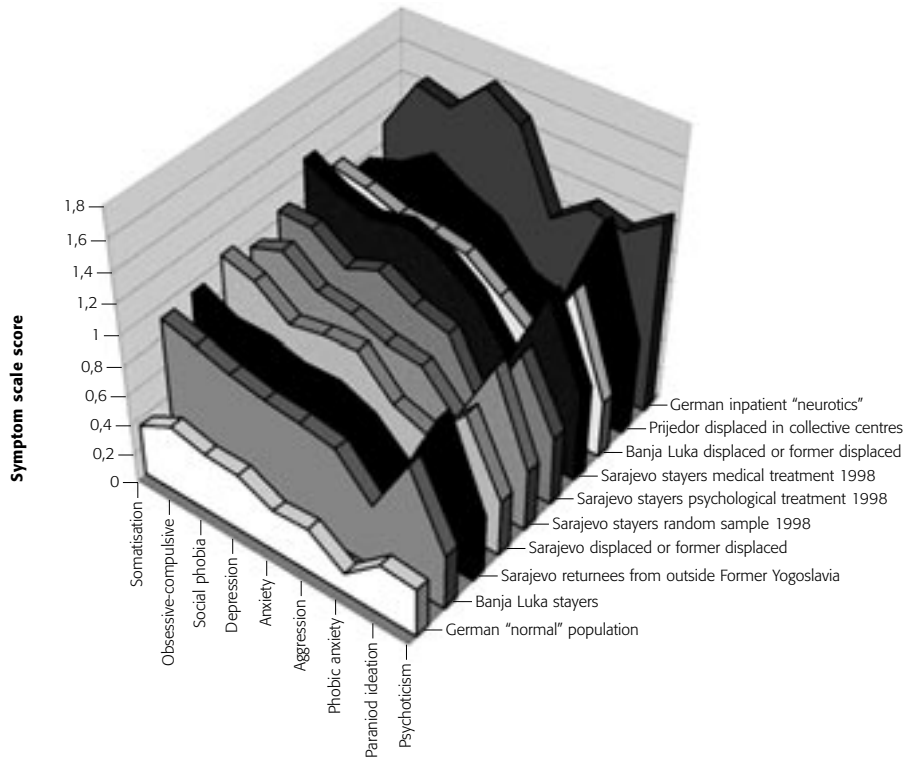

Figure 4: Level of symptoms for each of nine types of symptom, by sample including comparison with: a German "normal" population, German inpatient psychiatric patients, and three samples of Sarajevo stayers from 1998 (from: Powell, Rosner & Butollo, 2000)

As expected, the Banja Luka stayers are the least symptomatic. The people with most symptoms are the Prijedor and Banja Luka displaced persons in camps. In Sarajevo, the returnees are slightly less symptomatic than the displaced persons who are about as well adjusted as the stayers were in 1998.

The second chart shows the same information in a different way; here it is easier to compare the shapes of the profiles to the German reference samples. Very marked is the particular profile in all the post-war Bosnia-Herzegovina samples; There is a peak on the subscale named "paranoid ideation" which has to do with suspiciousness and feelings of being isolated. When one compares with the German inpatient sample, in this Bosnian sample the more passive symptom types such as anxiety and depression are less elevated than the subscales aggression, paranoid ideation, and somatisation.

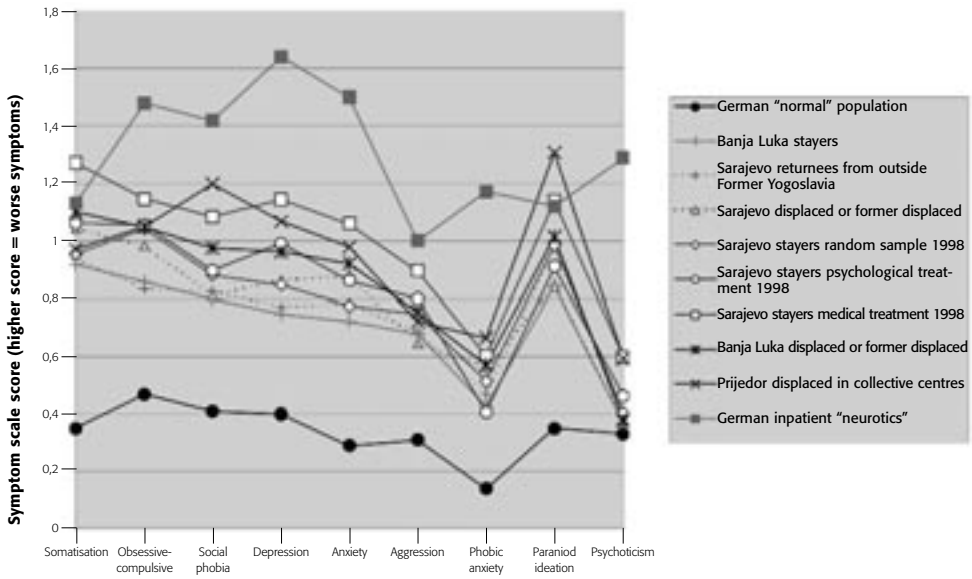

Figure 5: General symptom profile of the different samples: second view (from: Powell, Rosner & Butollo, 2000)

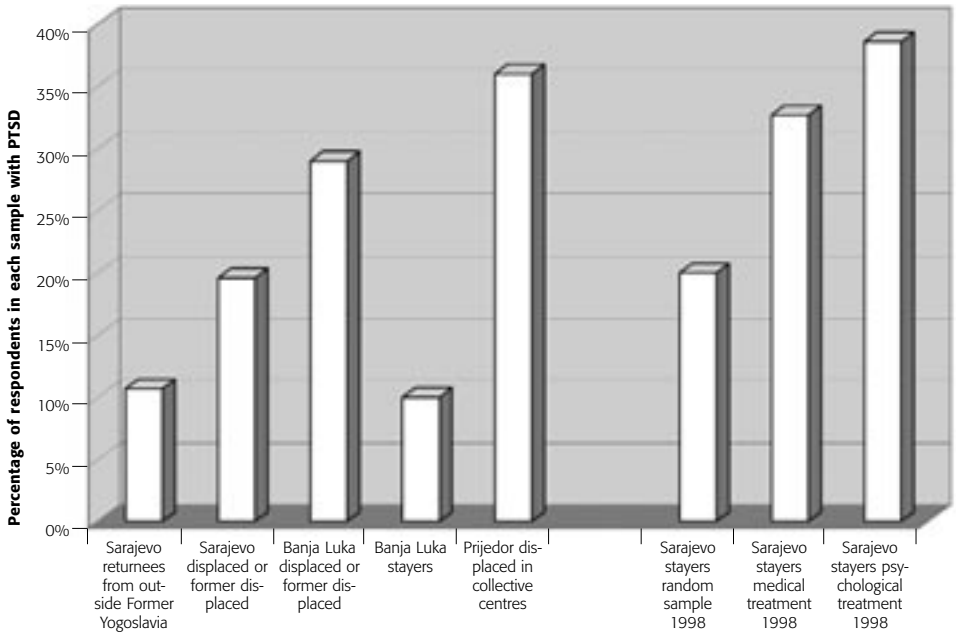

Figure 6: Percentage of respondents with the diagnosis "Posttraumatic stress disorder", by sample (from: Powell, Rosner & Butollo, 2000)

Figure 6 shows that not just general psychological symptoms but also, in particular, posttraumatic stress disorder (PTSD) is particularly relevant with people who have been through a war. People with PTSD have problems with hyperarousal (sleeplessness, restlessness), re-experiencing the events (nightmares, flashbacks) and avoidance (trying not to think or talk about the events; emotional numbing). PTSD is a serious disorder which can be extremely unpleasant for those affected and significantly affects their daily functioning at work and in the family. The fact that between 10% and 35% of the non-treatment samples have PTSD is a very worrying statistic.

The proportion of people with PTSD shows a much greater difference between the samples than the overall symptom level discussed in the last section.
As in the last section, three semi-random samples of Sarajevo stayers from 1998 have been included for purposes of comparison.
The samples exposed to most war stresses (see last section) have, not surprisingly, more PTSD. However the displaced people in collective centres have the highest proportion of PTSD amongst the 1999 samples, which could indicate that particularly difficult social circumstances can contribute significantly to the maintenance of PTSD.
The incidence of PTSD is higher in older people, and amongst women. This broadly agrees with results from the world literature on PTSD, although further research is needed to control for differential exposure to traumatic events.
The results for overall psychological symptoms as measured by the SCL-90-R are very similar.

Therapeutic Implications

A multiphasic integrative therapy for traumatized people (MITT)

So far this paper focused on self processes and semi-empirical findings about posttraumatic development. Now therapeutic methods will be summarized that are helpful in the rebuilding of self processes shattered by traumatic experience. Hopefully, that processes leads to integrated selves that incorporate pre-traumatic, traumatic and posttraumatic experiences in a mature way. These aspects of a social interaction model are, of course, more a heuristic guideline than a therapeutic technique. It helps to select therapeutic methods and techniques during different phases of post-traumatic adaptation, individually adjusted according to the speed of a person's recovery process and the level on which the client operates. It does, of course, include specific techniques that help to reduce specific posttraumatic symptoms, like intrusion, hyper-arousal, avoidance, depression, feelings of insecurity, cognitive deficits, flashbacks, sleep disturbances, bad dreams, dissociation processes, social isolation, achievement difficulties, concentration problems, and so on. But, as the theoretical model shows as well as our empirical data, social economic and educational support is strongly needed as well and multiplies the effect of any psychological intervention.

Especially in the posttraumatic phase clients are very concerned about their symptoms and therefore their motivation for therapy depends on the therapist's readiness to work with the clients on their symptoms. But like an ongoing tune, the dialogical (social interaction) aspect and the self processes might be touched from time to time, are brought into the foreground at suitable occasions and left for a while when the client's motivation seems to be caught by his intrusions, avoidance patterns or plain socio economic problems. The social interaction model of the traumatized self helps to reframe symptom-focused or psycho-social therapy which otherwise gives an a-casual and sometimes unconnected impression. Within this therapeutic context of self in interaction, the work leads hopefully to self assertiveness and greater self stability, which obviously has been shattered by traumatic experiences.

This therapeutic approach has been applied in a series of training programs throughout Bosnia, supported by Unicef and Volkswagen-Stiftung. Especially during the war the training program was offered to local professionals and paraprofessionals, who worked in camps, non governmental organizations (NGOs) and hospitals. The training was offered in different towns in Bosnia to groups of up to 30 participants. The goals of this training were to offer role models for therapy and to provide technical skills, but we also helped to work against burnout and to treat trauma disorders of participants whose war shattered self processes badly needed support. During the training in this strange and extreme life situations with its ongoing, man-created trauma, research was not in the foreground of our work. So, just as a feedback for us as trainers and for the participants, we gave them SCL-90 R (Derogatis, 1986) to get an impression of the stresses they were exposed to and the stress reactions they showed.

At the beginning of two different workshops (1994, 1995) most participants were in a terrible situation, with a lot of symptoms and scores on scales clearly above the clinical norms. But these scores changed dramatically already during the first training week.

One year later, with the same group, coming to another training workshop, we could see that after the stresses of another year of war, the scores were even worse than at the beginning of the first workshop. But again, after training not only the liveliness and optimism of the participants returned, in most clinical scales the extreme values of their scores showed to be reduced drastically again. One could ask what might be the use of such trainings and enterprises if the results do not seem to last very long. Looking at the decay of clinical scores during an ongoing war situation the critics might be right. But our data show, that during the war we could successfully conquer depression, despair and fear of our colleagues in Bosnia quite substantially, at least for a while. We certainly could activate some of their old strengths, which they could use in dealing with their clients, family members and children, to carry them at least for a few weeks or month through shelling, hunger, life threat and expulsion experiences and – what was reported to be the worst – to find out day after day, that friends have given up and left the country as refugees to bring themselves and their family members into safer places. But, as the results also showed, those seminars should have been offered in much shorter intervals.

Traumatic stress, like those people experienced, seems to function like an imprinting process

in many ways. One aspect, however, was that those who became friends through such experiences might remain friends forever, with strong bonds that last for a lifetime. It gave them feelings of connectedness and strength. This was not only valid for the participants in training but also for their trainers.

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Willi Butollo

Coping with War Trauma

An Integrative approach to PTSD-Therapy and Counselling
A Manual for Therapists

Coping with Traumatization
A handbook for the leaders of training groups in which basic skills for coping with post-traumatic stress reaction are taught.

Introduction

This handbook, is particularly intended for use in South-East Europe although designed to cover a wide variety of situations. It is designed for training groups offered to traumatized women and their relatives as part of a UNICEF program. It is intended to broaden the knowledge and competence of local professional and paraprofessional helpers. In this way we hope to be able to contribute to coping with the enormous need for support for traumatized people in this part of Europe. The training seminars are based on a multiplier system. People completing the course then themselves become leaders of training groups which in turn are open to para-professional helpers. Quality control is provided by a stable network of competent helpers and ongoing supervision. The program also includes the documentation of the effects both of the training and of the relief measures resulting out of this training.

In the first phase the training groups and the supervision will be led by external experts. The aim is to transfer existing knowledge and competence in the affected areas as quickly as possible, so that the training as PTSD-therapist can be carried out largely by local personnel.

In order to adapt the training program to the situation in Bosnia knowledge of specific local conditions must be introduced into the handbook and the design of the groups. For this reason it is important that group members are given the opportunity to extend and change the manual. The interaction between external experts and local professional helpers should result in continous revision of the training program after each application of the manual in the training groups. This applies also to the individual end-users who should see the manual as a companion to counselling and therapy; success in individual cases can be noted as in a therapy diary, in this way experience can be built up more systematically and the communication between helpers about this experience can be simplified. The aim is to combine existing local competence with the experience of international experts and to adapt help to the local situation.

Central to this training program is the activation of the individual's skills for coping with stress. The basis for this are the will to survive and the existing self-help-skills of the affected people. The program is intended to be used in groups in order to maximize learning. Essential here is a safe and supportive group atmosphere in which group leader and participants feel able to risk dealing with vulnerable and less familiar aspects of themselves. The enormous traumatization suffered by so many people in this country can not be erased; we can however try to limit the destructive consequences as far as possible.

Theoretical Background of PTSD

A. What does a person need after a trauma?

1. Phases of the psychological trauma reaction

There are a number of reliable indications that the psychological reaction to trauma goes through several stages in which a variety of symptoms appear. Affected people have different needs in each phase leading to different indications and contraindications for psychological intervention. The discussion about which phases the individual person goes through is still open. Similarly there are differences about the order of the phases and their duration. There is agreement that they depend on the severity of the trauma and the pretraumatic characteristics of the traumatic person (manifest or latent psychological disorders). For the purpose of training trauma counsellors and therapists in Bosnia it should however suffice to distinguish the following stages.

a) Acute shock

Although individuals often show exceptional ability to deal competently with injury and threat during the traumatic event itself this is usually followed by reduction of levels of functioning in all psychological areas. Perception, memory, contact and motor skills are all affected. The immediate concern is then the medical treatment of physiological and in many cases psychological shock depending on the nature of the physical reaction. The first priority here is adequate and empathic care in a peaceful environment. Psychological defence against being overcome by the trauma is weakened in this phase. Affected people experience serious attacks of fear and panic which often reoccur frequently. They seem to regress to earlier developmental stages in thinking, experiencing, feeling and behaviour. Psychological help in this phase should try to assist weakened defence mechanisms and should under no circumstances try to confront or block the regression processes.

b) Denial phase

This stage is characterised by a restrengthening of psychological defences against all memories

of the traumatic experience. People in this stage are quiet and seem to function well. They do not want to be reminded of the events and seem to have no need of this. They do not usually initiate discussion of details of the traumatic events. However during this phase problems appear outside the area of conscious control: sleep and autonomic functions in general. The connection between these problems and the traumatic event is however not usually recognised. Instead they are attributed to present difficulties, e.g. inadequate medical care, the bad atmosphere in the camp or hospital, poor financial support, poor food quality, problems with work, residence permits, relationships with relatives, etc.

c) Emotional expression phase

During this phase affected people again become able to experience strong feelings connected to the trauma, e.g. anxiety and fear, anger, hate, and even the first signs of sadness. There is a tendency to move from a depressive state towards fear and anger. Affected people become able to see others as responsible for their fate in a more realistic way then during the denial phase (b).

d) Phase of relative adjustment

In this phase a new form of adaptation to the real situation arises and affected people begin to reassess their fate. They work towards emotional and cognitive integration of the trauma. Grieving becomes possible. Clients want to speak about their experiences in a quieter way and tend to be less bitter and accusatory. They want to understand what happened, become more open and more differentiated in their interpretations and no longer consider themselves just as victims. If the affected people reach this phase it offers them a chance to reinterpret the terrible events and to integrate them into other areas of their personality. A stronger and more stable form of existence becomes available to them. The integration of a trauma can in certain cases enrich and strengthen in a way not possible for people who have not had to suffer in that way. Trauma survivors have the opportunity to reach a high level of humanity, contact quality, and well-grounded tolerance towards human weaknesses accompanied by a mature sense of humour and a loving attitude to life.

2. Victims' needs during the individual phases of the post traumatic reaction

a) Acute shock

Acute shock is a stage characterised by an extreme regression back to basic bodily functions. The person behaves and feels like a helpless child shortly after birth, with the following needs:

1. Stable care and non-demanding, warm-hearted contact.
2. Who am I ? What happened to me ? What will happen to me ?
3. Good medical and nutritional care.
4. Warm, friendly conversations in which the basic facts of life ahead are reinforced. The routines in the medical ward are named, the camp is explained and described, the weather is

identified and discussed, the season, plants visible in the neighbourhood; in short, all concrete and present perceptions should be named and reinforced. The affected people themselves and their functions, identity and meaning should also be identified and reinforced in these conversations.

5. No demands should be made. Even participation in simple routines should be offered but not insisted upon.
6. Care personnel should make no attempt to talk about the trauma, unless the client wishes to do so.
7. Self support should be highlighted and nurtured verbally and behaviourally, help and reinforcement should be offered for each small step towards recovery. Even where no progress is made, information and reinforcement should be generously given. An old rule from the theory of learning says that even where goal behaviour is completely absent, this should still be mentioned as if it were present thus reinforcing it. Stigmatised terms such as "refugee" or "victim" should be avoided as far as possible. Terms with higher social value should be used instead, directing clients' attention towards survival, progress and reconstruction: "trauma survivor" instead of "victim", "prisoner of war" instead of "refugee", etc.
8. It should be made clear to the survivors that what they are experiencing, however bizarre and incomprehensible it may seem is completely normal against the background of the traumatic experiences which they have had.

b) Denial

1. The survivor's first wish is to protect him- or herself against all traumatic memories. The feelings which may be connected with the trauma are also not allowed to arise in this stage since they would trigger too much fear of loss of control. Care personnel must always respect this wisdom with which trauma victims attempt to protect themselves. In fact they should be supported in their right to deny. Denial is a tool with which they protect themselves. A possibly distorted view of reality is in this phase certainly the lesser of two evils. Support the survivors in the way they establish barriers between themselves and others in the camp or ward; these barriers, however irrational they may seem, provide vital protection for the recovery of a self weakened by trauma.
2. Reassure the survivors that it is good that they survived.
   That it is OK at the moment not to want to look back.
   That the time may come, when the person may feel strong enough again to talk about the terrible events, even if this seems hard to believe at the moment.
   That you would then be prepared to listen attentively and that you will wait for a sign from them that the time is ripe.
3. Confirming boundaries
   Give the survivors plenty of feedback about who they are, what they are doing, who they are not and what they are not doing. Describe precisely what you experience and invite the

survivors to describe what they experience: you say, you see, you feel, you hear what now. I say, see and feel this now. That is your experience and that is my experience.

4. Assessment
   Give the clients positive assessments and positive concepts with which they can understand their present situation. You should also try to support clients in their activities and plans even if these seem unrealistic to you relative to the standards which you would use for yourself and your own behaviour. It is the attempt to plan and act which is to be reinforced. If mistakes appear you should still reinforce the intention behind the action. The reappearance of wishes and needs is a sign of recovering vital forces. These wishes and needs are usually contrary to the smooth running of the camp or hospital. To demand from an already weak client that they obey the rules completely would be to endanger the reawakening of an individual, autonomous personality. It is of course asking a lot from already overloaded care personnel to expect a generous approach here, especially when these actions or impulses are directed at the camp authorities and thus, to an extent, at the care personnel. Nevertheless a flexible approach here increases the chances of more rapid rehabilitation, shortening the length of stay, and helping clients to take responsibility for themselves.
5. The holding environment
   Help to create a holding environment. Ensure that all care personnel at all levels of the hierarchy respect the following points.
   Space must be given for temporary regressive reactions, which should be welcomed. The helping environment should provide safety at the biological and the emotional level. The development of symptoms should not be traumatised. Survivors should be helped to welcome these symptoms as a form of communication which is not yet possible in any other language. Of course these symptoms are often unpleasant for clients, care personnel, and relatives alike.
   Help must be given to transform the language of symptoms step by step into natural language. The expression of feelings, especially anger or a critical attitude towards care personnel, should as far as possible be seen as a sign of recovering ego strength and should not be taken personally by the addressees of these feelings, care personnel in particular.

c) Emotional expression

This level requires a higher level of psychological skills from the care personnel than in other stages. The following points should be noted:

1. Feelings which often begin with depression develop into anger directed at the self and then, as time goes on, at others. That should be accepted, named in the presence of the clients and welcomed. As far as the situation allows, clients should be free to express these feelings.
2. Subsequent emotional work should help clients to direct their feelings at the appropriate targets.

Who caused the feelings which I am experiencing now, when and how, and what was my situation at the time?

3. Help to establish cognitive connections between the feelings, thoughts about the feelings and the actions resulting from each. This enables clients to avoid being suddenly overcome by emotions and to see them as due to actual past events which justify such feelings.
4. Establish a space within camp or clinic routine which is safe and supportive enough to allow the expression of feelings. It will probably be necessary to establish certain times and events for this (e.g. emotional expression groups). This would also help the clients to differentiate between safe and unsafe environments for the expression of vulnerable feelings. Help to organise times, places and settings in which the clients can express their feelings and also settings in which such expression is not appropriate or desirable. People breaking this rule should however not have to face negative sanctions; instead interest should be shown towards the presumably very serious reasons the clients had for breaking the rules.
5. Identify and distance yourself from tendencies to manipulate others through the use of feelings and clinical symptoms. Address the function of these feelings and symptoms and try to help clients to express these wishes, needs and feelings directly. Work towards the direct expression of feelings and needs and towards the respect of boundaries as an important step towards rebuilding clients' self confidence and competence.

d) Relative adjustment and grieving.

This phase has a more obviously healing quality than the previous ones. The clients are less often overcome by emotional outbursts and the need to act out. They are more interested in speaking to people they can trust, not only about their present feelings and the everyday events which seem to have triggered them; clients also need the following five things:

1. To talk about past traumatic experiences.
   The clients need someone who will listen to them empathically, give them feedback and encourage them to continue working on their terrible memories.
2. Help in talking about the time before the trauma.
   Direct the conversation towards bright and joyful memories, recalling an intact life. This helps both to remind the clients that they are not just trauma victims and also to feel and express the loss and the feelings of grief and pain associated with it.
3. Feedback.
   Reassure the clients that the feelings of grief and loss which they are experiencing are normal feelings which anyone who had had similar experiences would feel. By welcoming grief, you are offering an alternative way to respond to trauma. The normal way is to try to divert people's attention from grief. That is indeed advisable in the early stages of dealing with trauma and loss. When the clients are psychologically stronger, the grieving process should be encouraged. It is an essential part of healing.

4. In the grieving phase it is important to progress from a state of depression, which tends to block feelings, to a stage of letting go, closing off and saying good-bye.
5. Appreciation.
   Encourage clients to really see and appreciate the things of value which are left. Even after the worst disasters life keeps offering ways to feel hope, relief and self-worth. Here it can be helpful to make use of the wealth of experience and symbols kept alive by the religious communities.

B. The tools of psychological intervention

1. Passing on good experiences

The counsellor should try to create situations in which clients can

a) experience competence, self control and success according to self-made standards (if these are set too high, they should be adjusted accordingly),
b) receive feedback from others on their success in coping.

2. Contact quality

a) Being aware of oneself and being capable of saying "yes" to oneself and one's internal processes.
b) Being able to make good quality contact to one's own experiences and to others'.
c) Being able to recognise emotionally unfinished contact to important others or life events and to resolve them to close the unfinished "Gestalt". These contact episodes should be continued either in reality or in the imagination in order to recognise and resolve ambiguous tasks or experiences and unresolved conflicts.

3. Support

a) Being able to recognise the desire for support from others or from oneself.
b) Being able to obtain this support from others and especially to take the risk of asking for support oneself:
   - Whom to ask; when and what to ask for.
   - Asking for support from relatives.
   - Asking for support from group members.
   - Organising support systems inside the existing subculture.
c) Being able to support oneself
   - through a supportive and accepting inner dialogue,
   - through supportive bodily awareness and physical activity (e.g. relaxation, breathing, posture, play, fun, eating, skin contact, etc.),
   - through reactivation of support from important others from the time before trauma in

reality or imagination. This involves recalling and appreciating happy moments with parents, brothers and sisters, partner and children,
- by activating new sources of support – for example preparing particular scenes in the imagination in which one receives support from others,
- by reactivating destroyed or disturbed aspects of the nurturing self and strengthening it against self destructive thoughts.

4. Developing or re-establishing trust

In one's own perceptions and competence and one's skills in the social group; in the meaning of one's own life; in the will and ability of oneself and one's people to survive; and in the forces at different levels of the belief system that make life possible:
- solidarity with one another and with the community.
- the history of one's own family and people
- philosophical and ethical traditions
- religious beliefs and practices .

5. Identifying and defusing destructive self-related thoughts

Sometimes it happens that a person's own processes of thought and imagination mistreat that person in the same way that he or she has previously been mistreated by others. In this case it is important to become conscious of these processes as they happen. The enemy, so to speak, lives on destructively in the consciousness of the traumatised person – without any action on the part of the enemy.

It is important to learn how to remove the power from such thoughts and instead to reinforce and elaborate self-supporting experiences from past and presence.

6. Role models

Adequate models for coping with difficult and tragic experiences are very important. These models can be taken from the present as well as from history or religious legends. Group leaders, therapists, teachers, politicians and religious leaders can also serve as role models if they are able to show how they themselves were able to cope constructively with negative experiences.

7. Specific training measures

Specific training measures have proved very useful in coping with post traumatic stress symptoms. Specific behaviour and interaction goals are set, tailored to the individual social and cultural context of the clients. They are designed to be practised in daily life.

8. Improving social interaction

In order to maintain supportive and nurturing social networks it is necessary to improve social skills. People who tend to give positive feedback tend to get positive feedback in return. People who praise and reinforce get praise and reinforcement in return. It is important to be able both to ask for positive feedback and reinforcement and also to feel the significance of this feedback when it comes.

- What does a person need in order to be able to accept positive feedback at all?
- What does a person need in order to ask for and give positive feedback?
- What does a person need in order to accept and value his or her own existence unconditionally?

9. The need to understand

The need to understand is a need for orientation. Understanding brings a feeling of everything being in its place which in turn brings a feeling of safety – whether justified or not. For this reason it is advisable to offer explanations for symptoms, events and bad experiences. That these are only hypotheses and not unconditional truth must be made clear to the clients.

10. Learning something new

It is important to create opportunities for learning new skills, e.g. languages, computing, typing, shorthand, cooking, sports, etc. Learning is living. Activity programs in which unusual skills are learned make a change from everyday routine and help clients to feel positive about life.

11. The full expression of feelings

The expression of feelings can heal as long as it is not used to reinforce pessimistic attitudes and philosophies which would in turn justify maintaining negative or destructive feelings. It is best to encourage the expression of feeling without allowing this to be connected to the maintenance of destructive and pessimistic attitudes and beliefs.

12. Developing a feeling for one's own existence

Along with fears and what ever else makes up our conscious life, the awareness of current sense data is a great help in establishing good contact to reality. It is helpful for clients who are still preoccupied with past pictures, scenes and events to develop a feeling for how the present actually is. It is a question of comparing one's thinking about oneself and one's thinking about the world with one's experiences of it. People who learn to value present existence regardless of personal tragedy have acquired something which will help to heal the consequences of trauma.

13. Working towards integration of the trauma

Trauma can be seen as part of a unique personal history. Quite apart from the question of their

meaning, traumatic experiences – how ever terrible they may have been – can contribute to strength and personal dignity if they are integrated into the whole personality. When this integration process is successful, it lends weight to the person's life and brings a deep human understanding for all living things with it.

Coping with stress as a consequence of trauma

Learning goals:
1. Recognising and understanding traumatic stress and typical reactions to it.
2. Introduction to working in a training group.
3. Emotional safety in groups.

Groups can be emotionally safe or unsafe. This quality can also change during the course of group work. Groups are safe when the participants accept each other even when they express unusual views, feelings, or wishes. This means listening to and being aware of the other without prejudice or making hasty judgements. It means respecting the experience and views of others.

Safe groups encourage relaxation. Participants do not need to suppress wishes, feelings, thoughts or movements through physical tension. In a safe group they do not need to fear the other participants because they are not criticised, rejected, laughed at or despised for their impulses.

Mental and physical tension in groups can however have other causes, e.g. individual fear of terrible memories, of feelings, thoughts or wishes which are too threatening and therefore become taboo. An emotionally safe group then seems like a threat at the beginning because it seems that everything is allowed here including that which is otherwise suppressed. The ease with which others express their feelings can make one's own tension seem all the more powerful and embarrassing. Implicitly or explicitly the idea can form that everyone should be so relaxed and easy-going, which leads to the group becoming subjectively unsafe. A hidden rule develops which puts pressure on all those who would still rather hold back. A really safe group allows every participant to be just as he or she is. It must be made explicit that it is acceptable to be tense, to be reserved in interactions and to hold back feelings for what ever reason. Of course groups in which some participants hold back become less safe for the other participants, but that can at least become a theme for the group to work on. So tension and stress have a number of causes and modes of expression.

However a central role is always played by the attempt to stop something happening or repeating itself –

a) in one's physical reactions
b) in one's thoughts, ideas and memories
c) in one's wishes, feelings and pain
d) in particular interactions with others.

A safe group atmosphere can to a certain extent be facilitated by psychological techniques. The goal of the first learning phase is to do just this using the participants` experiences here and now at the beginning of the group.

A. Introduction to how the group works – Establishing cohesion in the group and an atmosphere of trust

1. Introduction

Start off with a session for introductions to help participants feel safer in the group. This helps the people to get to know each other and to feel safe enough to start learning. Each participant should introduce himself by giving a few personal details, reasons for participating and to what use he or she intends to put the information and experience gained from the group. Encourage the participants to comment on their individual experience in counselling and psychotherapy or as group leaders.

Encourage them to say something about how they feel now as they introduce themselves. Since nearly all participants are very nervous during the introductory session at the start of a new group, this situation can serve as a live example for different forms of agitation and the variety of methods for expressing, controlling or ignoring it. You can make the following suggestion: "Pay attention to your arousal level during the introductions, how it changes and how you cope with this. If you want to and feel able to, tell us about it straight away; otherwise we can talk about it later after the introductions phase."

If your impression is that your group feels to insecure to start at this level, then suggest dividing up the introductions, for example starting off in pairs, then in groups of four, before coming back to the main group and continuing as above.

After the feedback on feelings here and now you could go on to "stress and coping with stress", basing the work on the participants' actual experiences.

2. Stress symptoms.

Collecting stress symptoms in the group at cognitive, emotional and physical levels, followed by a summary.

Information
Stress is the organism's natural and meaningful alarm reaction to perceived threats. Energy is made available to overcome the danger through attack or flight. It has been shown that the stress process depends on and is modified by an individual's cognitive evaluation of events. What one person experiences as an exciting challenge can be an existential threat for someone else. Stress reactions themselves can, however, become a threat to health if they affect the organism continuously. In this case physical complaints should be investigated medically. Draw attention to the dangers of psychologising physical symptoms too readily. You should model here how to find out to what extent the symptoms were present before the trauma (existing depression, conversion, perhaps substance abuse) and to what extent they are the consequences of trauma. (cass 1a, 733)

3. Counselling skills
Practice in small groups. Role play to learn or build on basic skills necessary for diagnosis and counselling. Organise groups of three ("client", "counsellor", "observer"). Set up the following exercise.

4. Establishing a working relationship
The important factors here are patience and an open and attentive attitude on the part of the counsellor. This attitude is one of being interested in and curious about the other, and relating to them without judging.
- How does the "client" experience and assess his or her world and how does he or she react to this?
- Exploring the present state.
- How does the client speak and sit? The aim should be to make contact with a person, not just with the client's story .
- Which stressors are prominent in the client's consciousness?
- How are these expressed?
- Has the client integrated them? Does the client distance him or herself from them? Does the client exploit them in social contact?
- How does the client increase, maintain or decrease stress through behaviour or cognitive assessment?

Draw attention to the fact that the counsellor usually feels a need put an end to the problems found as quickly as possible by means of giving advice, and thus putting him or herself under pressure to find a solution. This phenomenon can also be a reaction to perceived expectations in the client. Nevertheless, a thorough exploration of the present state is an essential requirement for this step. What form does the stress take? How often, how long and how intensely does it occur, when is it absent?

Underline the importance of this step by spending plenty of time on it yourself at this stage.

5. Avoidance of topics

From the first role play onwards watch out for the tendency to cut short the exploration by means of avoidance, to skate over important emotionally charged topics to reduce the intensity of the dialogue, or, on the other hand, to become confluent too quickly, agreeing with everything and thus failing to establish a productive tension between the conversational partners. Confluence can be an attempt to establish an accepting atmosphere, usually however, the interviewer ends up loosing the necessary energy and incisiveness.

Exploration of the possible *causes* of the present stress situation (external and internal, general and individual)

Starting points for short and medium term strategies for change:
What opportunities do the clients have (and which of these have they already put into practice themselves) to reduce stress?

Here the question can also be addressed of what self or social support is already available or could be build up. Stress reduction measures can be divided into two groups: firstly, those which lead to immediate stress reduction (e.g. satisfying basic needs, organising peaceful surroundings for sleep, increasing opportunities to communicate, and, secondly, those which in the medium or long term enable individuals to recognise stressors more quickly and to deal with them themselves as far as possible.

6. Identifying and activating self support skills

The participants now practice once again in groups of three how to assist in the identification of existing coping skills in the individual and in the environment. This time, however, role play and the three rotating roles are not used; instead, the idea is to explore the actual living circumstances of the three members.

- What have you done up to now in order to feel safe, comfortable and relaxed?
- Which people and things can you use to help you in this?
- What do you need to help reduce other stressors (substance abuse, alcohol abuse, inactivity)?

Point out that the emphasis should be on easily available activities which can be repeated often, either alone or in a community, to re-establish positive feelings and satisfaction with life. The simplest way is to reactivate activities which were used before the trauma for relaxation and for improving contact and general satisfaction with life.

Underline the supportive effect of simple quiet attentiveness and non-demanding physical contact of third persons while talking about circumstances of the trauma itself.

7. The diagnostic interview

The participants should familiarise themselves with the following basic principles of the diagnostic interview and then rehearse the required behaviours in role play.

- The aim of the interview must be clarified. What does the client want and what doesn't the client want? This should be as concrete as possible. What are the counsellor's aims and can a neutral contract be agreed on this basis?
- The first interviews should take place in a safe atmosphere. There should be sufficient time available and it must be established that confidential information will remain confidential.
- Try to get a picture of the clients' experiencing and behaviour and make, where necessary, a diagnosis. If you are using a standardised list of questions, make sure you do not leave out any important parts.
- Your questions should be as concrete as possible.
- Ask about painful events (torture / traumatisation).
- Be patient with the clients and do not expect to be trusted blindly from the first moment. Female clients should normally not be asked if they have been raped. They will mention it themselves when enough trust has been established.
- Work together with clients and not for them or behind their backs. Agree on mutual aims and decide together on steps towards these.
- When you feel that a more thorough medical or psychiatric examination is necessary, work together with the relevant professionals.
- As soon as a problem is described, ask for details, e.g. frequency and intensity of symptoms.
- What preceded the problem?
- How does the client behave, think and feel after the problem?
- What do others do, say and feel?
- Does the problem bring any advantages with it and to what extent does the client admit this?

8. Small Groups – Practising the diagnostic interview

The aim is to gather situational, behavioural and experiential information on stress-related emotional disorders and symptoms: origin, triggers, cause, course of development, frequency and intensity, others factors affecting the presence or intensity of symptoms, consequences and reinforcers, effect on and reactions of others).

B. Identifying stress symptoms in the client

Summary of the different levels on which stress reactions can appear.

Physical symptoms.
Usually several of these symptoms are present simultaneously; sometimes each one functions in turn as the main symptom.
- Muscular tension, which can take the form of indefinite pain (head and neck, back, stomach, heart and circulation).
- High pulse rate, tachycardia, irregular heart beat, dizziness.
- Breathing difficulties.
- Arousal.
- Increased or decreased appetite (weight change).
- Menstruation problems.
- Sweating.
- Tiredness/exhaustion.

Emotional symptoms
- Withdrawal, social isolation, confluence (giving in to others too easily and without making contact, agreement where disagreement would be appropriate).
- Feelings of fear and panic.
- Hopelessness.
- Feelings of being threatened which appear as the impulse to flee or attack (fits of rage).
- Helplessness and resignation.
- Rapid changes of mood.
- Loss of drive and interest in activities or other people.
- Negativity, aggressive rejection of suggestions or offers of contact.

Cognitive Symptoms.
- Perceiving one's own situation as threatening.
- Believing that meaningful help can not be obtained through one's own actions (loss of a feeling of control).
- Concentration difficulties. Attention difficulties, carelessness, perceptual items not registerd
- Brooding.
- Clouding and narrowing of consciousness.
- Disorders of learning and memory.
- Loss of ability to perform actions simultaneously (e.g. listening and thinking at the same time, driving and thinking, etc.)
- Oversimplified explanations and superstitious interpretations of stressful events.

Behavioural symptoms
- Restlessness.
- Poor impulse control. Attention difficulties.
- Numbness, rigidity.
- Substance abuse.
- Sleep disorders: difficulties in falling asleep and staying asleep, somnolence.
- Lack of energy.

Social symptoms.
- Dependency.
- Unstable relationships.
- Lack of empathy. Emotional numbness.
- Fits of rage, quarrelsomeness.
- Reproachful attitude.
- Idealising and then denigrating others in quick succession.

People affected by posttraumatic stress disorder may have many of the above mentioned symptoms without being able to describe them themselves or to recognise them as consequences of stress and trauma. Moreover the symptoms can change in rapid succession. However, most empirical investigations show the *number* of symptoms to be the best prognostic indicator. It is the *number* of symptoms rather than the *type* which determines future developments of the illness and severity of the psychological trauma. Sometimes it is difficult to identify symptoms as direct consequences of trauma. For example, sudden loss of weight and stomach pains may be due to other illnesses such as worm disorders, excessive alcohol consumption, malnutrition or intestinal infection. A medical investigation should be carried out when possible. It can also be helpful to find out from relatives to what extent these symptoms existed before the trauma or whether they are non-specific functional complaints due to depression or anxiety.

C. Coping techniques – Work in the main group

Model learning. Demonstrate how to explore stress symptoms and raise consciousness by asking questions in the group. Participants also learn how sharing can correct the feeling of being alone in having problems. This feeling is replaced by the experience of being cared for and accepted. The participants also experience how arousal and other feelings can be modulated and made more differentiated by sharing. Help them notice how the exchange of personal perceptions and feelings, even simply reporting one´s arousal level, can affect their relationships to one another. How safe has the group become during these conversations?

D. Relaxation techniques

Tension is the body's way of protecting itself against injury and pain. It affects both muscles and blood vessels. It can take the form of an overall increase of muscle tone or of tension in particular muscle groups (neck, forehead, stomach, etc.). From a psychological point of view muscular tension is a sign of a latent defensive attitude appropriate in the case of threat of sudden attack or injury. This becomes chronic when the individual no longer notices this latent defensive posture. This can be due to a disposition (low pain threshold) or it can be the consequence of previous traumatisation which could not be dealt with actively through attack and had to be suffered passively. This can be so in such extreme cases as torture, rape and bomb attack but also in the case of early experiences in the family such as physical punishments and unpredictable physical violence from stronger persons, etc. Psychological pain can also lead to chronic tension. This can be caused by extreme criticism, humiliation, abuse, threat, loss, denigration, etc.

1. Chronic tension is harmful

1. The imaginary defence of threats not actually present leads to poor adaptation to present demands. Body and mind can not react flexibly. Perception is distorted and reality is interpreted in a biased way.
2. The energy supply in tense body areas is poor, increasing the susceptibility to illness, further injury and tension pain (e.g. tense headaches).
3. Life becomes grey. Tension impoverishes self perception, feelings and expressiveness.
4. Tense people tend to be avoided socially. Other people feel tense in their presence and they become isolated for no obvious reason. Physical tension leads to interpersonal tension in dialogue, which becomes uneasy, artificial and tends to miss the point.
5. Chronic tension is a sign of the maintenance of a defensive alarm reaction the trigger for which is no longer present or has even been forgotten. The entire organism is on red alert, costing a great deal of energy and without the opportunity to turn this energy into meaningful action.

2. Why relax?

1. To reduce the non-specific activity level which is a response to a merely symbolic threat, consuming energy and totally exhausting the individual when no real danger is present. Induced relaxation regenerates mental and physical energy reserves. People suffering from trauma tend to maintain an unspecific alarm reaction perpetually. Exhaustion is the body's desperate attempt to relax.
2. To improve perception and recognise how attention develops. To improve control using targeted tension and relaxation designed for use in a variety of contexts.
3. To improve self expression and the perception of emotions and biological and emotional

needs. Relaxed people are better able to act on a basis of their genuine needs than people who are chronically tense. The latter are less self aware and act according to clichés ("I should eat now") and are thus exposed to further dangers: they are easily manipulated and do not register others' needs due to their poor social perception. This tenuous contact to the feelings and situation of others tends to lead them to aggressive acting-out.

4. To improve energy regeneration, body energy supply, attitude to life and resistance to illness.
5. To improve social relationships and to balance giving and taking. To enable play, celebration and a feeling of belonging.

3. Main relaxation methods

Relaxation is associated above all with muscle relaxation exercises. It is however important to realise that relaxation can be brought about in a number of very different ways.

1. The experience of safety and the conviction that one can defend oneself in a crisis. People who have been subject to torture, war trauma and random injury can only regain this conviction gradually by being led to experience a safe situation.
2. Contraction and relaxation exercises to improve control over the tension process at the level of muscle contraction – both physically and in the imagination.
3. Emotional expression of feelings and insights which had been suppressed by tension: the aim is to learn e.g. to establish boundaries verbally instead of suppressing vital processes through tension in the body.
4. Provoking relaxation through forced tension: stress positions, forced breathing, followed by acting out, usually with defensive gestures: expression of anger; pushing away the "opponent" symbolically; rebuke and reprimand; establishing boundaries through word, deed and expression. The person regains the ability to use language and action to establish boundaries externally rather than inside the body.
5. Awareness. The systematic observation of the present states of bodily tension and relaxation without the wish to change it is in itself an important exercise in relaxation.
6. Acceptance of one's own fate. Integrating damaging experiences into the personality.
7. Religious exercises – prayer and meditation – which help to renew trust in the indivisibility of the creator and the existence of a hidden meaning for all worldly experience.
8. Drug-induced relaxation. Where the social and political situation leaves no other choice, or the client is either unwilling or unable to attempt the exercises under 1 – 4, medication may be the only solution. The convenience of medication should not lead to its exclusive use since a) side effects are possible b) psychological and physical addiction can result c) the road to active coping is blocked and d) the view of the symptoms as something outside oneself and one's own responsibility is strengthened.
9. Relaxation through saying out loud, and genuinely accepting, verbal confirmations of one owns worth (OK-messages). A community under stress can maintain a degree of relaxation by attending to a culture of mutual respect and reinforcement. However personal relation-

ships are often the first to suffer under stress. Interaction quickly becomes brusque and derogatory and the community is in danger of breaking up. This is true for couples, families and also village and fighting groups and above all camps. Defending or re-establishing the virtue of respect and mutual confirmation in one's dealings with one another can also make a significant contribution to individual relaxation.

10. Sport. Moderate but regular sporting activities, especially when held in the community and when the play aspect is underlined, are an outstanding way to relax mentally and physically.

4. Practice of relaxation methods

Those of the above relaxation methods which are easiest to put into practice are now to be tried out in role play as dialogue, breathing and muscle exercises. This takes place in pairs with one partner as helper, the other as client. The roles are subsequently exchanged. The methods are most effective when firstly the training situation is as peaceful as possible, secondly when the trainees are able to rid themselves of distressing thoughts or images at least for a while, and lastly when the trainees carry out the exercises in a comfortable position. Moreover you should point out that the effectiveness increases by regular practice. The following exercises are suitable for partner or small group practice: Autogenes Training, Jacobson's muscle relaxation, fantasy journeys and breathing exercises, with massage as additional help (foot, head, neck or whole body massage) when appropriate to the culture in question.

5. Main group: relaxation exercises

1. Awareness
2. Muscle relaxation
3. Breathing relaxation
4. Fantasy journeys
5. Religious meditation
6. Group activities: sport, games, music, celebrations.

Awareness

Instructions: sit in a comfortable position and close your eyes. Pay attention to all body feelings in your immediate consciousness, pause for a moment by these sensations without wanting to change anything. Leave them as they are but continue to pay attention to them.

After a while start to pay attention to other body feelings. Shift your awareness to the top of your head. How does it feel there? Simply be aware of how it is there without wanting to change anything. Move further down to your forehead, eyes, and cheeks.

Then go on in the same way, taking in your whole body or parts of it.
In the final phase pay attention to how you feel overall. As your degree of tension, your breath-

ing or your feelings changed, did images or feelings appear spontaneously? Then share with the group what you experienced or found during this exercise.

Muscle relaxation
Instructions: Lie flat on your back. Become aware of how you are lying, which parts of your body are touching the floor and which are not. Pay attention to your breathing. Which parts of your body move in the breathing rhythm and which do not? Now raise your right arm and make a fist. Tense up your fist and arm with all your strength. Notice whether your arm or the rest of the body feel different. Maintain the tension for a few seconds more, then let go, breathe out with a sigh and relax into the support on which you are lying: mattress, ground, etc.. Put more and more trust into this feeling of being supported, breath by breath. Notice the feelings in your arm and the rest of your body.

Repeat the exercise, but now make a fist with both your hands and hold the tension again for 15-20 seconds, relax again with a sigh.

Go on in this way tensing and relaxing your jaw, forehead, stomach muscles and thighs.

Finally tense your whole body in one go, maintain the tension for about 20 seconds and then breathe out with a sigh. Stay on your back for a little longer, go through your body inch by inch, pay attention to how you are lying.

How tense or relaxed are the different parts of your body? How are you breathing? Let images come which express how you feel now.

Relax more and more every time you breathe out.

The end of the exercise: stand up quickly and take a few steps.

Note. This exercise should be practised daily for about 15 minutes. This is central in order to be able to relax the muscles at will in different situations and to be able to notice tension when it arises. Should strong feelings appear during the exercise it is important to allow enough time and to provide space for their expression. Reassure clients that it is quite normal that strong feelings arise during this exercise. Expressing them is important and healthy.

Ask for feedback on the rhythm and speed of your instructions, on the sound of your voice and the contact between yourself and them ("Did it help me to relax or did it make relaxing more difficult?").

Breathing relaxation
These exercises can once again be carried out in pairs. Person A instructs person B and then the roles change. The instructions are as follows:

"Lie on your back. Take some trouble to find a comfortable position that is right for you. Explore your body with your inner eye. Explore the feeling at those places where you touch the ground: the back of your head, your shoulders, slowly down your spine, vertebra for vertebra, your buttocks and the backs of your thighs, your calves and your heels. While doing this, breathe, so that your navel rises when you breathe in and falls when you breathe out. You can check this by laying your hand on your navel, so that you can feel the movements more clearly.
Take care to find a rhythm that is relaxing for you. Breathe slowly and take special care to breathe out slowly and deeply, so that your navel moves up and down and you continue to breathe in a relaxing rhythm."

One further breathing exercise is called pause breathing. It is named after the short pause, which can be gradually lengthened, is taken between breathing out and breathing in. Breathing follows a set rhythm. Pause breathing serves not only to relax, it also regulates and stabilises the breathing pattern. So it is particularly recommended for people who breathe incorrectly: shallowly and mostly in the chest with a tendency to hyperventilate (breathing too quickly accompanied by a feeling of not getting enough air)

Instructions for pause breathing in the main group
The exercise can be carried out in virtually every posture: sitting, standing and, of course, lying down.

Begin with short breaths with the emphasis on breathing out. Count out loud (if you are leading the exercise for others).
Say out loud: breathe in, 2, 3, out, 2, 3; pause; in, 2, 3, out 2, 3, …
This rhythm is kept up for about one minute.
The counted beats last about 1 second each.
Now the breathing out and the pause are lengthened:
in, 2, 3, out, 2, 3, 4, pause, 1, pause, 2, pause, 3, pause, in, 2, 3,
then:
in, 2, 3, out, 2, 3, 4, 5, pause, 1, pause, 2, pause, 3, pause, 4, pause, 5, in, 2, 3, out, 2, 3, 4, 5, etc.
Then:
in, 2, 3, out, 2, 3, 4, 5, 6, 7, pause, 1, pause, 2, pause, 3, pause, 4, pause, 5, 6,7, in, 2, 3, out, 2, 3, 4, 5, 6, 7, etc.

The whole exercise should not take longer then 10 minutes.

Feedback round in the main group:
• How was the exercise for you?
• What was good, what was bad?
• How does your body feel?
• How are your thoughts?
• What changes do you suggest?

Fantasy journeys
People who find it difficult to relax with direct instructions usually have less trouble with imaginary voyages. The group leader tells a story out loud – he or she describes situations in which the client moves or has pleasant experiences. Common to all such voyages is, that they involve relief, movements, lightness, warmth, comfort, joy and a feeling of security.

Here are some typical instructions:
Sit up comfortably, close your eyes and imagine flying from here to the sea where there is a warm beach. You take off your shoes and feel the warm sand under your feet, the warm sun on your skin and a light warm breeze in your hair. You see a small rowing boat lying on the beach. You climb in and lie down on the bottom of the boat. The boat takes to the water. You feel a rocking motion and you hear the splashing of the water on its sides. It floats off now in one direction, now in another and after a while it comes to rest on a sandbank. You climb out and find yourself standing next to a grassy hill on top of which there is a big tree. You go up to it and sit down on the ground, next to its trunk, enjoying the shade of the leaves. Then suddenly you notice how you are beginning to grow. Your body, your arms, your legs and your head are soon twice as big a usual. Then you are as big as the tree and then bigger and bigger. Now the tree is far below you, you are taller then everything around you. Feel this sensation of growing in every part of your body, in each individual cell. Now you can see the whole country and the sea far below you. And then gradually from this great height, you notice that you are starting to shrink again. The tree and the grass around it come closer, now you are still a little bigger than the tree. Now only twice as big as usual and now you are your normal size. But you continue to shrink. Now you are only half as big as usual, now a quarter. You become smaller, now you are only a few centimetres tall until finally you are just a tiny point. And just as you have shrunk to your smallest size you start to grow again. You feel yourself getting taller and taller until you have reached your normal size again. Now set off on the return journey. You find the boat that carries you back to your beach. You turn back and find yourself here again. Open your eyes.

Religious meditation
Religious feelings can encompass joy, safety, security and the feeling of not being left alone, and are accompanied by a certain independence from the hassles of every day life. Those clients who had experiences of this kind in their lives before the trauma have a reservoir of additional ways to regain their trust in life. Those who did not have such experiences in their lives before the trauma would have more difficulty in taking this route, although it is not impossible.

Main group:
Sharing memories of religious feelings of being safe and protected. Those listening refrain from making value judgements – instead they give feedback on how they experienced the speakers during the sharing. Finally religious exercises are identified which can help to reawake feelings of safety and security. One of the participants could lead an exercise in the group, e.g. Thiker in Islamic contexts, saying the rosary in Christian contexts.

Group activities: sport, games, music, celebrations

People suffering from chronic tension as a consequence of trauma usually find it difficult to take part in simple cheerful collective activities. They need special help: stimulation, encouragements and organisational support. The most important thing is, that contact, play and the collective activity are emphasised rather then performance and perfection.

Main group:
Collect ideas on how group activities appropriate to the context and the education and norms of the clients can be selected and introduced. The participants discuss difficulties involved with participating in informal group activities and how to overcome them. Learning by doing: play a group game from the locality in the main group.

The above relaxation techniques should help to reduce physical and psychological stress at least temporarily. The inability to relax or a lack of balance between tension and relaxation (lack of daily routine) – problems which may also be caused by difficult living conditions – can be reduced in this way.
You should emphasise the importance of regular practice.

The unspecific interventions mentioned above aim at changing particular behaviour patterns:
1. re-establishing normal sleeping rhythms and useful and pleasurable activities during waking hours
2. conveying positive ways of coping with stress
3. cutting out destructive ways of dealing with stress

6. Coping with sleep disorders

For dealing with stress related sleep disorders, additional measures may be appropriate: explain the importance of sleep for health (sleeping – waking rhythm) and a balanced frame of mind. You should build here on the participant's experience.

Participants discuss in small groups: what keeps one awake and how and what changes can someone make in order to fall or stay asleep better. Some basic information follows as a framework: clients may find it useful as an explanatory model.

Information:
Sleep disorders can result from physical or mental illness, they can also be a consequence of alcohol, tablet or drug abuse or of recurrent worries and fears which keep one awake. An unclear present situation and future perspectives in a camp can contribute to a general feeling of insecurity. Traumatic events may give rise to frequent and reoccurring nightmares which can be very distressing.

Intervention

- Practising routines leading to sleep
- Establishing quiet surroundings for sleeping.
- Establishing the actual amounts of time spent asleep (often people who believe "I didn't sleep a wink" did in fact sleep for a considerable time).
- No stimulating activities shortly before bedtime.
- No food, coffee or tea before going to bed. Avoidance of excessive sleep during the day.
- Insuring enough activity during the day to bring about tiredness.
- Foot massage before going to bed.
- Sleeping tablets only in consultation with a doctor and never in the case of chronic sleep disorders.
- Meditative and religious relaxation exercises for quietening down and to create an at least temporary feeling of safety and security.
- Exploring and talking through the worries preventing clients from sleeping.
- If the anxiety is a symptom of a physical or mental illness then this illness must be treated.

E. Somatisation of psychic distress: functional psychosomatic disorders

Information:
Some clients present themselves with symptoms which are varied, vague, fleeting and changeable and which are difficult to relate to a particular illness. These clients have often been from doctor to doctor without experiencing any significant improvements from med-

ical intervention. During contact the counsellor often has the impression of not really getting to the point even though the client is obviously really worried by the complaints and mentions them repeatedly during the conversation. The counsellor feels helpless, sometimes angry and may feel a wish to get rid of the client with a single tip hoping never to see him or her again. Escape is usually not so easy as the clients' complaints are genuine and not invented and can be the expression of considerable suffering. However the disorder enables the client to transfer his or her helplessness to the counsellor. The disorder acquires a social function from which the "functional psychosomatic disorders" get their name.

The term "functional disorder" means that the presented complaints have a functional value for the client in his or her situation; the client profits in a sense from the illness. The counsellor is unable to recognise this function at first glance, nor is the client usually aware of it.

Functional complaints are relatively common. They may be the expression of an underlying more serious disorder

a) substance abuse
b) anxiety or panic disorder
c) a depressive illness.

They may also be the consequence of a trauma, i.e. the way the client deals with a stressful experience.

- Physical complaints are better accepted in most cultures than psychological or social problems. They can be more easily talked about.
- People with physical illnesses are not in danger of being called "mentally ill" or "mad".
- Some clients do not feel the stress which they are exposed to. The effect of being constantly subject to this stress then becomes visible as an illness. It is transferred to the level of physiology.
- It is possible that clients assume that one tells medical (in the broadest sense of the term) helpers about physical complaints and not about the feelings or problems associated with them.
- The client may be testing whether the counsellor can be trusted. Is he or she interested in the presented complaints, is he or she patient, understanding and sympathetic. The client will not open up and speak about psychological difficulties until he or she is sure about this point.

1. Common psychological disorders resulting from traumatisation

a) Functional complaints and depression

Clients with functional depressive illnesses suffer from depressive mood, unhappiness and loss of interest. They have difficulty in motivating themselves to carry out activities which used to

present no problem. They tire more quickly and report reduced self confidence and feelings of guilt and worthlessness. They are pessimistic and do not believe that they are able to bring about any change. Further common symptoms are loss of appetite and sleep disorders. Such clients report previous suicide attempts and current thoughts about suicide, they have no energy, are tired, cannot get out of bed in the morning and are chronically unhappy and lacking in drive.

b) Functional complaints and drug abuse

Clients with functional alcohol problems are possessed by the desire to consume alcohol. They are hardly able to control the time when they begin drinking or the quantity drunk. They need continually increasing quantities to bring about the desired effect. Alcohol consumption becomes an evermore important interest at the expense of other interests. The usual rules of drinking behaviour are ignored. Consequences are physical (health problems) social (unemployment, social decline, neglect of personal appearance) and psychological (loss of performance, depressive states). Alcohol serves to elevate anxiety, tension and in some cases pain. Chemical addiction to alcohol appears later as an additional factor determining drinking behaviour. Addiction to other substances (drugs, pharmaceuticals) is very similar. Patients with functional complaints are particularly susceptible to substance and alcohol abuse.

c) Functional complaints and anxiety

Patients with anxiety disorders show the following symptoms to widely differing degrees: continual restlessness, nervousness, trembling and muscular tension, palpitations, dizziness and anxious worries or fears. In the feared situation itself, clients breathe in shallowly and spasmodically without breathing out properly. The thought processes of chronically anxious people are devoted to avoiding fear and its stimuli. This leads to the expectancy of fear which in turn leads to chronic arousal. Anxiety disorders may be restricted to particular situations. They also can be elicited by particular objects. Clients are often afraid of the next anxiety attack. Anxiety and depression may appear together. Anxiety clients usually breathe poorly and have chronic muscle tension.

The above mentioned functional complaints are frequently but not exclusively consequences of trauma. The main consequences of trauma are frequent reexperiencing of the traumatic situation and the surrounding circumstances in the form of memories and nightmares leading to loss of interest and social isolation. Clients talk incessantly about their terrible experiences and are nervous and anxious. Functional complaints which can be mediated by fear, depression and alcohol abuse as described above are often however also direct consequences of trauma: flashbacks, nightmares, numbness, concentration problems, obsessive brooding, fears, nervousness and loss of interest.

2. Experiential exploration of functional psychosomatic complaints in the main group and in subgroups

1. Main group: Discussion of the possible social function of vague psychosomatic complaints:
   - Who is being controlled, what is the aim?
   - Which social processes , risks and personal experiences are being avoided?
2. Subgroups: Role play of a counselling session with a client complaining of functional physical problems.
   - Who is on top in this conversation?
   - What are the implicit and explicit interaction rules which give the client social power?
   - What would a counsellor who tried to escape the client's "control net" then be afraid would happen?
   - How can the counsellor avoid being socially controlled by the client's complaints without hurting him or her?
   - Is there a "contactful" way of dealing with this allocation of roles?
   - Which posture you think you should adopt in order to be able to accept client's complaints without yourself feeling responsible for them?
   - Do you feel under pressure not to maintain this demarcation line while remaining in friendly contact?
3. Summary of the results of the subgroups in the main group.
   Possible demonstration of solutions found using role play.

3. Intervention steps

Here follow a number of principles for work with clients showing the above-mentioned tendency to somatise. The practical implication of these points should be underlined using role play or counselling sessions. Allow yourself time to help the participants and exploit the store of competence in the group using feedback sessions.

Medical investigation by a competent person. Tell your medical colleagues that you suspect the complaints are the expression of an underlying personal or social problem. The referral to a medical investigation which should exclude the presence of a genuine physical illness (or the beginning of one) avoids the danger of psychologising the problem too quickly.

Inform the client about the results and explain them. Tell the client that no organic cause could be found for the symptoms in question. In this situation there is no point trying to talk the client out of the symptoms. This physical expression is the client's best method of coping at present. It will make it more difficult to work together if you attack or criticise the client on this point. Help him or her to realise the connection between his or her psychological or social problems and the physical symptoms.

Explain the relationship between stress, the feeling resulting from it and the physical symptoms in a way the client can understand. Illustrate this with common sayings: "It broke my heart to have to watch that", "This problem is like a millstone around my neck", "I had to choke back my anger".

Symbolisation. Tell the client to try to become the complaints, disorder or pain and then to try to speak with the voice of the problem. What is the pain trying to say? Speak it out loud.

Do you have or have you had other important personal relationships in which you had to resort to illness in order to be heard? Can you obtain what you hope to get from the illness more directly?

Work together with the client to make a summary of the most acute problems. Decide together which problems you want to try to solve. Put these problems in an order of priority. Involve the client in looking for solutions. Reinforce his or her commitment and initiative. In this way the client's attitude, that it makes no sense trying to change things and that self help cannot work, can be changed. With every success, highlight the connection between action taken and the change resulting from it.

Identify possible sources of social support together.

Prescribing medicines reinforces the client's idea that the problem is a physical one and hinders the search for the underlying problem and for better forms of expression and coping. Medication is therefore not advisable in such cases. In this way you can identify in advance those factors which hinder or prevent putting plans for change into practice in everyday life and you can more quickly take steps to correct this.

Subgroup exercise: Intervention with functional psychosomatic complaints.

Go through each recommendation for intervention in groups of three. Act out each recommendation in role play (counsellor, client, observer). Pay attention to the feelings arising in each role. Give each other feedback on the effects of each intervention, specific forms of words and contact quality. In particular, give the counsellor feedback, about the specific problem-related interventions, on the impression he or she makes: attentive, warm hearted, authentic, sympathetic, yet clear in establishing boundaries, or cool, rejecting, critical, hurtful, calculating and disinterested or easily manipulated, stressed, superficial, a helpless helper. Bring these experiences back to the main group and allow time to discuss the implications.

4. General points on dealing with psychosomatic clients

- Make it absolutely clear to the client that you will not pass on anything he or she tells you without his or her explicit permission. Keep to this promise strictly.
- You should know the main symptoms of common psychological disorders and as far as possible have practice identifying these through interview questions. Familiarise the group with the most common names for the psychological disorders in question. Here it is useful to know the names and usual forms of treatment both from your own culture and from the client's culture. This should ease information exchange between the cultures. You can gather information on attitudes to different illnesses and their treatments in the clients' culture from the clients themselves, their relatives and friends and local medical and advice centres.
- Visiting the client where he or she lives ("housecalls") helps you to get a better impression of the client's circumstances and problems and also enables you to ask relatives for their opinions. This is a good way to obtain information which the client could not give you or did not want to.
- Avoid using technical terms in front of clients. Relate to them in a way they can understand, so for example, ask if they often feel followed or watched and if not if they have paranoid ideas.

F. Anxiety disorders, phobias, panic attacks

The clients we are dealing with here have a number of genuine fears due to their experiences as refugees or exiles. These fears may relate to experiences at their place of origin and in the past, but of course also to present circumstances. It may be that situations and or objects are feared or avoided. Symptoms – physical, cognitive, emotional and behavioural – can be very varied. Individuals' coping strategies vary correspondingly. The picture can be complicated by the attempt to cope with the fear using medication or alcohol.

1. Subgroup diagnosis

The participants use the interview guidelines on anxiety and panic worked out earlier in the seminar. Counselling sessions are role played, leading to a final diagnosis and to the planning and introduction of intervention on that basis. Here it is important to have explored the fears thoroughly (triggers, symptoms, coping attempts), and not to give in too early to the temptation to begin with intervention steps on fear reduction. The participants should find out in these conversations how and where fear arises and which symptoms the client has.

- When did the anxiety begin and how has it changed since?
- What coping strategies did the client use and were they successful?
- Did undesired side effects arise, e.g. in the case of extended avoidance rituals?
- Have attempts been made to treat the problem?
- Is the anxiety a side effect of depression or another physical or psychological disorder?

2. Intervention

- In some cases of prolonged anxiety or where a more serious underlying disorder is suspected of being responsible, it is useful to work together with a doctor or psychiatrist. Do not create unrealistic expectations, i.e. that someone else will solve the clients' problems for them. The client's conviction that the treatment has given him or her a coping strategy for responding to threats rather than being at their mercy has proved to be an important factor in successful treatments of anxiety. Clients' problems often improve when their circumstances improve.
- Anxiolytic medication, when available, can be administered under medical supervision. Successful psychological treatment methods include confrontation and systematic desensitisation. Confrontation can be organised in the form of "therapy partner exercises"; clients support each other in coping with problems.

Main group:
Explain the rationale of the two approaches (information) and then role play them in the subgroups using the participants' own problems.

Pay attention to how the relationship changes when the counsellor
a) gives direct instructions on how to confront fear or
b) increases problem acceptance using nondirective conversation.

Bring the results back to the main group and discuss them.

G. Depressive disorders

1. Manifestation

Depression is probably the most frequent psychological problem amongst exiles and people traumatised by war. It is manifested not only directly in the form of clearly depressive symptoms but also indirectly by vague physical symptoms, suicide attempts and dispairing agitation. Depression can be more or less severe, resulting in a variety of main problem behaviours. Common to all of them, however, are specific destructive thoughts and thought processes.
Thoughts: negative expectations and judgements of self, others and the future.
Processes: Obsessional, circular brooding on fateful events; concentration disorders
a) feelings of dejection, guilt and lack of self-worth
b) physical side-effects such as sleep disorders and reduced appetite. ICD 10 lists a large number of depressive disorders. The most important distinction is between bipolar mood disorders (manic-depressive fluctuations) and depressive episodes with or without psychotic symptoms.

Depressive episodes without psychotic symptoms are divided into three groups: mild, moderate and severe episodes.
The following points are common to all of them:
• despondent mood, loss of interest, joylessness
• loss of drive, increased tiredness and reduction in activities
• reduced concentration and attention, unability to listen
• reduced feeling of self worth and self confidence, tearfulness
• feelings of guilt and worthlessness; negative and pessimistic view of the future
• suicidal force and actions, self injury
• states of anxiety
• temporary motor restlessness, hypochondric brooding
• reduced ability to react emotionally to friendly surroundings or joyful events
• sleep disorders
• reduced appetite
• waking in the early morning two or three hours before the usual time with a "morning low"
• extreme despondency
• objective psychomotoric restlessness or agitation
• loss of appetite, loss of more than 5 percent of body weight in the past month
• significant loss of libido.

Depressive episodes with psychotic symptoms show some, if not all, of the above symptoms with the addition of delusion, hallucination or depressive stupor. The delusions usually concern blame, poverty or an immanent catastrophe for which the client feels responsible.

2. Interview on depression
Subgroups:
The participants practice in role play how to question clients on symptoms in order to come a diagnosis. Here the following information is necessary.

• What symptoms does this client have and since when?
• Under what conditions (triggers) does the depressive mood appear and what do mood variations depend on?
• Under what conditions does the client notice an improvement in mood, and what was the client's contribution?
• How do the client's social surroundings react to the depressed mood?
• Do the words or actions of others tend to reinforce the depression or to reduce it?
• Is the client suicidal? Warning signs are as follows:
• Concrete suicide plans.
• Availability of the means to commit suicide.

- Past suicide attempts on the part of the client (not followed by significant improvement) or on the part of others close to the client.
- Loneliness and loss (lack of social surroundings, serious illness, unemployment).
- Direct or indirect hints about suicide intentions.
- How does the client answer questions such as : "Would you rather be dead?" "Have you ever thought about killing yourself?" "Is your life worth living?"

Persons in danger of committing suicide must be kept under observation until the danger has passed. A premature release out of the protective environment is dangerous. However counselling should begin here on how to tackle social and/or psychological problems. Medication (antidepressants, or minor tranquillisers in the case of agitated depression) can be helpful. Patients in danger of committing suicide are very sensitive to criticism; blaming the client for a suicide attempt does not prevent further attempts and can harm the client-counsellor relationship.

- Client needs support in returning to the usual social surroundings. Plan the necessary steps with them. Work on related fears and help to find ways for them to explain their absence to others, e.g. using role play.

3. Intervention

Overview:

1. Client-centred measures

a) therapeutic dialogues: expression of feelings, experiences, worries
b) planning and supervising behaviour change: stimulating activities and learning, analysing and reorganising "reinforcers"
c) identifying self-destructive cognitions, questioning them and offering alternative cognitions

2. Reactance centred measures

a) informing family members how their reactions can influence depressive behaviour positively and negatively
b) helping relatives to support the client in building up new activities
c) helping relatives to establish boundaries to "depressive infection" while maintaining contact
d) supporting the process of grieving in the family. Suppressed grief freezes depression whereas released grief stimulates other emotions: e.g. anger at "lost objects"
e) work on re-establishing a sense of meaning and purpose in the family after trauma-related change (e.g. loss)

3. Community-centred measures

a) information on the possible connection between loss, trauma and depression

b) organisational help in establishing activity programs
c) workshops on communication
d) encourage resource orientation in the community

These measures should be discussed in the main group. The measures should be illustrated using examples from the participants' experience.

General points should be highlighted and reinforced during the discussion

1. Making use of the healthy aspects of the client's psychology, family and community
2. Identifying, respecting and reinforcing bursts of energy (interests, plans, wishes) conversation and collective activities
3. Using or re-establishing techniques clients used in the past to stabilise and accept themselves, real (restarting favourite habits, religious activities, etc.) and remembered (this is what I have seen, experienced, loved and achieved; this belongs to my life and to my potential)

4. The problem of agitated externalisation

Externalisation is the projection of inner conflicts and problems to the outside. That can happen in a number of ways:

- feelings and motives which one can not see or accept in oneself ascribed to others;
- other people are drawn into an interpersonal conflict around the clients (e.g. arguments about incorrect treatments or negative attitude);
- external circumstances are taken to be exclusively responsible for one's own feelings and problems.

This last version is especially often adopted by exiles or refugees with depressive general mood. These clients put their helpers and counsellors under very strong pressure to solve these external problems for them. They are often incapable of seeing their feelings as the result of psychological trauma, instead ascribing them to present living circumstances, which are often indeed very difficult.

This can bring clients some relief, because:

a) they are not responsible for these external circumstances and therefore not for the feelings and problems which they believe are merely consequences;
b) this model gives them a plausible explanation for their problems – psychological explanations seem suspect or are interpreted as implying culpable personal weakness;
c) they can act out against care personnel part of the aggression they deny having. This aggression may be a small step to rebuilding their self respect.
   - They can use their emotions to put themselves under pressure which in turn puts pressure on care personnel to try yet harder to solve their problems.

- They can perpetuate their self-destructive defence mechanisms (dissociation, blaming, playing the role of victim without feeling responsible for it)

d) devaluating the carer who is seen as being unable or unwilling to change anything or help.

Intervention
Counsellors are faced with a kind of balancing act: on the one hand they have to listen to the clients, win their trust and try to understand them. And the living conditions are after all often extremely difficult.
On the other hand they have to maintain the boundaries dictated by their role. Helping people to help themselves, improving clients' consciousness of themselves and highlighting how clients hang internal problems on external "hooks".

Many carers tend to fall to one side or the other during this balancing act, at least for a time. They end up moving the clients furniture or running errands for them. Or on the other hand they cut themselves off too much from their clients' everyday problems. This is normal and always happens as part of gaining professional experience. Supervision is very important here.

Subgroups should be formed to discuss this point.

H. Acute and chronic psychoses

1. Manifestation

The first thing one tends to notice about people with acute psychotic symptoms is a sudden change in their social behaviour. For example they tap on the floor or the walls without any apparent reason. They hide, cover their faces or shout the names of people who are not present. Or they become too quiet and do not answer questions, threaten to injure themselves or others, and are then overcome by fits of crying or start criticising themselves out loud. Sometimes they lose their orientation, forget who they are or what day or time it is. Sometimes they speak nonsense or give answers which do not seem to relate to the questions. Usually they are brought by worried relatives who are afraid the client could hurt him or herself or others.

Maingroup:
Discussion on how acute and chronic psychotic states are manifested and their connection to traumatic experiences.

2. Short version of the diagnostic criteria for psychosis based on ICD 10

The detailed diagnostic groups will not be discussed exhaustively. Those who wish to do so are referred to DSM-IV or ICD-10.

For our purposes it is important to distinguish between:
1. acute, episodic courses of illness, with acute stress
2. chronic disorders.

On point one: the acute beginning of a psychotic episode is defined as a fairly sudden change from a state without psychotic symptoms to a clearly psychotic state within two weeks or less.

Defining features of such an episode are:
a) rapidly changing manifestation ("polymorph acute psychotic states")
b) the presence of typical schizophrenic symptoms.

Acute stressors should also be noted as far as possible. Clients often recover completely after only a few days or weeks, less often after several months.

Diagnostic guidelines for acute psychotic episodes are as follows:
1. the beginning must be acute
2. several different hallucinations or delusions which change their nature and severity from day to day or during a single day
3. fluctuating affective states
4. symptoms are insufficiently consistent for the diagnosis "schizophrenia" or "manic or depressive episode".

On point two: Chronic psychotic (schizophrenic) symptoms which often appear together:
1. audition of thoughts, the feeling that one's thoughts are being implanted and/or extracted by others
2. delusions of being controlled or influenced; the feeling that one's own perceptions or thoughts are controlled by somebody else
3. voices commenting on or conversing about the client and his or her behaviour
4. persistent culturally inappropriate or completely unrealistic illusions (religious or political personalities are attributed with having special powers or skills)
5. persistent hallucinations of any of the sense modalities
6. monologues, neologisms, speech too fast or too slow
7. catatonic symptoms, overexcitement, stereotypic postures, waxy flexibility, bizarre movements, negativism, mutism, stupor
8. "negative" symptoms such as: excessive apathy, verbal poverty, shallow or inadequate affect, social isolation, social inadequacy
9. clear and universal transformation of particular wide areas of behaviour: aimlessness, weariness, helplessness, social isolation, excessive fear of contact.

In combination with paranoid features:

1. delusions of persecution, reference, descent, etc.
2. voices which threaten the clients or give orders, non-verbal acoustic hallucinations (coded knocking, whistling, etc.)
3. olfactory and gustatory hallucinations.

a) Treatment of acute cases

- A medical investigation should be carried out where possible to establish if there are organic causes. Could the symptoms be the consequences of another illness, e.g. head injuries, poisoning, acute infections, withdrawal from alcohol, etc?
- Or are the symptoms a reaction to a traumatic event and have no direct physical cause?
- Distinguish " clients with acute loss of control" or " from confused clients" who have lost their orientation with respect to space, time and their own person.
- Intervention: clients should be brought into an environment which is quiet and where they do not feel observed or threatened.
- They should not be brought together with people whom they could injure. Care personnel should be calm, polite, supportive and clear in their relations with clients.
- Patients having a fit should be removed from their surroundings (and thus from the attention of others). It is important to ensure that they will not endanger themselves or others. They should not be left alone however. It is important with such clients to cooperate with a competent doctor since they usually need psychiatric drugs. Medical treatments of particularly agitated clients usually includes haloperidol or chlorpromazine as well as medication to reduce side effects (rigor, restlessness, rotation of the eyeball)

b) Treatments of chronic cases

- The treatments of not only acute but also of chronic psychotic clients should involve co-operation with a doctor. He or she is responsible for dosing the medication and will also decide if the psychosis is the result of a physical illness or belongs to the mood disorders (this has consequences for medication).
- Diagnostic interview: the participants should practice obtaining the following information on the basis of questionnaires:
- Which symptoms are involved and since when?
- Have there been fluctuations or deteriorations?
- Previous treatments or hospitalisation due to these or similar symptoms.
- How was the client treated?
- Is the client a danger to him or herself or others. For example, if the client hears voices the following questions should be asked: "Do your voices tell you should kill or hurt yourself or others?" "Do you have to follow these orders?" Under what conditions does the client improve and can these conditions be established here and now? If so, do they then lead to an improvement?

- Such clients must be kept under observation until it is sure that they do not present a threat to themselves or others. Medication compliance can also be better controlled under observation (depot injections!!! can also be helpful here)
- Establishing a basis of trust with the client: frequent short contacts are easier for both parties. Once this is been achieved, it should be established together with the client which situations or people help him or her to feel better and which do not. Abuse of alcohol and or drugs leads deterioration.
- Patients should become involved in daily routines and regular activities which they are able and willing to carry out.
- Family counselling: family sessions should be practised in which the relatives are informed that the client is ill and that the symptoms are the expression of that illness. What help can be given in dealing such clients – e.g. how can relatives make caring for the client easier for each other. In particular, relatives will be able to report if the client's state deteriorates.

Subgroups. Self exploration.
Psychotic symptoms can frighten relatives and professional carers so much that they are incapable of dealing with the clients adequately. Putting oneself in the shoes of a client with psychotic symptoms can help to defuse these fears. This can be attempted in role play in the subgroups by imitating psychotic language or behaviour. Participants should pay attention to what it feels like and whether there is any gratification in giving in to the psychotic symptoms. The participants should be encouraged to try this difficult exercise and to explore this side of life.

Main group. Discussion and sharing.

This exercise should be followed by
a) feedback on the experiences the participants had
b) an exchange of memories of psychotic or quasi psychotic experiences which the participants have had in the past
c) work on any emotional reactions to the exercise in the form of a low structured experiential group.

3. Quasi-psychotic states following trauma

Information:
Victims of torture and other trauma at the hands of others may sometimes develop quasi-psychotic states. They often have disturbed sleep, nightmares, are easily startled (e.g. by sudden noises) and they feel constantly sad and hopeless. In these stages they are afraid

of being left alone and feel threatened by others. They often have flashbacks while asleep or awake in which they relive terrible events. This leads gradually to exhaustion. They are afraid of being hurt again. The most decisive factor is a perpetual state of exhaustion. Constantly reoccurring memories which appear especially when the clients attempt to relax make life extremely difficult.

Subgroups interview techniques.
Role-play followed by discussion of problems arising in the main group.

Direct questions
- "Have you been tortured or injured? Could you say how often and how long for?"
- "Did you have to watch while others, especially relatives were raped, injured or killed?"
- " Were you fired on or threatened?" rather than general formulations such as "Were you a victim of trauma?"
- How often did the symptoms appear and how much do they influence life at home, at work, etc.? To what extent does the client suffer from reoccurring memories (e.g. sleep disorders)?
- Identify all factors affecting the symptoms: triggers, "reducers", reinforcers, client's attempts to take control, reactions from other people.

a) Intervention
- Improving sleep patterns is an important treatment goal: combination of relaxation techniques, sleeping drugs, possibly combined with rearrangements of sleeping areas and/or changes in the daily routine.
- Providing the client with an explanatory model: these serious symptoms are the side effects and expression of an illness with which the client requires help. Distinguish clients who are helped by talking about the symptoms and the experiences underlying them from those who at first do not want to speak at all. Clients who are still occupied with their symptoms should be supported in this and not forced to explore further. Psychotherapeutic work on the underlying trauma requires time and training: treatment steps involved, helping clients to express the feelings and impulses which could not be expressed at the time ("paralysis") but which can now be remembered, relived and expressed verbally and nonverbally; supportive analysis of how the client managed to survive such an event and of the self and social support systems available, e.g. social support on the part of family members (bringing families together) or fellow-members of a regional or religious group.
- Remind clients that the opportunity to talk is always there but they themselves should decide when the time is right to speak about the trauma.
- Informing the community that the symptoms are the result of an illness, thereby cultivating an atmosphere of tolerance.

Chronic after-effects of trauma.

Information:
Torture and violence can have chronic after-effects. Alongside often substantial bodily injury, possible signs include diffuse headaches, loss of drive and tiredness, problems at work and in social relationships, character changes, irritability and violent outbursts, over-sensitivity and thought, memory and concentration disturbances.

- Diagnosis of victims of violence: the preliminary investigations can involve gathering information from the relevant authorities: Who was beaten, tortured or abused? How long ago? Did the victim lose consciousness and for how long? The danger of chronic damage increases with the time spent unconscious. Ask about other after-effects (chronic temporary paralysis, convulsive fits, visual and auditory malfunction). Work together with doctors on these points. Problems in memorising and concentrating can be identified using questions on everyday life:"Do you often forget tasks? Do you have problems memorising recent events since the trauma? Do you often lose things"? Information on possible character changes: "Have you had the feeling since then that your are someone else? That something strange is happening? How have you changed in your own eyes?" Relatives can also give information here.

Intervention.
- Depressive mood (see above) often worsens the effects of injury. Improving the depressive syndrome usually results in the improvement in the physical consequences of trauma.
- Explain to client and relatives the hypothesised link between the events and the symptoms. Explain the therapeutic program.
- Help the client to cope with everyday problems: planning and structuring the daily routine and involvement in work as far as possible. In the case of memory disturbances a diary or time planner can be used.
- Convulsions, headaches, depressions and outbursts of violence can be alleviated using medicines (co-operation with doctors is necessary here)

A. Drug and alcohol abuse

Information:
Drug and alcohol abuse can lead to serious personal, family, social and health problems. Refugees, often having experienced trauma in the past and faced with an unclear future for themselves and their relatives, without work or permission to work but with a lot of free

time, often use drugs or alcohol for their initially sedative effect in the attempt to escape from real and terrible problems.

This can lead to further health problems, quite apart from cases of accidental overdose which can result in coma or death. A further consequence is that energy is diverted from tackling real problems in the immediate environment and into aquiring and trading drugs. Crime and a deterioration in life circumstances may be the consequence.

It is characteristic of addiction that those affected need to gradually increase the dose to achieve the same effect. Addicts often experience unpleasant withdrawal symptoms after giving up which can lead to relapse. Fear of withdrawal symptoms can also lead addicts to delay treatment. Medical support should be sought in difficult cases.

Parallel preventive measures must be taken to make obtaining and consuming drugs or alcohol more difficult. Exiles and refugees with some hope in the future and who are certain of their ability to contribute to improving their own situation do not normally become interested in substance abuse.

Members of the community should be informed about the potential dangers and invited to cooperate in prevention programs: This can take place through information evenings which can also be used to start tasks groups of lay people. These teams will need regular supervision, e.g. from professional carers.
If this co-operation can be established, advice workers will have information more quickly on who is in danger or already has a drug or alcohol problem. In this way help can be offered more directly.

Those who turn to substance abuse as an escape from the experience of trauma should be brought through care and advice work to see that only they themselves can solve their problems. On drug and alcohol abuse the collective stance must be: stop it before it begins.

Subgroups: experiences with substance abuse. Presentation of case histories.
What are the signs of substance abuse?
What do withdrawal symptoms look like?
What experiences have the participants had with clients who did or who did not manage to break an addiction?
Which behaviour patterns are reinforced by alcohol and drugs?

Main group. Discussion of the results.
Working out intervention plans.

Intervention:

- A useful training exercise which the group participants could carry out at their place of work is to organise task groups whose members would take on caring roles and who would support one another.
- Briefing the task team members: Clarifying who should look after whom, how and how often. Identifying the extent of members' motivation. Who is really prepared to change their behaviour in relation to addiction and who only wants to "talk about it" without being defined as being an addict. Take some of the pressure off the course participants by telling them about the high recidivism rate and about the limits to treatment in this setting and by people not specialised in addiction therapy. In order to maintain their supportive effect, the contact between carer and client should be continued after the end of treatment although with decreasing frequency.
- Other members of the family should be involved.
- Reinforcement for small successes.

These diagnostic dialogues for establishing aims should be practised in role play. It is recommended that the group leader demonstrates a few model dialogues, showing how to be directive without being moralistic. Clients with addictions have a low frustration threshold and so criticism is especially likely to harm the relationship and lead to the therapeutic alliance being broken off prematurely.

B. Working with victims of torture and violence

Information:

Violence and torture of prisoners of war and civilians are sadly everyday occurrences during war and other military activities. The mental and physical consequences are numerous and prolonged:

- reliving the traumatic events again and again in the imagination – with these images come the feelings which the victim actually experienced at that time (pain, mortal fear, humiliation)
- difficulty falling and staying asleep
- nightmares
- eating disorder
- lack of drive, lassitude, markedly reduced performance
- loss of social interests (relatives, sexuality)
- violent outbursts
- lability (e.g. uncontrollable fits of crying without any visible reason)
- nervousness, anxiety

- memory disorders, difficulties in memorising
- avoidance behaviour in situations which are reminiscent of the trauma
- increased susceptibility to illness
- guilt feelings as the ones who "got away"

If there are victims of torture or violence amongst the training group members, they should receive emotional support and help in coping with their problem and or be encouraged to obtain this for themselves. Empathy and support in expressing emotion facilitates the counselling of victims of violence. So the opportunity can arise in the group to demonstrate therapeutic work with traumatic experiences. Consciousness-raising on how one is oneself affected and the consequences of this (e.g. here in dealing with other victims) are both very important. Trainees can make use of the opportunity to share their terrible experiences and the feelings accompanying them and in this way to distance themselves from them.

1. Typical post traumatic experiences of tortured people

Survivors are often later surprised how well they functioned during the terror. The shock usually comes later with all its mental and physical features: fear and panic, arousal, anger and grief. Survivors who are able to turn to someone they can trust recover better.

Nevertheless trauma changes people. Often they are not as open and attentive as previously, becoming shy of contact, touchy and irritable. Sometimes they seem hypnotised - and perhaps to some extent they are. Torture makes people extremely susceptible to personality change through suggestions about themselves and others.

Guilt feelings arise frequently. Victims of torture feel guilty for having survived, for the death of companions or family members, for being a victim of torture. They start to feel guilty for things which the torturers accused them of, as their ego boundaries slowly dissolve and they identify step by step with their aggressors. For these reasons they feel themselves to be traitors although they were powerless to defend themselves.

The terrible experiences force themselves repeatedly into the victims consciousness even though the victims do not want to remember or be reminded. Still these images break through, violently taking control of consciousness and feelings, as if the terror were starting all over again. Sometimes the victims succeed in blocking out the memory for a while only to find that they pour in again all at once as if the victims were completely at the mercy of this storm.

The goal of counselling is together with the clients to develop aids to regain more control over the process of remembering. Carefully dosed and controlled recall and working through of feelings without falling prey to them or having to suppress them completely.

Counselling and group meetings gradually help to process these experiences so that those psychological wounds which do remain can be reduced as much as possible. It is important always to remember that these wounds are normal in the face of such terror. It is not mad to have intense anxiety attacks or recurrent, almost compulsive nightmares. Everyone exposed to torture or terror has problems of this kind.

It helps to share these states and experiences in a protective environment like that of a group. This brings a feeling of relief. Although the terrible thoughts and images reccur they gradually lose their intensity. They become easier to control and less frequent, and in the intervening periods mood improves, clients can enjoy themselves more and take more interest in the process of reconstruction.

In the actual work with torture victims a decision between individual or group work has to be made. For example a client may have an important position in the community and would not open up in a group; or a client may be too reserved or too badly hurt.

2. Groupwork

Subgroups.

Practising strategies for working through and coping with trauma due to torture and violence. The most important factors here are

1. a safe, accepting group atmosphere
2. relaxation and systematic desensitisation
3. confrontation – in the imagination and possibly in reality
4. work on emotion: perception and expression of feeling
5. closing off unfinished traumatic relationships (e.g. to the torturers) in dialogue
6. cognitive integration of the circumstances of torture
7. highlighting and making use of existing psychological and social resources
8. relapse prevention
9. Planning the transfer of therapy experience to everyday life (including self help models).

On point 1.

Building up relationships of mutual trust.

Victims of torture have experienced violence at the hands of human beings and this now influences their relationships to other people. The participants learn through role play how to give space to their clients in a patient and respectful way and to respect mistrust and resentment. They can help their partner elaborate the story and invite them to open up further where appropriate by using simple questions.

On point 2.
Training of relaxation techniques.
Relaxation has already been dealt with in this course. Systematically involving images from the trauma reduces fear and stress reactions automatically, giving more freedom in consciousness and action.

On point 3.
Assistance in overcoming avoidance behaviour.
Following trauma through violence, particular situations, objects, or people in general are often avoided because they remind the victims of the traumatic situation and bring back the corresponding feelings. The tight connection between stimulus and reaction can be broken using e.g. systematic confrontation. (Establishing a hierarchy of stressful situations followed by confrontation, in connection with relaxation exercises.)

On point 4.
Support in expressing emotion.
This is a further contribution to closing unfinished "Gestalts" which inevitably appear on the level of social relations following torture and which are psychologically very stressful. Here it is important to establish precisely in interview what actually happened and how the victim responded to the individual attacks (which are still capable of arousing fear on the emotional, behavioural, cognitive and physical plains). Essential factors are time and an atmosphere of trust and safety and the knowledge that information revealed is not passed on (see above). Fully expressed feelings bring the satisfaction of having completed a task. Something which had been bottled up for a long time, costing energy, has gone. A hierarchy of stressful situations is worked through; the feared image is made conscious while maintaining relaxation.

On point 5.
Dialogue.
Finishing of unfinished emotional business with the aggressor in role play is an essential goal of coping with trauma. Recurrent images, feelings and symptoms as a result of trauma at the hands of others (torture, rape, violence) are an indication that essential aspects of the trauma have not been fully processed, that the victims have not finished with them. Unfinished thoughts and feelings tend to force their way back into consciousness, demanding attention. So what techniques can be used for working through unfinished business? There are a number of methods; the choice depends on clients' wishes and on the phase the clients have reached in working through their trauma:

a) dialogue with the empty chair
b) provocation and expression of anger at the aggressor(s) combined with physically attacking a mat, etc. (beating, kicking, throttling)

c) role-played condemnation of the aggressor(s) and also of those who should have protected the victims but who were unable or powerless to do so
d) the expression of grief that this intrusion occurred in the victims lives and is now an indelible part of the biography.

On point 6.
Cognitive and experiential integration of the traumatic experience.
Understanding the processes which led to the trauma helps clients to see it as a tragic political development which took place independently of them. The experience of torture should therefore not be understood as a devaluation of the individual even though the torturers' aims were in this direction: destructive suggestion during this state of extreme defencelessness, destruction of ego boundaries, forcible transfer of the aggressors' value systems, identification with the torturer and development of self-hate directed at the pretrauma personality. Discussions on the political background and on the processes which the torturers themselves were subjected to facilitate cognitive integration. Warning: identification in dialogue – taking the aggressor's position in role play is a very powerful therapeutic instrument. It is not yet certain how useful this is for victims of torture and violence. It may be helpful in particular phases but it should not be used when there is a danger of relapse into identification with the aggressor.

On point 7.
Using existing resources (e.g. perception)
Especially when working on the past one should not forget the present: re-evaluating it and improving perception of it. Encourage clients to look again and again at their actual surroundings to notice and appreciate sense impressions. That flower, the sky, the grass, the air, the earth and the water and person opposite: these are all there. By observing and appreciating the present surroundings of everyday life in a meditative way help your clients to do the same. The power that past events have is partly the power we give them by letting them dominate our consciousness. Teach your clients, even if they find it difficult to accept, that life goes on even after the trauma and that joy and vitality need not necessarily be regained by fulfilling mighty dreams but also by respecting the details of life around one, metaphorically and literally speaking appreciating the "flower at the edge of the path".

On point 8.
Dealing with relapses and setbacks
Clients should realise that the terrible memories may come again later. Make it clear to them that they have acquired skills to cope with such moments (perception, distinguishing the past from the present, relaxation techniques).

C. Help for rape victims and their relatives

Main group: exploration of the subject.
In the framework of an experiential group the participants share how they have been affected directly or indirectly by rape.
Pay attention here to
- any change in the group atmosphere
- any change in the participants' readiness to take risks - any tendency to avoid particular aspects of the subject - any fractionation in expression
- intense emotion amongst the participants.

Give your observations to the participants as feedback and proceed to work on the aspects which participants now find particularly relevant.

Subgroups. Facts and fiction on rape and coping with it.
The participants gather information, opinions and experience from their own lives and make one list of facts accompanied by another list of fictions. These lists are the brought back to the main group and discussed once more. In order to separate fact and fiction it is important to distinguish genuine observations from reports and mere rumour. It is important to give the participants immediate feedback on the forms of emotional defence against the impact of this topic arising in a way which shows respect for these kinds of defence. In this way the group should be a model for work with rape victims. Intimate injury is only to be discussed with the greatest care and consideration. Pressure for self disclosure or group pressure to take particular standpoints should in no circumstances be supported.

1. Information
Information on rape for work in the main group.

Rape and other forms of sexual violence are serious crimes against the victims' human rights.

They are forms not only of sexual but also of psychological abuse. They serve to give the aggressor a feeling of power and superiority over the victims on whom hate originating elsewhere is acted out. Rape and sexual violence are directed above all at women and girls, but rape of men and boys also occurs. The latter seems to be even more strictly taboo than rape of female victims.

Rape and sexual violence can occur at any stage of the process of fleeing from war or repression; at home, in the intermediate camps but also in camps in the country in which the refugees finally end up. The rapists can be found on all sides of the conflict and often also

amongst the "protectors". Sometimes the tolerance of rape is the prize for assistance rendered such as transit permission, food or accommodation.

A negative reaction on the part of relatives to a case of rape reinforces the destructive effect of this crime against human rights and dignity. The same applies to belittling, appeasing or mistrustful behaviour from officials (police, doctors, etc.) Victims of rape usually try to hide the fact. Indication of traumatisation through rape is given by the following signs.
- PTSD symptoms in combination with hints from the family.
- Indications of physical violence.
- Denigratory gossip on the part of other camp members ("she provoked it, she deserved it, was otherwise so prude, did it for favours, prostitutes herself, etc.")
- When a woman or girl is screened from contact with others in an unusual way.

Faced with these signs it is necessary
a) to make contact with the family and other important people in the community
b) discretely and indirectly to offer the victim herself the opportunity to talk about a trauma of this kind
c) to conduct the conversations in a safe environment where possible, so that others do not even know they are taking place
d) to find out from other information sources the background of these events e.g. flight, invasion, etc. in connection with which rape could have taken place.

A basic principle is to find out the victims preparedness to talk about the events and to respect refusals. Typical somatic and emotional reactions to rape are basically the same as to post traumatic reactions in general, however there are some aspects which are especially prominent:
- the feeling of being dirty often combined with the intense desire to clean oneself
- guilt feelings about the scandal brought upon the victims themselves and their families
- fear of strangers
- feelings of the deepest humiliation
- a strong tendency to be isolated from the community and the family.

From the spectrum of symptoms typical of other traumatisations the following are particularly prominent:
- compulsive brooding over the tragedy.
- resignation, helplessness and fear of the future.
- fear of change (changing accommodation, travel)
- disturbed sleep with nightmares.
- anger
- avoidance of food or loss of appetite and possibly the developments of anorectic symptoms

2. The meaning of the rapist – victim relationship

Crimes between people who know each other well are often committed particularly violently. The psychological consequences for the affected women are therefore very serious and remain longer acute. Private spheres of safety are infringed upon. The violence was committed by people the victims relied upon for support and protection, and what is more these are people whom the victims can not easily avoid in everyday life.

Fear of reactions from the social environments including public opinion, police and the law makes the victims particularly reluctant to prosecute the aggressor or aggressors openly. This second stigmatisation is a great hindrance to rehabilitation since it is constantly present.

There are a great many myths about rape which abandon the victims to their fate. The sexually abused woman is made to seem guilty or the subject of rape becomes used as propaganda to national or personal ends. Common sayings have a similar effect. Such as "it always takes two" or "women need it and like it anyway". At the very least the women are accused of provoking the attack, of not having defended themselves adequately, being too careless, or inventing the whole incident.

This stigmatises the victims and obscures the violence of the act. The aggressor is judged lightly since "he couldn't help it". The victims in fact feel guilty as with all trauma. This is the consequence of an internalised accusation and the psychological mechanism "identification with the aggressor". The traumatic event and the enormous difference in power lead to a strong tendency to regress, with features of a return to infant states. The wish to become one with object as the baby experienced its dependent relationship to the mother can arise as a consequence. The victim's minimal identity is strengthened by the borrowed identity of the powerful aggressor used for this ego-merging. This process of delegating important ego functions to the aggressor lays the basis for passivity and the feeling of shared guilt. This leads to the attempt to protect the aggressor. This process which was a survival tactic at the time of the trauma leads later to a confused ego identity which hinders rehabilitation.

3. Groupwork

Subgroups. What do rape survivors need?

Material and ideas from the participants and experience with survivors of sexual violence is shared and systematised with the aid of the information given here. The results are brought back to the main group and summarised.

Information:

- Confidentiality has top priority. It must characterise not only the interviews but also the setting: the centre or the counselling sessions must not be given names referring to rape

or sexual violence. The counselling sessions should not be publicised by word of mouth; care personnel should not say to others things like "that's understandable, she was so badly abused", etc. The same holds for written notes which should not use names.
- Resistance to opening up in interview should be respected.
- Counsellors should be accepting, empathetic, warm, supportive and understanding. Formal questioning and authoritarian distanced interviewing should be avoided.
- It should be made clear to the clients that the counsellor will listen whenever the client is ready to speak. Clients must not be hurried.
- When emotions arise in counselling contact they should be accepted and their expression encouraged, not avoided, criticised or denied.
- Discussion and activity groups should be established to counteract social isolation. Groups need guidance on emotional support, structure and safety.
- Agreement should be reach on further counselling. The subject should be kept open. The clients' experiences of the rape should not be worked through until the client is ready to do so:
- supporting the expression of anger at the aggressor
- dialogue exercises
- confrontation with the aggressor in the imagination.

Following rape there is a tension deep in the body which often persists for a long time not only blocking sexuality but also diminishing vitality in general. Clients do not usually want to work on content, feelings or physical tension. Basic non-specific body work often changes this: opening up the breath, standing stress positions (the bioenergetic grounding position) kicking and beating cushions, shouting, etc. The subject for the session should always come from the client. Even when "breakthroughs" are reached by pushing the client, she may then not want to work further on this theme due to shame and fear of repeating these outbursts of feeling; or she breaks off the work completely. So don't push.

Important points for working through rape trauma:
- Take plenty of time during sessions to deal with these issues.
- Ask the client to describe the event exactly as if it were happening now: "I hear steps behind me …, someone grabs my arm, … pulls me by the hair …"
- Catharsis is really essential here: anger, fear, rage, shock, pain, etc. should be expressed as fully as possible.
- How does the social environment react ? How did the parents, husband, police, friends, etc. respond? It may be necessary to invite the family to counselling sessions. The social environment usually distances itself from the rape of a woman, does not understand and adds to the woman's injury through inappropriate comments. The counsellor should ask what support the client would have wished and what support she received.

- Imagination exercises in which relatives, etc. show the desired acceptance of what had happened. Grief that this was in fact not possible should be accepted. At least the image of how it could have been ideally can be created.
- Anger may also be expressed at those who let the rape happen through passivity cowardice or inability even when they did not approve of it.
- Particularly difficult: are there also positive feelings for the rapist ? Is it possible to accept this without diminishing the magnitude of the crime?
- It should be made clear to the victim that she is not to blame for the rape. Cognitive integration of the events as consequence of religious, cultural, imperialist or simply chauvinistic warfare.
- Clients' attempts to blame themselves should be questioned: these events are not the "wages of sin" for previously committed misdemeanours even when such thinking is understandable in a traumatised state. It is an attempt in the midst of the experience of helplessness and powerlessness to gain a measure of control over otherwise incomprehensible events.

D. Non-specific skills in psychosocial trauma rehabilitation

Counsellors working on the rehabilitation of psychological trauma injury are faced with a range of extreme adaptation tasks which can not be predicted in individual cases. However it is possible, alongside skills necessary for work with specific trauma, to set out a list of skills useful in almost all situations and which help to avoid mistakes, failures and unnecessary disappointments for clients and counsellors alike. These non-specific skills are not explicitly trained in this seminar although they do appear at a number of points. The group leader decides the structure and timing of the seminar.

Here follows an overview of the different types of non-specific skills.

1. Counselling skills: empathy, reinforcement, information
2. The art of respecting boundaries while maintaining contact
3. Finding the balance between practical help and psychological support
4. Thorough knowledge of the organisation of local medical and social care and of legal issues
5. Awareness
6. Work on suppressed feelings and their expression together with finishing off recurrent unfinished experiential, behavioural and interactional patterns
7. Mental hygiene for carers: working through and letting go of the suffering of others who can at best only be inadequately helped; self-help for the carers should be organised.

1. Counselling skills

1. Paraphrasing: repeating and summarising what the client has said in one to two sentences. The client gets the feedback that they have been understood and can correct if necessary.

Dialogue speed is reduced. Meanings and dialogue become more intense and the exploration becomes more precise.

Exercises

a) summarising what has been said at frequent intervals
b) summarising the content with stress on mentioned and therefore conscious feelings
c) summarising content, highlighting feelings not yet mentioned by the client and which are difficult for the counsellor to infer.

2. Repeating the last sentence or word

3. Conveying understanding: "I understand, it's similar for me, I feel the same in that situation"

4. Communicating empathy verbally and nonverbally

5. Questioning contents, concepts and convictions expressed by the client while maintaining empathy (empathic challenging). The aim is to learn to highlight contradictions and inaccuracies while maintaining contact. This should improve reality testing while reducing selective perception and the necessity to split off individual aspects of experience. The suspect concept e.g. an overgeneralization or an introjection must be identified in order to modify it in a subsequent phase.

2. The art of respecting boundaries while maintaining contact

Establishing boundaries is generally seen as being unfriendly and is often understood as a sign of unwillingness to help or interpersonal coldness. It is however essential to survival when working with severe traumatisation. Counsellors incapable of separating themselves from the tragedy of their clients will adopt the trauma themselves through the very attempt to be helpful, friendly and open.

Respecting boundaries while maintaining contact means that one sense of one's own self, of one's wishes, feelings, thoughts and perceptions is maintained while simultaneously attempting to understand the other person. Understanding the other person means putting oneself in their place and understanding their motives without "becoming" them.

People who find this difficult tend to fluctuate between two extremes. They either withdraw completely from contact or they dissolve literally into the other person and two people become one. The isolation in the first case is due to the fact that there is no real contact or exchange between the counsellor's self and the client's self, as if the two people were two disconnected spheres floating separately in space. Thus it is possible to be physically very close without really encountering one another. The client usually notices this subconsciously and is full of despair without knowing why.

The second case of bad contact, confluence means complete accordance between two beings without any ego-boundaries between them. One person determines how the world is and the other agrees. The stronger the pressure to which people are subjected the more they try to draw other people into confluence with them. This infectious spreading seems to promise salvation from loneliness and powerlessness. In a certain sense, confluence is an attempt to regress from a higher psychological developmental level to a lower one; the primitive desire to become one with the object is activated in order to get rid of the burden of trauma.

3. Balancing practical help and psychological support

This point is an application of point 2.

Allowing oneself to become confluent means having to work for the other person i.e. solving their practical problems as well. This is common in the caring professions even though this is not their actual task. Psychological support is aimed at helping people to help themselves, to accept themselves, to be aware of themselves and to know themselves.

Giving psychological help means recognising and accepting the client's problem rather than trying to solve it immediately. It means asking how the client has already tried to solve the problem and how successful this was. It means questioning the clients conviction that they will always fail and it is not worth trying. It means counsellors making their own limitations, capabilities and tasks clear to their clients even when this means disappointing their expectations.

The ability to correct clients' false or overoptimistic expectations of care personnel clears the air and enables genuine work with the clients' motivation. Some clients have slipped so far into the role of victim that this task seems too dangerous or arduous. In these cases it is advisable to work on these expectations and to spell out the boundaries and limitations again and again. Otherwise psychosocial helpers end up doing their clients' donkey work. They are left with no energy to do their own tasks.

However, especially with severely traumatised people there are phases in which practical problems are really too much for them and they need practical help. This help can often open the door to working on emotional problems. Moreover many people in severe trouble do not understand this distinction between practical and psychological help and retreat in resignation.

Nevertheless it is more use to them in the long term to show them how they can help themselves – one step at a time of course.

Psychological care personnel becoming swamped by their clients' practical matters is too high a price to pay at least in the long term and loses them for the task for which they are actually trained.

4. Knowledge of organisational structures

The problems mentioned under point 2 and 3 are easier to cope with when counsellors are

well informed about the whole system of available care. They can then refer clients to the individual organisations when practical problems arise. In addition it is advisable to hold regular information sessions in camp during which the relevant people and organisations are introduced, together with their areas of responsibility.

5. Awareness

1. The unstructured awareness continuum. Pair exercise: one person reports what they are experiencing now … and now … and now. There follows a short discussion and then the roles change
2. Three levels of awareness: inner perception, outer perception, cognitions.

Exercise on "emotional awareness":
The eyes are closed and the attention is turned to inner perception (posture, tension, digestive tracts and organs, breathing rhythm, contact with the ground), then needs (hunger, thirst, sex, intimacy, movement) then feelings (joy, fear, grief, anger, love, hate, shame, etc.).
Then with the eyes closed the attention is turned to outer awareness: smell, taste, hearing and touch and finally, with the eyes open, seeing "like a baby" (without a concept of foreground and background). Cognitions: judging, thinking, imagining, planning, expecting, believing, classifying, etc. Pair exercise: describing the here and now according to the three levels of awareness.

6. Working with suppressed feelings and dealing with unfinished business

1. Symbolising and helping with the expression of diffuse physical and emotional reactions:
   - becoming aware of diffused reactions and amplifying them: "Where is this feeling located in your body? Let your breath flow in that direction, increase the feeling"
   - finding and experimenting with ways to express these feelings: "take on the posture that fits the feeling", "make a gesture that fits", "make a sound, say a word", "increase the expression of this feeling", "direct the expression to the person who is really meant"
   - experiment with exaggerating gestures, etc. and with "significant statements": "say it louder, again, more of the same"
   - symbolising: "Do you feel like some living creature? Which one? Like a plant …?" etc.
2. Do not encourage talking *about* feelings and intervene to stop this where necessary. Instead move straight to the perception and expression of feeling.
3. Work on polarities. Simultaneous feelings can block each other. Polarities in feeling, posture, etc. should be identified and brought to expression one after the other. Reintegrate poles which had been disowned.

7. Mental hygiene for helpers

UNICEF has developed a very good compilation on this topic, centred on burnout symptoms

arising in work with children, written by ATLE DYREGROV and with the title "Helping the helper". This overview can be applied, without any major changes, to work with all traumatised people.

It is recommended as a basis for work in a training seminar. The points covered – stress factors, stress reactions, prevention and intervention should be explored experientially. This should start with a discussion in the main group during which the participants discuss their burnout symptoms and explore the individual factors affecting this form of exhaustion. The measures on prevention and coping with burnout symptoms should then be gone through and rehearsed in the subgroups.

In both the subgroups and the main group the work with suppressed feelings should be emphasised; they may be a reaction by carers to their own failures or to their shared experience of trauma in others. Especially in professional groups with a job hierarchy and a social network it is difficult to express personal experiences and feelings. This resistance, however understandable, should by all means become the subject of discussion and the barriers to free interpersonal communication should be removed.

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Why do people in Bosnia-Herzegovina go into treatment? The role of Posttraumatic Stress Disorder in psychotherapy service utilization

ABSTRACT

The central research question in this paper is to estimate the connection between current prevalence of Posttraumatic Stress Disorder (PTSD) and psychotherapy service utilization in two study samples in Sarajevo, Bosnia-Herzegovina in 1998, three years after the end of the war. 212 people surviving the siege of Sarajevo were assessed with the Posttraumatic Diagnostic Scale (PDS), the Coping Inventory of Stressful Situations and an extensive demographic questionnaire. The study groups consisted of a randomly selected residents' sample (N=98) and a group of individuals in psychological treatment (N= 114). Subjects in treatment suffered from more PTSD symptoms than subjects in the randomly selected sample of residents. Service utilization was predicted by task-oriented coping style and employment status.

The connection between PTSD symptoms and treatment utilization has been discussed from two different standpoints – on the one hand PTSD is considered to be particularly prevalent in treatment populations, albeit often not diagnosed as such; on the other hand other studies demonstrate that large percentages of people with PTSD do not receive any treatment at all. For example, a lifetime PTSD prevalence of 28 % was found in a sample of psychiatry inpatients largely suffering from affective or anxiety disorders in a psychiatric clinic (McFarlane, Bookless, & Air, 2001). Switzer, Dew, Thompson, Goycoolea, Derricott, and Mullins (1999), who investigated 181 patients in an outpatient psychiatric clinic found even higher prevalences: 94 % reported at least one traumatic event, and 42 % had PTSD during the preceding year.

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Yet only three of these patients received a PTSD diagnosis in the course of the standard clinic diagnostic procedures; instead, substance abuse and depression were more often diagnosed. Moreover the patients with PTSD reported more use of psychological and psychiatric services and were less satisfied with these services than patients without PTSD. Davidson and Smith (1990), who investigated a sample of newly referred outpatient psychiatric patients, reached a similar conclusion: 82 % of them had experienced at least one traumatic event in their lifetimes. With 31 % there were signs of previous or current PTSD. Yet not one of these patients was referred for PTSD, i.e. PTSD symptoms were not specified as reason for referral either by the patient or the referring institution. A further study with psychiatric patients conducted by Mueser, Goodman, Trumbetta, Rosenberg, Osher, Vidaver, Auciello, and Foy, (1998) found that 43 % of the patients with a psychiatric diagnosis also suffered from PTSD, but that only 2 % of them had a PTSD diagnosis in their treatment records.

The other group of contributions to this discussion attempts to assess how many patients with a full PTSD enter treatment. The authors of the National Vietnam Veterans Readjustment Study (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1990) reported that 86 % of the Vietnam Veterans exposed to a high level of war zone stress were – more than 15 years after the end of the war – not receiving any psychological or psychiatric treatment and 59 % had never applied for any services. Kahana, Harell, and Kahana (1988) found that, although 92 % of Holocaust survivors reported that the Holocaust negatively affected their health, 77 % never received psychological help. Bramsen, and van der Ploeg (1999) investigated a large sample of World War II survivors 47 years after its end. 22% of those contacted had entered treatment (mostly with general practice doctors) for what they considered to be problems caused by the war. PTSD symptomatology differed most strongly between those entering and not entering treatment. In a logistic regression, treatment was predicted by level of education, stressor intensity, depression, intrusion symptoms and divorce. Overall, treatment status was correctly predicted in 89% of cases. However this study suffers both from oversampling those who had experienced more traumatic events and from the long time which elapsed between exposure and investigation.

However one explanation for the low percentages entering treatment amongst Second World War soldiers and Holocaust survivors could be the minimal availability of psychological or psychiatric help as well as the negative image of psychotherapy in the case of these earlier cohorts. Correspondingly one would expect increasing rates of treatment utilization in younger cohorts. In the case of Bosnia and Herzegovina before the war, psychotherapy was a rarity and PTSD as a diagnosis was largely unknown even to psychologists and psychiatrists (Koic, Delalle-Zebic, & Bosnic, 1992). Largely due to a particular emphasis on psychological models in the work of international relief organisations during and after the war in Bosnia and Herzegovina, the concept of PTSD was adopted very quickly there (Powell, in press). For example, radio programs on the topic were transmitted regularly over a long period of time and knowledge about reactions to traumatic events has become everyday knowledge in Sarajevo.

Based on these results, the following two questions arise.:
• How many people suffer from PTSD in treated and untreated samples?
• Which factors predict utilization of psychological services?

Method

Samples

The following analyses are based on two samples collected between February and June 1998 in Sarajevo, Bosnia-Herzegovina, as part of a larger study (for further details see Rosner, Powell, & Butollo, in press). The two samples were each stratified by gender and age, as it was assumed that these variables are correlates of PTSD and service utilization (Schepank, 1999; Statistisches Bundesamt Wiesbaden, 1998; Referat für Gesundheit und Umwelt der Landeshauptstadt München, 2000). Data from 1990 was used for the stratification, because at the time of the study a detailed demographic description of the population after the war was not available. Other potential correlates such as pre-war socio-economic status were considered to be no longer relevant and were therefore not assessed, with the exception of the number of years of schooling. All subjects participated voluntarily and gave fully informed consent.

In total 212 persons participated in the study. Inclusion criteria for both study samples were a) age between 16 and 65, b) living in Sarajevo between February and June 1998, c) living in Canton Sarajevo during the war (between April 1, 1992 and December 31, 1995), d) not suffering from a psychotic disorder or an acute crisis and e) literate enough to answer the questionnaires with help. Additional criteria were defined for the two samples. The sample in psychological treatment consisted of 114 patients participating in some kind of psychotherapy, or psychiatric treatment, or psychological or psychosocial consultation with at least one session in the last three months. These patients were approached directly through the staff of 10 psychological treatment centers selected to be broadly representative of psychological treatment in Sarajevo. Each participating psychotherapist or counselor was allocated a quota based on the stratification. The seven interviewers approached each new client presenting after the start of the study until their quota was filled.

The sample of residents consisted of 98 non-institutionalized subjects. To approach these individuals a map of the city of Sarajevo was divided into 1 km squares. Two streets from each square were chosen at random. Each pair of interviewers was then given the names of two streets with instructions to find if possible a total of eight subjects from these two streets. The interviewers started at the first apartment in the first building and asked the occupants questions to ascertain their eligibility according to the general inclusion criteria, the sample-specific criteria, and the quotas. Having found suitable subjects in one apartment the interviewers proceeded to the next apartment, interviewing people in a maximum of two apartments per build-

ing. They then left that building and moved to the next one in the street. Each pair had a quota for each cell in the stratification table to fill.

From the households approached, in 24 % there was no reply. From the households where the door opened, in 50 % access was refused. Of the people in the households where entry was gained, 83 % were eligible in terms of the inclusion criteria (i.e. were in Sarajevo during the war). Of these people who were eligible for interview, 35 % decided they did not want to be interviewed or began but did not complete the interview. As it is not known how many people were living in the households where access was refused, a responder rate was estimated by multiplying the percentage of households not refusing access (50 %) by the percentage of people eligible for interview in those households who then finished an interview (65 %), giving a rate of 32 %.

Table 1 provides a description of the demographics for the three samples. Religion as a descriptor is included rather than ethnicity, since religious confession gives a less ambiguous estimation of "ethnicity" in post-war Sarajevo than a direct question about ethnic affiliation. Education was measured as a ordinal variable with three levels (completing basic, secondary or higher education), which is also recoded into approximate number of years of completed education (8, 11.5 and 15 years respectively). Employment status was coded as a three-level ordinal variable.

Interviewers

The interviewers for the psychological treatment sample are described in the section above. For the sample of residents eight pairs of final year and third year students of Psychology at Sarajevo University served as interviewers. All interviewers were trained in the use of the questionnaires. Two pilot studies were performed to insure the appropriate use of the assessment. During the studies constant supervision for all interviewers was provided.

Mode of Administration

Although all applied measures are questionnaires rather than interviews, not all subjects proved literate enough to complete them on their own. Therefore in some cases the interviewers had to read some of the questions to the subjects and sometimes to reread or reformulate the questions.

Assessment of PTSD

For the assessment of current PTSD symptomatology the Posttraumatic Diagnostic Scale (PDS: Foa, Cashman, Jaycox, & Perry, 1997, German version by Steil & Ehlers, in preparation) was applied. The PDS consists of four parts. Part 1 originally has 12 items and asks for possible traumatic events. In part 2 the time of occurrence of the "most upsetting" event, whether the event was life threatening to the persons themselves or to others (A1 criterion of DSM-IV) and whether it was accompanied by feelings of helplessness and intense fear are all evaluated (A2-

criterion). Part 3 asks about the symptoms of re-experiencing (5 items; criterion B), avoidance (3 items, criterion C), numbing (4 items, criterion C) and arousal (5 items, criterion D). Part 4 explores the duration of the disturbance (criterion E) and the consequences of the symptomatology for important areas of functioning (criterion F). Since the original PDS was designed for a civilian population in times of peace we replaced part 1 with a checklist specific to the war situation in Sarajevo (Checklist of War Related Experiences, CWE; Powell, Rosner, Krüssmann, & Butollo, 1998). In an effort to focus memory recall we increased the list of events in part 1 to 72 items. The new items were based either on the items used in a study on children and adolescents (Layne, C.M., Personal communication, November, 1997) and adapted for adults, or on the original items in the PDS, or on our own qualitative interviews performed before we started this study. Some of the items reflect experiences specific to the siege situation in Sarajevo such as the following item "During the war, did you stay in a cellar longer than 3 weeks without a break?" While the first 56 questions describe traumatic and stressful experiences during the war, the last 16 questions deal with other traumatic experiences before or after the war. This additional information allows an assessment to be made of whether the symptomatology is based on a war event or some other event. The amount of trauma exposure not related to the war permits a comparison with the results of other studies which have been carried out in other countries not affected by war. Some other additions to the instrument will not be subject of this article.

Table 1
Demographic description of the two samples

	Random sample (N = 98)	Psycholog. Treatment (N = 114)
Age	39.94	36.39
Sex		
female	51	58
male	47	56
Religion		
Islamic	61	78
Catholic	9	17
Orthodox	8	2
other	20	16
Income (Convertible Marks)	287.90	366.47
Education		
NSS (elementary school)	10	19
SSS (secondary school)	69	55
VSS (further or higher education)	19	40

	Random sample (N = 98)	Psycholog. Treatment (N = 114)
Family status		
Single. divorced. widowed	43	55
in relationship. married	54	58
Number of Children	1.11	.80
Employment		
Unemployed or waiting list	21	6
Other. e.g. student	48	47
Employed	29	61

The scores on the different subsections of the PDS are combined according to DSM-IV criteria in order to arrive at a PTSD diagnosis. The instrument has been shown in previous research to be reliable and valid. Cronbach's alpha for the total symptom score is .92; Alpha coefficients were .78 for re-experiencing, .84 for avoidance and .84 for scales; test-retest reliability of the overall severity score of after three weeks was .83 (Foa et al., 1997). The results based on American samples suggest that the self-report version underestimates PTSD prevalence compared to interview measures (Foa et al., 1993). To obtain a Bosnian version we applied a cyclical procedure of translations, back-translations and field-testing as recommended for the translations of psychological assessment measures (VanDeVijver, & Hambleton, 1996). The Cronbach's alphas for the Bosnian version correspond well with the American version (re-experiencing = .85; avoidance = .82; arousal= .80, total symptom score =.91).

The Coping Inventory of Stressful Situations (CISS; Endler & Parker, 1994) is a self-report paper and pencil measure of coping and consisted originally of 48 items. 16 items assess task-oriented coping, 16 items assess avoidance-oriented coping and 16 items assess emotion-oriented coping. Kälin and Semmer (1996), in their German version of the instrument, divided the content of item 28 ("Wish that I could change what had happened or how I felt"), into two new items. Since this seemed to us to represent a meaningful improvement, we adopted their modification and so the Bosnian version also contains 49 items.

Data Analysis

Chi-square analyses were used to test the differences in the current prevalence of PTSD by sample and sex. A logistic regression was carried out in order to predict service utilization. For all analyses the SPSS software package (Version 10.0.5) was employed.

Additional information about the war situation in Sarajevo between 1992 and 1995

Generally it can be assumed that each theater of war is characterized by a specific pattern of traumatizing events embedded in a specific cultural situation. The description of the number and type of events experienced allows a description of the war environment for the population. Sarajevo was besieged between 1992 and 1995 by Bosnian Serb forces which occupied the surrounding hills, shooting and shelling down at the city from their higher positions. For most of the war it was virtually impossible for civilians to leave the city. The center of the city was less affected than the periphery by direct combat but was highly exposed to sniper and shellfire. Many civilians took refuge in cellars, some remaining for weeks without returning to the surface. Other citizens were forced to leave the part of the town where they had been living and had to take refuge elsewhere in the town. Some food was provided by the UN and other organizations, but securing food was often very dangerous as this involved exposure to enemy fire while waiting at or reaching collection points. The situation with water supplies was similar. For most of the time there was no electricity and no heating of kind. Nevertheless the majority of the population tried to continue with as close an approximation to normal life as was possible in the circumstances and continued to report for work and school. The city was ethnically mixed before the war, with Bosnjaks constituting the largest group (International Federation of Red Cross and Red Crescent Societies, 1998). However by 1998 the proportion of Bosnjaks had increased at the expense of the proportion of Serbs. The sample composition (see table 1) is comparable to numbers reported for the city of Sarajevo.

Results

Although there were minor deviations from the stratification quotas, this did not lead to any statistically significant differences for age or gender between the samples.

Current Prevalence of PTSD

18.6 % of the persons in the sample of residents and 38.6 % of the people in psychological treatment fulfilled the DSM-IV criteria for PTSD (Rosner, Powell, & Butollo, in press). Thus the PTSD rates in the treatment sample is about twice that in the non-treatment sample yielding in a Chi Square Test for overall differences between the samples a significant result (Chi-Square $= 10.14$,df $= 1$; $p = .001$).

Predictors of Service Utilization

A logistic regression was carried out in order to investigate the role of various predictors of service utilization. All the predictors were entered in one block rather than sequentially. A prior analysis showed no serious problems with collinearity. The omnibus test of the model coefficients is significant ($\chi^2 = 34.681$; df $= 10$; $p < .000$). Nagelkerke's $R^2 = .205$. Nagelkerke's R^2

is an analogue of R^2 in linear regression. Overall, 69.2 % of the respondents were correctly classified. Table 2 presents the results for the respective variables.

Table 2
Prediction of Participation in Psychotherapy: results of a Logistic Regression

Variables	B	S.E.	Wald	df	Sig.	Exp (B)
War events	.006	.037	.026	1	.871	1.006
Intrusions	.009	.053	.027	1	.868	1.009
Avoidance	.081	.043	3.564	1	.059	1.085
Hyperarousal	-.073	.061	1.442	1	.230	.929
Education	.205	.288	.507	1	.477	1.228
Income	-.096	.110	.770	1	.380	.908
Employment status	1.063	.317	11.245	1	.001	2.896
Task-oriented Coping	-.051	.018	7.820	1	.005	.950
Emotion-oriented Coping	-.009	.016	.323	1	.570	.991
Avoidance-oriented Coping	.006	.016	.154	1	.695	1.006
Constant	1.307	1.204	1.179	1	.278	3.695

The Wald statistic was only significant for two of the indicators, employment status and task-oriented coping. The unique positive contribution of avoidance symptoms to treatment utilisation (i.e. people with more avoidance symptoms are more likely to seek treatment) just misses being significant. The connection between employment status and treatment is such that those who have work are more likely to be in psychological treatment. Income and education, as further indicators of socioeconomic status, show on the other hand no unique contribution to treatment status. The connection with task-oriented coping is negative, which means that persons showing this kind of coping are less likely to enter treatment.

Discussion and Conclusions

Interestingly, the prevalence of PTSD in the sample of residents is quite similar to those found in the two other representative civilian non-treatment samples under war conditions reported in the literature. Thus a study from Sri Lanka after nine years of civil war reports 27.5 % PTSD (according to ICD-criteria; Somasundaram, & Sivayokan, 1994), a study with displaced persons in Croatia reports 25 % (Arcel et al, 1998). This is in spite of the fact that there are differences in methodology between the studies (interviews in Sri Lanka and different questionnaires in Croatia) and differences in the kind of experiences since the end of the war.

Whereas random samples of civilians in war areas are very rare, there are even for Bosnia and Herzegovina quite a large number of results based on convenience samples of refugees in treatment. The prevalences for studies carried out two to three years after the end of the war lie between 18 and 53 % (Favaro, Maiorani, Colombe & Santonastaso, 1999; Drozdek, 1997; Dahl, Mutapcic & Schei, 1998; Thulesius & Hakansson, 1999). The prevalence in the present study for the treatment sample is in the middle of this range. Overall it seems that our results fit well with published studies. People in treatment two and a half years after the end of the year suffer more from PTSD than a random sample from a population which was overall exposed to a very high level of traumatic events. It should also be mentioned that the difference between the treatment and non-treatment samples would probably have been higher if unstratified samples had been used, because the treatment sample would then have contained higher proportions of women and older people.

Overall the answers to the first and second research questions seem to contradict one another. On the one hand, there were significantly more people with PTSD in the treatment group, whereas on the other hand PTSD symptoms did not play a large role in predicting treatment utilisation. This apparently contradictory result however only confirms a tendency found throughout the literature on this topic and in particular in another study which was methodologically very similar (Bramsen, & van der Ploeg,1999). In that study, people in treatment differed most strongly from people not in treatment on PTSD symptomatology. However in a logistic regression, treatment was best predicted by education, divorce, stressor intensity, depression and intrusion symptoms. That study, in contrast to ours, investigated veterans of the Second World War 47 years after its end, and they sought treatment mostly with general practice doctors. This latter aspect was explained by Bramsen and van der Ploeg (1999) as due to characteristics of the Netherlands health system, in which the general practice doctor is the first point of contact. It is indeed in general true that factors of the individual society and its health system including for instance attitudes to psychological symptoms play an important role in utilization of psychological and psychiatric support.

As far as the individual variables are concerned, and in contrast to other studies the present investigation did not find that a higher level of education increased the likelihood of treatment use; and the same is true of income. The latter result is probably explained by the fact that most psychological treatment centers in post-war Sarajevo operate free of charge. As "donor fatigue" amongst the international community has already set in with respect to Bosnia and Herzegovina it is to be expected that psychological support will become more expensive in the future. In that case the latter result can be seen as being of temporary nature.

At first glance it seems surprising that those who were in employment were significantly more likely to be in psychological treatment. One explanation for this could be that being in employment helps to overcome the withdrawal tendencies common in people with PTSD. In addition it is possible that the contacts established in connection with employment help to alert PTSD sufferers to the possibility of treatment. It is also plausible that in a society with an extremely

high rate of unemployment that those with a job will do anything to remain healthy in order not to lose it. On the other hand, this result could also be trivially due to a selection bias between the samples: to the extent that some of the people living in the contacted households were working when the households were contacted (in the evenings and at weekends), employed people will be underrepresented in that sample.

Task-oriented coping is negatively connected with treatment utilization. Possibly active problem solvers already have other sources of help and are therefore less likely to seek institutional help. The positive connection between avoidance symptoms and treatment use just failed to be significant but corresponds to the results of a series of other studies confirming such a relationship (Kulka et al., 1990, Bramsen, & Van der Ploeg, 1999, Solomon, 1993). However one or two studies report the opposite result. For instance in a group of school employees who witnessed a shooting incident, those with avoidance symptoms made less use of treatment (Schwartz & Kowalski, 1992); and a similar result was reported by Weisaeth (1989) for the victims of an industrial accident. These seemingly contradictory results can perhaps be explained by the length of elapsed time since the traumatic event. Whereas on the one hand the latter two studies took place shortly after the traumatic event, the first three were carried out after a longer lapse of time. The persons in our sample were contacted three years after the end of the war, and thus our sample is more similar to those in the first three studies. It could be that avoidance symptoms immediately following a traumatic event tend to reduce the chances that treatment will be sought and are therefore functional in the sense that the other symptoms are kept under control in the short term. After a longer period of time the individual's surroundings no longer tolerate the avoidant behaviour and indeed that behaviour does not lead to a reduction in the other posttraumatic symptoms, since early avoidance predicts chronic PTSD (Ehlers, 1999). Possibly the avoidance generalises, making it harder to cope with everyday life and increasing the likelihood that outside help will be sought.

In all this research it becomes clear, although mostly only implicitly, that not only demographic, social, psychological and symptomatological factors but also sociopolitical and structural variables play a role in the utilisation of psychological help. Relevant factors could include density of service provision and costs on the one hand and social acceptance of seeking help for psychological problems on the other hand. Unfortunately, in the case of PTSD, little effort has been made to date to explain with these kinds of factors the considerable proportion of unexplained variance in treatment seeking. One reason for this could be the specificity of the results for individual geopolitical contexts, as it is difficult to generalise the results from e.g. the Netherlands or Bosnia and Herzegovina to other healthcare systems. Moreover the health sector is subject to such rapid change that demand for and use of psychological help can change very quickly. This is also true for Bosnia and Herzegovina. Psychological and psychiatric support in the sense of psychological counseling or psychotherapy was a rarity before the war. The latter was carried out almost exclusively by psychiatrists and with a psychoanalytic orientation. Much more common was exclusive reliance on pharmaceutical therapy via large psychiatric clinics. The war and

the break-up of the Titoist system changed the health system irrevocably. Many international and national organisations offered treatment and support in an outpatient setting. Density and type of service on offer varied however very much from place to place. In Sarajevo there were a number of local psychological services, mostly supported by international organizations, some independent and some placed in city health centers. International financial help is now disappearing and it remains to be seen at what level of service can be offered without continuing help from outside.

Future studies on PTSD and service utilization will not be able to avoid taking account of structural factors as possible predictors of service utilization.

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