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Continuing the discussion with Chris Gilligan
Traumatised by peace? A critique of five assumptions in the theory and practice of conflict related trauma policy in Northern Ireland.

Introduction

The contribution made by Chris Gilligan in this paper is to be welcomed for a number of reasons.

1. Widens discussions it relation to the role of mental health support in the community
2. Useful for the mental health community to engage with other opinions
3. It gives us a chance to review and reflect on our own practice

Many of the concerns raised in this paper about policy and practice developments in the field of mental health and well-being have been the subject of discussion for some time amongst, but not exclusively amongst, psychotherapists, counsellors and other mental health practitioners. Having studied this paper, I am aware that there is a need to make these discussions common place. The view of sociology as a widening of the process is to be welcomed. All disciplines are, after all, simply lens through which to make sense of and engage with, the human condition.

These discussions have been occurring, albeit slowly, and patchily -most notably but not only over the last 10 years[1] and are changing how practitioners think and work in this unique context. These discussions often draw on a wider international field of radical thought and practice in relation to therapeutic support and therapeutically informed practice and related fields.

There is a need for all of us to understand the unfolding aftermath of armed conflict in order to contribute to good mental health and wellbeing - including our own. Mental health and emotional wellbeing are inextricably linked to all other structures within which people live – the political, economic, cultural forces present in the

[1] In September 1994, the Falls Community Council brought together a number of community representatives to discuss the possibility of of producing a policy framework for the reconstyruction of nationalist West Belfast. Clár Nua was established and was followed by 6 weeks community consultation. This included mental health.
Clár Nua was revisited in 2005. In Clár Nua – 10 Years On.

Clár Nua - A Policy Framework for Reconstruction in West Belfast 1995

environment and recognising that the quality of life of one person affects the quality of life for all. System theory tells us that when one part of the system is affected the whole system is affected

The World Health Organisation, 2004 stated,

"A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health."
(Gostin, 2001) quoted in (WHO, 2004):[2]

World-renowned trauma therapist Judith Herman states,
'In the absence of strong political movements for human rights….the active process of bearing witness inevitably gives way to the active process of forgetting.
Repression, dissociation and denial are phenomena of social as well as individual consciousness. (Judith Herman, 1992)

We need proper, systematic well-funded research to guide our policy and practice - research which recognizes the complexity of traumatic experiences not just on those directly affected or even the generation most directly impacted, but also how these experiences structure and organize the world of future generations.

And there is much to agree with in this paper. The initial statements for example as outlined by the author in the Introduction to the paper, make for easy agreement and reflect closely questions that have formed part of many discussions.

However, often the ideas are confusing in places and based on questionable assumptions, particularly re mental health practice here in the North and in particular in relation to therapy theory and practice

I want to focus my comments in the following way

[2] Used as a framework for the work carried out in the Flying Horse Ward 2004-6 . cThe action research was ommissioned by the Flying Horse Ward Community Forum and the Down and Lisburn Trust. The work was carried out by myself and Rosie Burrows and waspublished in a report *Out of Town Out of Sight*

1. to comment on the function of the basic assumptions and their support for the argument made the paper
2. to challenge the model of psychotherapy and therapeutic practice outlined in the paper and how they are employed in support of the wider arguments
3. to comment on the context of therapeutic support in the North, as described in the paper

Section 1 Conventional Understandings

A key phrase used through out this paper is **"***conventional understanding*". The author's arguments are based on the acceptance of the reality of this "conventional understanding". However, nowhere in the paper does the author explain what he means by conventional understanding. It is my understanding that this is another name for dominant ideology, which appears as common sense. Common sense is the wisdom and knowledge of people in general within a particular culture and is assumed to be free of political tension.[3] (Gramsci, 1971) Clearly he is not challenging ideology and prefers fares to leave his basic assumptions unattributed somewhat in the context of "if the cap fits wear it."

It becomes clear in the latter part of the paper that he is referring to those working in the field of mental health. In his conclusion he says:

"We are not expecting those working in the area of conflict-related trauma to agree with all the points made in our analysis, but it is incumbent on them to respond to the criticisms made here. In responding to our criticism,s mental health professionals will have to reconsider some of the fundamental premises that have informed their practice to date. (pg 338)"

I'll return to this and a moment.

The author outlines these conventional understandings initially as 5 assumptions

1. A dichotomous view of war and peace; (war is bad and peace is good)
2. A traumatic event is the cause of traumatic symptoms;

3. The market in counselling referrals ie the growth in referrals is primarily a response to 'patient'-led demand for mental health interventions
4. Treatment of trauma is necessary and worthwhile
5. The growth in referrals is specific to the end of the conflict in Northern lreland.

The author then frames his critique in three ways ie a critique of

- the conventional view of trauma in the North of Ireland
- the conventional view of the Peace Process
- The conventional understanding of the role of psychosocial interventions….
  ""well-meaning interventions construct(ing) war-affected civilian as victims not just in Ireland but Internationally. Pg339

Each section begins with a statement of "conventional understandings". In practice, these conventional thoughts serve as Aunt Sallies – targets set up for criticism and as a device to allow the author to arrange his arguments accordingly. I believe this undermines many of the useful points made in the paper

In addition, this reflects what is at best a partial knowledge of local mental health practice, with little evidence of current thinking in therapy theory or clinical practice in general or in reference to conflict-related trauma in particular. It seems strange to me that the author would weaken his arguments by not possessing a thorough knowledge of the very subject of his criticism. The exploration of the position of mental health practice in our context would have benefited greatly from research into the actual practice and practice concerns of those working in the sector and by doing so contributing to a much fuller exploration of the issues.

Instead the author establishes a stereotyped mental health worker and sector and then proceeds to criticise this stereotype. In doing so, the paper rests on faulty and unsustainable assumptions about the work.

The mental health sector is not an undifferentiated bloc anymore than is sociology, mathematics, history, childrearing or any other area of work. Yet there is little evidence of knowledge of the differences *within* the sector in the North of Ireland

and how those differences and similarities link with other disciplines. That may have produced a way of thinking about the issues –horizontally- across experiences of class, poverty, deprivation rather than- vertically - through opposing one discipline against another. This would be a fertile and valuable area for consideration.

There is a view held by the author that the mental health sector *has not been reflecting on these* issues. This is clearly not the case. In my work as a trainer over the past five years as a consultant to Barnardos, I have seen increasing concern relating to for instance the medicalisation and pathologising of traumatic experiences, - levels of dependency on prescription and non-prescription medication, lack of availability of a range of support including therapeutic support reflecting the various needs of people.

Theories in relation to trauma impacts which take a more holistic view of trauma and its impacts - types of therapeutic interventions, the benefit of group or and individual work, impacts on levels of system and field theory to name a few are already being debated within mental health and community development circles and related fields. None of this is evident in the paper. Instead the author focuses on Critical Incident Bebriefing, EMDR and CBT as if everyone in the sector agreed with or practiced these approaches. (Thompson Brenner ,Western,Novotny,2004)

Where some actual practice is cited e.g. my own work with Rosie Burrows it is misunderstood or misrepresented with quotes seemingly harvested for the sake supporting the conclusions of the author. This selective approach to the use of quotations I find again in reference to RFJ – an organisation with whom I have worked as a therapist for seven years. Part of my involvement has in developing the policy and approaches to the provision of therapeutic support within the context of truth recovery and “handling the past”.

In terms of research practice, it seems that this paper has not taken into account the awkward or confounding[4] (Thompson Brenner ,Western,Novotny,2004) elements which may have in fact given more accurate data for the author's arguments, such as

- What are differences in practice approaches and how do these reflect the field of the work and policy?
- How do mental health workers understand the context of their work?
- Who are the mental health workers, where are they drawn from and what are the conditions of their practice?

The conventional understandings are at best very generalised comments *aimed at* or "putting it up to…". the field of mental health - to stimulate debate. This is one way of doing it. It has produced this conference today. However, this approach is more likely to draw antagonism than collaboration. If we apply field theory, the author could be seen as reflecting and repeating the splitting that is historically characteristic of the wider environment.

The discussion may have be enhanced by a more holistic view of what needs to be done, drawn from *across the disciplines*, identifying the similarities as well as differences in radical thought, reducing isolation and establishing connection thus preparing the ground for a more informed analysis and understanding of what we need to do as a community. It seems to me, that this can work best only when the other disciplines are involved in the work at some level, particularly when this is not the field of the author or no thorough understanding of the subject.

However, having said all that, I do not want to do an injustice to this paper either, as I often found myself agreeing with the conclusions! I hope what comes out of today is a problematisation [5] (Heaney) of the issues under consideration. By this I mean, an engagement with the questions that more accurately reflect the current concerns of workers in trauma support and related field.

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[5] Problematization is the antithesis of "problem-solving." In problem-solving, an expert takes distance from reality and reduces it to dimensions which are amenable to treatment as though they were mere difficulties to be solved. To "problematize" is to engage a group in the task of codifying reality into de Problem-posing is a logically prior task which allows all previous conceptualizations of a problem to be treated as questionable. Problematization recognizes that "solutions" are often difficult because the wrong problems are being addressed.

Section 2

I was in two minds whether to address the politics of the paper or to limit my remarks to the theoretical understanding of trauma and my knowledge of therapy practice. However, this would have meant splitting myself and my understandings. To honour my own view that these areas are integrated, and to meet the author on the ground of his work, I will try to address the main points of difference and agreement.

I will discuss the assertions of the paper by considering 3 main headings. Under each of these, I will gather the various comments made by the author, as I understand their relationship to each other. I will attempt to draw into focus the differences that I had with the central arguments in each section. Having said that however, by the nature of integration, this process is more like focussing on lines of connection as I see them appear in the paper, rather than moving through discreet sections. (Partlett 1994) As far as possible, I will try to hold each lens in place for as long as needed to make the argument re each of the following. (The list below illustrates the sections of the paper where I have found related issues or comments.)

1. **the political context as outlined**
   - *A dichotomous view of war and peace*
   - *Growth in referrals and the end of conflict*

2. **the theoretical understanding of trauma**
   - *Assumption that a traumatic event is the cause of the traumatic symptoms*

3. **trauma support and mental health practice**
   - *Assumption that the treatment of trauma is necessary and worthwhile*
   - *The market in counselling referrals*
   - *Growth in referrals and the end of the conflict.*

The political context

The first point I want to make is about language. Language is a contested area here, as much as anything else is. In the practice of trauma therapy support, it plays a central role in the creation of a safe environment of the work. (Hermann 1992,

Bloom 1997) As a therapist, I listen to the clients respectfully to discover what language is used to describe experiences - their encoding of experience - part of the process of establishing connection and safety. (Heaney)

In this respect, I find the author sometimes quite startling in his use of language and this may be intended as a way of challenging perceived conventional thought – in this case the political environment following the signing of the Good Friday/ Belfast Agreement.

An example of this is the use term "Peace Agreement" - used in a seemingly unproblematic way in the second paragraph of the introduction. It refers to the Good Friday /Belfast agreement[6]. To my knowledge, the term "The Peace Agreement" appears predominantly in US websites[7][8] and press releases as captions. However, as it becomes clear later, its function is to create the ground upon which to challenge the purpose of the Agreement and the implication of that for both political developments and specifically, in relation to trauma support.

The author later expands on this by declaring that the "peace agreement" did not bring peace. He uses an unsourced definition of peace as "*an historic agreement ..between the various signatories in the sense that they reached a consensus about the conflict and the best way forward*." However, there are many definitions of peace including peace as a relationship characterized by respect, justice, and goodwill. I am left wondering if peace exists anywhere in the world according to this.

What becomes clear is that if peace according, to the definition of the author, has not been established, then all other structures and actions arising in this context - including the response to conflict related trauma – are at best misguided and at worst suspect.

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[7] United Sates Institute for peace
[8] The Agreement (also known as the Good Friday Agreement or Belfast Agreement) was reached in Belfast on Friday, April 10 1998 NIO website

Winipeka
The **Belfast Agreement** (also known as the **Good Friday Agreement** and, more rarely, as the **Stormont Agreement**) was a major political development in the Northern Ireland peace process. It was signed in Belfast on 10 April 1998 (Good Friday) by the British and Irish governments and endorsed by most Northern Ireland political parties. It was endorsed by the voters of Northern Ireland and the Republic of Ireland in separate referenda on 23 May 1998. The Democratic Unionist Party (DUP) was the only large party that opposed the Agreement.

Not everyone – and that includes the British Government - defines the conflict here as war. Some people, including Republicans do accept this term. It is contested. The problem is illustrated by issues relating to inclusion of names of local soldiers and reservists on war memorials, Remembrance Day practices, battlefield wills, criminalisation policies and post service veteran support to name a few. Within mental health support, it has been documented often – including in this article – that people have have not had access to therapeutic support or have had conditions placed on it because of the connections to particular organisation. For many years, therapeutic support was not available because its provision was seen as an arm of the state.

If, however, the author agrees with the term war, he is selective when drawing upon the evidence of former combatants to support his argument. He refers only to members of the security forces. But all former combatants are a significant factor when considering the future.

In addition, the criticism of conventional thinking, ie that war is bad and peace good again allows the author to introduce the term "transition" as a way of describing this period after armed conflict. I agree with the author (Burrows and Keenan,2004) and I am also aware that, in the local political arena, the term has been in use certainly since at least the discussions leading to the Good Friday Agreement in 1990's. In therapeutic work, it is a core concept related to process and change.
Things are never fixed but in process,[9] and this provides a framework for change and engagement to occur.

Comment [BK1]: quote from Gestalt

In addition, the phrase war is bad and peace is good, allows the author to introduce arguments in relation to the distribution of violence and its various effects on communities. That conflict is experienced differently between and within communities and individuals is axiomatic. So is the fact that conflict related violence

[9] Every change in the substance of the world occurs in space and time. Every change means that particles of the world are either drawing closer together or moving away from each other. :
Everything is in a state of flux

in many forms continues as part of the context of our lives. (Keenan and Burrows 2005)[10] There have been many studies illustrating these costs and impacts.

Studies in the impacts of transgenerational trauma however[11](Dannielli, (1998) Bar-On 1998) give us further understanding of the distribution of impacts as these emerge in subsequent generations and is not researched here as matter of priority. We need to be aware of this when we are planning a response, not only where need is greatest but also what is the most relevant and effective intervention. This phenomenon is not addressed at all in the paper.

The author argues that there is a danger of over diagnosing PTSD and that this medicalisation *"is a process that tends to relocate distress 'from the social arena to the clinical arena."* In addition, the clinical discourse - as described by the author and premised on the application of DSM-111 means that *"The introspective, individualised and depoliticised approach to dealing with political violence is inherently self-limiting and may even serve to undermine peace-building efforts by promoting a view of the human subject as inherently vulnerable and in need of professional support.*' (pg 339) This discussion has its roots in the debates in 1970s and 80s in relation to the role of psychotherapy in social and cultural change.[12] I welcome the extension of this discussion.

What has not been considered by the author, however, is that theoretical frameworks and therapy practice already exist locally and are developing in relation not to the individualisation of the impacts of trauma but the experience of the individual as a member of a larger group[13].(Keenan and Burrows (2005-6), Bloom, (1997) Herman (1992))

Section 3: Trauma support and mental health practice

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[12] Here I recognise the debate about the role of psychotherapy and psychoanalysis, language and ideology[12] (Coward and Ellis 1977), and social change as discussed by the left in 1970s and 80s–particularly in relation to cultural struggle (the Centre For Contemporary Cultural Studies of Birmingham University). A similar debate was conducted in education particularly in relation to the 16-19 curriculum[12] (General Studies Workshop 1977-83) and the experience of Black children in British schools.[12](Coard 1971) and Irish Children in British Education[12]. (Hickman)

- ***The market in counselling referrals***
- ***assumption that the treatment of trauma is necessary and worthwhile***

In this section of the paper the author suggests that there is a market in counselling referrals and as with all economic analysis identifies a demand side and supply side model

Marketplace[14] economics takes place where the state does not regulate a service as a function of the state or does not regulate well, possibly as a result of being reluctant to act. In addition, the power of the unfettered market place is something of a rightwing illusion. However, it produces amongst other things the survival of the fittest, carpetbaggers, wide fluctuation is quality and efficiencies. This seems to be part of the meaning here as there is a suggestion that self-aggrandisement and financial gain are part of supplier led demand, play their part in influencing the market. There is no evidence provided, nor any attempt to illustrate this point.

Community development is a major section of the "market place" provision of services in this region. Self help groups become community organisations, staffed by volunteers or low paid staff on fixed term contracts, reliant on piecemeal funding. When proper regulation – including employment practices - is absent, duplication and gaps in service, efficiencies, quality of provision are compromised.

Community and voluntary organisations here have traditionally provided what the state has not eg Irish language education, early years care, community based counselling, women's and carers' support. The market may simply reflect peoples' attempt to establish a much needed service - probably like some of the groups, who came into existence after funding became available. This fact could be explored and included thus benefiting the author's analysis.

On the demand side, he identifies what seems to be legitimate demands such as

- GPs may be more aware now of PTSD and therefore refer people more readily

[14] I am reminded of the early days of Race Relations in England 1960s and 70s when almost overnight race related structures emerged and activities mushroomed. This was referred to disparagingly as the Race Relations Industry ie largely unnecessary development with money and careers to be made. It struck me then - as does the reference to the market - that this usually encapsulated the response of those opposed to the development as well as the government's less than whole hearted commitment to the intervention.

- greater degree of safety and personal security, giving people more access to services
- services are emerging in relation to specific group need

Then there are those of more dubious origins ie supplier induced demand.

My colleague Rosie Burrows and I[15] are included in this group ie stimulating new demand through education and awareness raising during which people are encouraged to *"reinterpret their responses to political violence through the discourse of trauma."* He also places the emergent groups in this supply led demand.

I do not intend to defend my work with Rosie Burrows in this paper but rather address the two general points made.

a. That the groups–respresentative of other groups- who were involved in awareness raising and psychosocial education - was not self identified. However, evidence of a lengthy process of consultation and self-selection is clearly described in the work. This seems to suggest a cursory glance at our - and possibly - other work being done on the ground.

b. That some groups only discovered need after education and awareness raising and this is considered to be a bad thing. However, I am reminded of the power of the women's movement's education and awareness raising and its effect on women's power in society, as with Black Consciousness, the development of the trade unions movement, education of the working class, Black education and Saturday schooling etc.

Furthermore, I find it strange that the author implies such gullibility on the part of the very people he argues have agency a fact which he claims is not recognised or undermined by the mental health worker.

That has not been my experience either as a member of the community, a teacher for 20 years or as a psychotherapist. As he says elsewhere, people are active agents and not passive recipients of experience. The question is not whether or not people are

[15] Barnarods is a Voluntary world wide organisation, not a community based organisation

duped but how people make sense out of their experiences and what they do as a result. (Gramsci, Perls, Hefferline and Goodman, Heaney)

Section 4. **Structures for handling the past**

On the supply side, the author identifies the availability of funding and the governmental infrastructure for victim support, which he links to the contradictions inherent in the Peace Process.

The juxtaposing of therapeutic support and truth recovery in such as organisations as RFJ, is another example where the author has not fully investigated this issue. In "Supporting Your Journey" (2003), RFJ clearly states the organisation's commitment to both truth recovery and counselling support as integral to the regaining health and of well being and as part of peace building. In their strategic plan Tarraingt Le Chéile – Providing Support (2003), they quote Judith Herman *"Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims....When truth is finally recognised, survivors can begin their recovery"*

I agree that the limited clinical discourse based on DSM-111[16] is positioned to serve - in the absence of any other – as a way of "handling the past".

Clearly, people working as advocates for those suffering from PTSD have challenged the discourse of victimhood and many organisations have argued a need for some form of truth recovery mechanisms (The Eolas project,). In every group that I have worked with in Barnardos or Contact Youth since 2002, the question of the victim has emerged again and again - not just as an interrogation of the term and its political context but in relation to strategies for supporting agency.

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[16] DSM –III's definition off what could cause PTSD was limited. It was seen as developing from an experience that anyone would find traumatic. There were at least two problems with this definition: it left no room for individual perception or experience of an event and it mistakenly assumed that everyone would develop PTSD from such an event. The currently accepted definition as revised in DSM (APA 1994) it is much broader. This definition takes into account led PTSD can develop in an individual in response to three types of events (1) incidents that of our or perceived as threatening to one's own life or bodily integrity (t2) being a witness to acts of violence to others or (3) hearing of violence to or the unexpected or violent death of close associates.

In addition, the clinical discourse is not the only one employed. There are further discourses of religion (atonement and forgiveness), morality (good and evil), war (combatants, civilians, prisoners of war), legal (innocence and guilt),

Where the clinical discourse stands as a political intervention instead a properly structured and funded commitment to peacebuiding at government level, the victim takes on a particular role. I do not agree however, that politicians have tried to appropriate the victim. Instead, I see reflected in the area of victim support, the contested constitutional issues eg in the hierarchy of victimhood described by Relatives for Justice and others which reflects a kind of political legitimacy conferred by the state on selected groups.

The field of mental health and well-being - specifically of conflict-related trauma - is also a contested and politicised field. Practitioners as much as decision-makers, statutory agencies and funders, academics, researchers take political positions and are politically influenced both as professionals and private individuals who have lived throughout the most recent period of armed conflict.

At the same time, clearly there is a danger that traumatology might become the "theory of everything", that everything can be reduced to psychological processes and that this could result in fragmentation of society, isolation, reduced agency and restricted living - in effect, serve to reinforce and repeat the central effects of trauma itself.

Conversely, the compartmentalising of support for conflict related trauma into the field of mental health or mental illness, reliant on professional intervention, limits our understanding of the sorts of support needed, severely limits the types of support available, and can in many instances disempower people and reduce the quality of life and well-being generally.

Sectioon 5 **The theoretical understanding of trauma**

- assumption that the traumatic event is the cause of the traumatic symptoms

Now I want to turn my attention to how the author applies the word trauma.

He begins with a the definition of Post Traumatic Stress Disorder (PTSD) as described in The American Psychiatric and Statistical Manual of Mental Disorders (DSM-III) (1980) despite the fact that the DSM definition has been heavily criticised from many quarters and for many of the reasons outlined by the author. (Bloom, Herman, Van der Kolk, Levine Rothschild…)

Despite his claim that the individualising and medicalising of traumatic experiences is a mental health practice response to the application of DSM - 111 , the author gives little indication that he has researched current theories and clinical practice of trauma which may contradict this.

The World Health Organisation for example in 2004, provides three general categories under which to discuss mental health and wellbeing.

- Social inclusion
- Economic Participation
- Freedom from discrimination and violence

Judith Herman 1992, has developed the concept of Complex Post Traumatic Stress to challenge the narrow medicalised diagnostic framework contained in DSM-111.
'" Post-traumatic stress disorder," as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly for of circumscribed traumatic events…..The responses to trauma are best understood as a spectrum of conditions rather single disorder.'

The DSM-111 definition of trauma whether it is widely used here or not, serves as a convenient hook on which to hang a critique of causality. The implication is that therapeutic practice behaves here as if - like a biscuit cutter and dough - the traumatic event imprints itself onto a passive recipient of the experience. A selected number of the related psychological phenomena - memory, time, meaning including expectations, present functioning, active agency, inter-subjectivity, adaptive defences etc.are employed in order to reveal the fundamental errors underpinning therapeutic interventions or therapeutically informed work in the North.

Causality works both ways ie it does cause it or it doesn't cause it. Posing the problem in this simplistic way excludes complexity, dialectical relationships, paradox and the co-existence of polarities.

An alternative way to frame these complexities is to "look(ing)at the total situation" rather than as (Partlett, 1991) remarks

"Instead of reducing complex interactive phenomena to separate component parts, the overall picture or total situation is appreciated as a whole with its whole-istic aspects recognised as such. There is a willingness to address and investigate the organised, interconnected, interdependent, interactive nature of complex human phenomena".

Section 6 Understanding trauma

At this point, I would like to offer an understanding of the impact of trauma which I hope will put into context some of my theoretical differences with the approach to trauma contained in the paper.

The core features of this framework can only be sketched out here but, ironically it may bring the author closer to a more useful theoretical support for his conclusions.

Briefly stated these are

■**Response to Traumatic events is not pathology and the human being is naturally orientated towards health. (Levine)**

■**Trauma is in the Body not in the Event (Levine, Rothschild, Van der Kolk.)**
Working in a way that does not recognize the predominance of somatic experiences in the resolution of trauma, will have limited impact.

■**Every human being registers trauma in the central nervous system. The meaning we make of it and the actions we take are ideologically and culturally defined.**

■**Trauma resolution belongs as much in the field of politics as to therapy. (Herman, Bloom, Lichtenberg, Hellinger)**

■**Trauma support cannot be separated from the environment in which it occurs. (Perls, Hefferline and Goodman)**

■**Trauma impacts are felt at all levels of system – intra psychic, interpersonal, and group (family, community, national) (Levine)**

■**Traumatic experiences have impact across generations (Seigal, Danieli, Bloom, Hellinger)**

■**Working with groups is fundamental to trauma integration (Bloom, Herman, Gaffney)**

To experience trauma is a natural process of growing and changing. "*Beyond the mechanistic, reductionist view of life, there is a sensing feeling, knowing, living organism. This living body, a condition we share with all sentient beings, informs us of our innate capacity to heal from the effects of trauma.*" (Levine). If we do not recover well from the terrible experience we may develop life-limiting responses.

Trauma is not mental illness. Given adequate, timely and informed support the long term painful effects are limited. Support can come from a wide range of sources such as the family, the community, self-help groups and *in some cases*, professional intervention.

However, trauma is a very over-used and indiscriminately applied word and could lead to the idea that "everyone is traumatised". Having said that, traumatic experiences have occurred and many people continue to engage in trauma based responses to life events. But not everyone goes on to develop longer-term effects of trauma.

"*The most extreme form of stress of course, is stress that results from a traumatic incident – traumatic stress. Post traumatic stress (PTS) is traumatic stress that persists following a traumatic incident. Only when post traumatic stress accumulates to the degree that it produces the symptoms outlined in DSM-4, that the term post-traumatic stress disorder can be applied. PTSD implies a high level of daily disfunction. Though there are no statistics one can guess that there are a significant number of trauma survivors with post-traumatic stress*

those who fall between the cracks - not recover from the troubles but without the debilitation of PTSD. (Rothschild, 2000).
By extension, not everyone is traumatised by events, even when they share the same event.

Why this happens is beginning to be understood in relation to resilience i.e. the ability to bounce back from adversity[17]. This has implications for us in relation to childcare and provision for young people. (Keenan and Burrows, 2006)

Trauma is also creative and transformative. Traumatic events can and do strengthen and empower individuals, communities and nations producing also art, music, stories, community structures of well being.(Brid Keenan and Dr.Rosie Burrows) community cohesion, community activism, transforming of whole societies. This has community resilience at it core. We see examples of that here all the time.

There are number of different kinds of trauma. Whereas trauma affects everyone fundamentally the same way in the central nervous system, the source of the traumatic experience will however determine the type of intervention required to support self regulation.

- Shock trauma (single events)
- developmental trauma (trauma sustained over a long period of time affecting the developmental process. This is very important in our understanding of Transgenerational trauma.
- Conflict related trauma.
- Trans generational trauma - the process by which, experienced in one generation is experienced by subsequent generations.

Trauma occurs when there is disregulation in the lower brain / body, when life is threatened. The danger comes too fast and therefore is felt as an overwhelming force,

[17] resilience is a key concept in promoting and supporting them people's mental health. Individual young people cope very differently in the face of stressful dramatic and adverse life experience so that resilience has become increasingly important as an area of study. …… three fundamental building blocks appear to underpin resilience a (1) secure base, as sense of belonging and security (2) good self-esteem as sense of self-worth and competence (3) a sense of self efficacy, of mastery and control along with an accurate understanding of personal strengths and limitations.

which pushes beyond the normal capacity to cope. The automatic response is to get away from danger (flight) or to resist (fight) and where neither of these can occur, the only alternative for survival, is freeze.
'Trauma is an internal straitjacket created when a devastating moment is frozen in time. Trauma stifles the unfolding of being, strangling our attempts to move forward with our lives and disconnects us from ourselves, others, nature and spirit. When people are overwhelmed. In effect we're frozen in fea.r It is as if our instinctive survival energies 'are all dressed up with no place to go' (Levlne,1997).

Because trauma forces the person outside the normal range of resiliency – beyond the normal capacity to cope, in the moment of the event(s), the person must take action in order to survive. This action is referred to as creative adjustment and takes many forms. In describing this process as 'creative adjustment', we are emphasising survival and focussing on the power of the individual to handle devastating experiences.

However, both the creative adjustment and the continuation of life and social relations are affected by the freeze experience. These adjustments, as they develop in the aftermath of the event, sometimes become symptomatised into various bodily symptoms and social actions and are perceived as problems, located with the individual (e.g. misusing alcohol, prescription drugs, depression, addictions of all kinds, fragmented memory, poor sleep and other expressions of a destabilised system). Trauma itself is not pathology. It is the person doing what is necessary in order to survive and handle a system charged with trauma energy.

Generally, when the effects of trauma are seen as pathology and treated medically the symptoms are individulaised, located only with the individual as the source, and therefore the resolution, of the problem.   The effect of this is to heighten the isolation imposed by trauma.

The nervous system is frozen, whilst we continue to live. Therefore, although the event is past, the present is where we experience the effects and this impacts on our ability to engage with life now or hold an optimistic sense of the future. Trauma is held in the implicit or somatic memory of the body whilst cognitively and

intellectually we continue to make meanings in relation to the environment. Memory can be fragmented, absent, forensic in its detail or lacking continuity. However, the memory is a embodied experience((Kepner,2001) unique to the individual. In that sense, a memory cannot be changed since it is a captured moment relating to events of that moment. However, we continue to make meanings in our current lives in relation to our environment, part of which is the freeze deep in the nervous system. The experience of the freeze is what gives rise to discontinuities in time.

Trauma causes a disconnection from the body and from others around us. From the feeling of being alone and in terror or horror, hypervigilence, living a restricted life and deadening of sensation are major components of trauma experienced in somatic memory. From this we regularly encounter people who although having recounted the story of the events many times perhaps, still suffer the distress in many different ways.

The range of Resiliency

It must be remembered that trauma does not only affect the individual. The family and community are also affected by the experience - even where the experience is a single event. We are profoundly affected by other peoples' affect states and where someone tells terrifying stories we resonate to the emotion (Bloom 1997) Likewise, we also resonate to joy and excitement.

If trauma attacks the normal range of resiliency in the individual that allows us to 'bounce back,' this also holds true at the level of the group, family and community

Where responses in the body are above the range, these are known as hyper responses and involve the adrenaline pumped into the system during trauma and include hypervigilence, high levels of activity that triggers the adrenaline to stay stuck in the 'on' position.

The hypo response is that which keeps the system below par, always feeling tired, using alcohol, prescription drugs, sleeping a lot.

Using the framework of resilience we could start to look at other social phenomena differently too e.g. car theft, despair, suicide, addictions and some of the 'psycho somatic' illnesses and conditions.

At the heart of trauma is what Hermann refers to as the dialectic of trauma: the overwhelming urge to speak out and an equally strong need to stay silent. Often there is pressure on the injured to stay quiet and "to move on" because it may be unbearable for others and the time taken to work through them, distressing and painful. By extension those who work with people in the aftermath of trauma, can be included in the isolation of the traumatized person who cannot move as quickly as events in the environment.

"To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and joins the victim and witness in a common alliance. For the individual victim, this social context is created by relationships with friends and lovers and family… for the larger society the social context is created by political movements that give voice to the disempowered."(Herman)

Trauma support and recovery need not be an individualized experience. I would go further and state the support of a group is essential to resolve isolation and support integration. *"The restoration of social bonds begins with the discovery that one has not alone. Nowhere is this experience more immediate powerful or convincing than in a group ……survivor groups have a special place in the recovery process"* A group can provide a safe container for trauma energy by allowing the opportunity to reconnect slowly and safely and to re-establish relationships that focused on the present relationships. There are many self-help groups and it is important that any intervention or facilitation is sensitively timed and managed.

Caregivers can transfer the traumatic experience to babies who have never directly experienced the event (Dannielli) . The mechanisms of transgenerational trauma are

Attachment

An attachment relationship is the nature of the bond between carer and child that influences how we organise our emotional and behavioural responses throughout

life. This is affected where the caregiver is already traumatised or there is trauma in the family (trauma bonding). Attachment allows a child's brain to *develop 'a balanced capacity to regulate emotion, to feel connected to other people, to develop an autobiographical story and to move out into the world with a sense of vitality'* (Siegel 1999).

Memory

Explicit memory is language based and is a co-created family narrative. This may not be the child's direct and personal experience but has been created in the family. Children say they 'remember' things when in fact these are stories about their experiences told in the family. Implicit memory is the somatic memory held in the body.

Reenactment

Re-enactment behaviour is repetitive, ritualised and highly symbolic behaviour often out of awareness that re-invokes trauma. It is a signal to the community that trauma has occurred and help is needed. Bloom argues that there is a direct connection between ritualised, wordless behaviour resulting from trauma and the lack of response from the community.

Family responses

Where family structures have developed around keeping secrets, telling stories or taking other action to protect the family from the impact of traumatic events. '*Separated from their original purposes, these emergency measures become family styles of interacting, family belief systems that rapidly become impermeable to change*' (Bloom, 1997).

Social structures/ Political contexts and leadership

Where trauma is generalised across the whole community then for the child, this is 'normal' life. The community reflects, reinforces, expands the child's initial experiences and vice versa.

In the context of this complex framework, we can begin to understand social phenomena familiar in our culture as trauma responses, particularly transgenerational processes. This might be a reason for adults to look again at aspects of our community life for example car theft, drug use including alcohol,

youth suicide and, child neglect etc. as aspects of unresolved transgenerational trauma

We do not know enough about transgenerational impacts of trauma in this environment. There has been no strategic intervention at the level of research to try to discover how the conflict has left its mark on this current generation of children. What we may be seeing is this process of social forgetting and denial.

The Victim

In therapeutic terms the model of the Drama Triangle (Karpman, 2007) is one that illustrates the closed relationship between Victim, Persecutor and Helper, each needing the other to maintain its existence. The person can move through the roles as the stress of maintaining the role forces a change in aggression or passivity. This model has been added to by Bloom who describes how the action of the bystander increases the experience of terror and when the number of bystanders increase, the community becomes an increasingly frightening environment. Cumiskey[18]adds the work of (Phillip Lictenberg 1994) to this model.

Lichtenberg defined the victim as one who subject to deprivation, unnecessary suffering, or oppression. He was concerned to challenge the blame and judgement that lies at the heart of the Drama Triangle model and the view that victims were only "helpless and innocent". He argues that if we focus only on innocence and helplessness, we deny agency and impair the regaining of a sense of power and control. Human beings are also agents and therefore also influential and culpable.

If we support only the innocent/helpless configuration we are likely to support disempowerment by acting *for* the other. If we support only the influential/culpable we are likely to blame the injured for their injury and distance ourselves from them.

Conclusion

[18] Fergus Cumiskey Clinical Director of Contact Youth has further developed this model in his teaching and training in group facilitation

The author uses the question *"what was it all for?"* and says that this goes to the heart of the issue. He does so as a way of illustrating that therapeutic intervention is not sufficient to resolve the issues that we currently face in this transitional period.
I do believe that anyone says it is.

The connections for the author seem to be

1. Good Friday Agreement did not bring peace ie an agreement on the causes of the conflict and an agreed way forward future
2. This is not a sufficient ground for handling the past or planning
3 In the absence of a political structure for handling the past and to find an agreed narrative for our experiences, this area has been left to mentalhealth and in particular to victim support
4. Victim support draws on theories of conflict trauma to explain current personal and social difficulties and employs psychotherapy and counselling as a way of alleviating pain and distress
5 This has been funded widely and structured poorly leading to a mish-mash of unregulated activity
6. This being the case, the relatedness needed to develop real social change has been eroded to the realm of the intrapsychic, professionalizing normal social interaction and deskilling human response and capacity to survive.
7. This is not unique to the North of Ireland. Anglo-American interventions of this kind can be seen in other areas of conflict in the world.

The question "what was it all for" suggests the further questions "what have we gained from what we did in the past the pain of which we endure in the present and what hope is there for the future?" There is hopelessness in the question - was it worth the cost? This of course, is one of the polarities of life in the North of Ireland. Another polarity is the sense that we came through it, that we have gained from this and the future has possibilities.

To focus on one polarity as if there is only one, maintains the division and makes the effective action less possible. The unfinished business of the past is a question for all of us are not just psychotherapists. To scapegoat and blame mental health workers

for this unfinished business serves only to deflect from the difficulties we face as a society.

Problematization is the antithesis of "problem-solving." …. To "problematize" is to engage a group in the task of codifying reality into symbols, which can generate critical consciousness and empower them to alter their relations with nature and oppressive social forces. …. Problematization recognizes that "solutions" are often difficult because the wrong problems are being addressed.

Let us problematise.

Bibliography

Bloom S. (1997)	Creating Sanctuary Toward the Evolution of Sane Societies, Routledge
Burrows, R. and Keenan, B. (2004)	'We'll Never be the Same': learning with children, parents and communities through political conflict and trauma. Barnardo's publication
Burrows, R. and Keenan, B. (2004)	Out of Town Out of Sight “Action research on the mental health needs of the community in the Flying Horse,Model Farm and New Model farm areas of Downpatrick Down and Lisburn Trust and the Flying Horse Community Forum
Clár Nua	Clár Nua - A Policy Framework forReconstruction in West Belfast 1995 Falls Community Council 1995
Clár Nua – 10 Years On. 2005	West Belfast economic Forum
Coard B (1971)	How the West Indian Child is Made Educationally Subnormal in the British School System Caribbean Educ. & Community
Coward Rand Ellis J (1977)	Language and Materialism Routledge
Danielli, Yael (1998)	International Handbook of Multigenerational Legacies of Trauma. New York: Plenum Press
Eolas Project(RFJ)	Consultation paper on Truth and Justice – a discussion document
Gramsci, A. (1971)	Prison Notebooks. Lawerence and Wishart
Gostin, L.	Beyond Moral Claims. A human rights approach to mental health, Special section: keeping human rights on the bioethics agenda. Cambridge Quarterly of Healthcare Ethics. 10: 264-274(2001)
Heller, D. with Heller, L (2001)	Crash Course: a self healing guide to Auto Accident Trauma and Recovery, North Atlantic Books, Berkley

Herman, J. L. (1992)	Trauma and Recovery - from domestic abuse to political terror London: Pandora
James, B. (1989)	Treating Traumatised Children: New Insights and Creative Interventions. New York: the Free Press
Keenan B. and Burrows Dr. R (2004)	Bearing Witness: supporting parents and children in the transition to peace. Child Care in Practice Vol. 1 0 No.2, April, pages 107- 125
Keenan B. and Burrows R (2005)	Do You Think We're Mental? A therapeutic approach to group work with with young people Contact Youth
Kepner J (2001)	Body process A Gestalt approach to working with Body Psychotherapy Gestalt Press
Levine Peter (1997)	Waking 1he Tiger: healing trauma - the innate capacity to transtorm over whelming experiences. North Atlantic books Berkeley, CA
Lichtenberg,P. Gibbons, D. (1994) van Beuskorn, D	The Empathic helper Working with Victims, Clinical Socvial Work Journal 22 211-222
Partlette, M	Reflections on Field Theory The British Gestalt Journal, 1991, 1, 68- 1991
Perls,F. Hefferline, Goodman,P(1992)	Ego Hunger and Aggression Gestalt JournalPress
Perls,F. Hefferline, Goodman,P (1951)	Gestalt Therapy Excitement and Growth in the Human Personality Souvenir Press
Relatives for Justice (2003)	Supporting your Journey /Tacaíocht don Turas
Relatives for Justice(2003)	Tarrainght Le Chéile providng support

Rothschild B (2000) — The body remembers: the psychophysiology of trauma and trauma treatment
W.W.Norton and Company

Scaer R.C (2001) — The Body bears the Burden
The Haweth Medical press

Siegal D. (1990) — The Developing Mind: towards a neurobiology of interpersonal experience
Guildford Press New York

Thompson Brenner H Western D Novotny C. — The Empirical Status of Empirically Supported Psychotherapies: Assumptions Findings and Reporting in Controlled Clinical Trials
American Psychological Association Psychological Bulletin 2004 Vol 130 No 4 631-663

Van der Kolk, B., (1996) Mac Farlane, A, Weisaeth, L. — Traumatic StreeThe effects Overwhelming Experience on mind body, and Society
The Guildford Press

Willis P, (1977) — Learning to Labour How Working Class Kids get Working Class Jobs

Web Sites

Coard B (2005) — Why I wrote the ERSN Book
Guardian
http://education.guardian.co.uk

Heaney T — Issues in Freirean Pedogogy
http://www3.nl.edu

Karpman S (2007) — The Coaching and Supervision Academy may 6th
http://www.coachingsupervisionacademy.com

NIO — http://www.nio.gov website
Winipeka — http://en.wikipedia.org

Unpublished

Fergus Cumiskey	
General Studies Workshop papers1977-83	(not published) The General Studies Workshop section of NATFHE,