Trauma, Disputed Knowledge, and Storying Resilience

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When events of mass violence came to the attention of mental health professionals in Western countries in the latter half of the 20th century, their responses largely reflected that era's dominant psychiatric paradigms. The primary focus was on the individual psychopathology of traumatic stress. Diagnosing and clinically treating what was eventually named Post Traumatic Stress Disorder (PTSD) was a professional and scientific milestone that led to the relief of suffering for scores of persons and redefined clinical approaches to trauma survivors globally.

However, as the traumatic stress theory paradigm was applied to new catastrophe, its limitations in situations of mass traumatisation became more evident to more observers. It could not explain social and cultural phenomena, nor why some never became ill or suffered only transient distress. Trauma work organised around PTSD could also not explain how to deliver helpful services to families and communities or to those individuals that did not seek or accept treatment.

This essay uses a narrative approach to rethink trauma work in situations of mass traumatisation. We begin with an overview of several key disputed issues in the current discourse on trauma in situations of peacebuilding and development that reflect some of the struggles currently besetting trauma work. Next, we will examine some existing conceptual and practical alternatives to the dominant trauma paradigm, and consider how they involve new narrative strategies. Lastly, we will elaborate some considerations of an alternative framework on trauma in situations of peacebuilding and development, derived from the concept of dialogic work, which proposes several ways that narrativeness may contribute to trauma work.

DISPUTED MEANINGS IN DIFFICULT SPOTS

"…for the vast majority of survivors posttraumatic stress is a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counselling are applicable" (Summerfield, 1999).

"An emphasis on trauma, useful in an emergency context, can, subsequently, divert resources and energy from the 'social and economic conditions [which] have a decisive effect on health and disease'" (Stubbs & Soroya, 1996).

Trauma, according to its sharpest critics, is not just an inappropriate explanation of the suffering engendered by political violence but for survivors, their communities, and societies, a potentially costly one. What was intended to be a helpful approach may instead become a substantial problem. It drains away social and economic resources that could otherwise contribute to healing and recovery. It creates a frame of meaning that may detract from community narratives that could lead to desired outcomes. The most clear beneficiaries are the professionals and the organisations that they work for, who acquire financial, professional, and scientific capital.

These critiques of the dominant trauma narrative are to a degree critiques of psychiatry. For example, in Summerfield, one hears echoes of Foucault's arguments of a psychiatry trying to establish its foothold as a profession by gathering capital and accumulating power (1965). One may also hear R.D. Laing and the anti-psychiatrists who saw psychiatrists unwittingly serving societal power interests by sacrificing large swaths of persons as patients (1960). PTSD as power play. PTSD as conspiracy. PTSD for profit. PTSD as limiting human freedom. This hyperbolic line of critique reads more as a polemic than either an inquiry, a theoretical contribution, or a blueprint for action.

The legacy of Pierre Bourdieu's social analysis of professional helpers in liberal societies is also at work here. Bourdieu would have said that the explanations being offered by trauma mental health professionals often seem not to recognise the ground where they stand. In *Weight of the World* (1993), Bourdieu called these locations, "difficult spots" which are, "difficult to describe and think about" and where "simplistic and one-sided images must be replaced by a complex and multi-layered representation capable of articulating the same realities but in terms that are different, and sometimes, irreconcilable"(Bourdieu, p. 3). Too often the responses from trauma professionals to difficult spots – including those of some trauma critics - often merely replace one set of one-sided images with another. Are there better (e.g. more complex and multi-layered) ways to deploy trauma frameworks in difficult spots? What kinds of narratives would this require?

In contrast to the harsh tones of trauma's critics, the histories told by trauma mental health professionals of their activities in situations of mass traumatisation are rather positive if not zealous regarding the transformative power of trauma work. For example:

"People deserve to be believed when they speak of traumatic experiences and their painful sequelea"(Kudler, 2000, p 4).

"In our opinion, PTSD is a clinically meaningful diagnosis because of universals in human experience in response to trauma" (Marsella et al, 1996, p. 531).

"I propose that our next professional assignment is to go beyond the treatment of new trauma populations: the long-range cure of war-related trauma requires prevention of traumatic stress" (Chaim Shatan as quoted in Sandra Bloom, 2000, p 46).

These statements are not unreasonable, but they do embody a positive regard for trauma work that may be characterized as a self-fulfilling, self-serving drive that creates its own narrative. Where does trauma mental health professionals' zeal for the transformative power of trauma work come from textually?

One defining document was Judith Herman's *Trauma and Recovery* (1997) with its insistent claim that trauma has a "forgotten history". The notion of trauma's forgotten history has been used by trauma mental health professionals to argue for the necessity of a trauma mental health movement, because the persistence and remembrance of trauma work requires the support of a political movement. Because our history has been forgotten, we must remember, we must spread knowledge, we must combat forgetting.

Take note of the clever semantic substitution which underlies the trauma movement's claim to legitimacy: in place of the trauma survivor's forgetting, the mental health professionals' own forgetting is emphasised. Thus when professionals take a stand for trauma work, they do so with the moral legitimacy of all trauma survivors. The stands they take sometimes are social or political in nature, if they recognise that their patient's suffering comes as a consequence of societal ills. They are at the same time professional in nature, as when they fulfil the roles of providers or provider organisations. This admixing of the social and political with the professional creates a potentially productive but complicated and under-examined moral positioning for the trauma field.

This moral position has a power which the trauma field has used to advance the care of trauma survivors and to advance the organizations for which they work. By embracing human rights, and by forging disciplinary alliances such as "mental health and human rights" and "peace psychology", the moral positioning of trauma mental health

has been further strengthened and legitimised. The trauma fields' insiders endeavour not to disrupt the movement by seriously challenging this moral positioning, but to better equip it for its journey to more and more places. In the trauma field, one finds little enthusiasm to stop or slow a train that is roaring down the tracks. Rather, the momentum has been to further stoke that engine with beliefs, evidence, stories, and theories that fuel the progress of trauma mental health work.

This "not forgetting" and zealous attitude is of concern because it applies a centripetal pressure to the field to perform trauma work everywhere. This may have the effect of overly constricting the nature of trauma mental health work in one of its most centrifugal undertakings: situations of political violence in non-western global settings. In those situations like Bourdieu's difficult spots, trauma work faces new languages and social and cultural differences which likely script traumatic injury, resilience, and healing very differently from western middle class, white, Anglo points of view. No less important are major contextual differences, such as the interaction of trauma with other pressing social and economic problems (e.g. poverty and epidemics), different traditions of psychiatric and mental health work, and different types of social resources.

Another reason to call the moral positioning of trauma work into question is that some observers have noticed that for all its ambitious claims about healing the wounds of war, this attitude has not helped to position trauma mental health to reach out beyond the clinic walls into the surrounding communities where people lead their lives. Large numbers of trauma survivors never seek mental health services and mental health professionals have yet to devise ways to deliver services to these people.

We call this positioning into question in the hope that we can find trauma work based upon other narrative strategies that while not making the same types of ambitious claims will reach into peoples lives in difficult spots. We claim that this calls not for minor readjustments but for wholly different strategies, including different narrative strategies.

Underlying our view is the claim that trauma is not simply a thing in and of itself, but as we have seen, a subject of narration by people at all walks of life and levels of society, including both its promoters and critics. Trauma is created, revised, and negotiated through narratives. This of course includes survivors' narratives but also those of observers from the professional and scientific realms, law, religion, the media, and the arts. This implies that we must be open to many different possibilities of how trauma is represented, including the possibility that trauma is not the high priority that is inscribed in the dominant trauma narrative.

Trauma's narration through the traumatic stress paradigm has been remarkably successful. It was able to bridge the disparate phenomenon of railway spine, shell-shock, and rape trauma, to name a few, and to create a unified trauma concept. The histories of trauma consolidation into PTSD have been retold many times, most recently in the spate of books on disaster mental health that came out after September 11, 2001 and Hurricane Katrina. We regard these not simply as histories but as textual site of the contemporary trauma movement. They knit together into one fabric the work that has taken place with different survivor groups, at different points in time, in different contexts, from different vantage points. These narratives have played important roles in defining a professional and scientific community, the fruits of which are real and evident. For example, they

gave birth to the International Society for Traumatic Stress Studies (ISTSS), which many in the trauma field consider as a professional home base. Through annual conferences, peer reviewed journal publications, treatment guidelines, listservs, and the activities of its professional members, the trauma paradigms they promoted have had a substantial impact in the programmes, policies, and science concerning trauma globally.

The trauma mental health field has had considerable success in marketing the trauma paradigm to the NGO sector of humanitarian aid which came from the west (Beristain, 2006). In the 1990s with the burgeoning of humanitarian interventions, western trauma experts brought trauma mental health work to various locations where those organisations worked including IndoChina, the Balkans, and Africa. They conducted trauma trainings of local professionals and para-professionals and set up trauma focussed services to treat victims of violence. Much good work was done, but in our opinion, many human resources were wasted or inappropriately used. One of the authors (Weine) was involved in organising and leading a task force at the ISTSS to consensus produce guidelines on international trauma training which critiqued the practice and tried to shape a more productive practice pattern (Weine, et al., 2002). These guidelines did little to get trauma professionals to question the dominant paradigm. The professionals were far more committed to spreading the dominant trauma practices than to examining or modifying their approaches to dissemination of knowledge. It is not called a *traumatic stress* society for nothing.

In recent years, we have seen the birth of the disaster mental health field, which centres on mental health care during and after natural or man-made catastrophes. The trauma paradigm is a strong presence in disaster mental health—for example in the

efforts to provide Cognitive Behavioural Therapy (CBT) treatment to survivors—but other paradigms have also gained footholds, including critical incident debriefing, community resilience, risk communication, family assistance, psychological first aid, each of which poses key challenges to the central assumptions of the trauma paradigm. In the field of disaster mental health, there is a legitimate possibility for trauma to interact with other points of view, leading to new insights and approaches.

The present era remains largely one of consolidation and expansion of professional and scientific dialogue on trauma. Given the activities of professional associations (e.g. ISTSS) and government-sponsored research (e.g. NIMH and SAMSA in the US) in promoting the dominant trauma paradigm, sometimes the NGO community has seen itself as the keeper of local knowledge. In some cases local, national, and international NGOs in fact are. In other cases this may be more of a marketing strategy than the truth. NGOs are no less prone to creating and selling problem-centred narratives of "those people" than are other organisations. They may take advantage of the moral spectacle which may be created by images or narratives of victims to accomplish their public relations and fundraising objectives (Weine et al., 2003).

In some post-conflict countries we have seen examples where local professionals were taught by international experts to embrace traumatic stress theory without engaging in any serious inquiry regarding its relevance to their context and culture. The trauma paradigm was hard for them to resist, as it was touted as "modern" psychiatry and psychology, and came wrapped with clinical, scientific, and human rights credentials. Local professionals, who had been practicing a mental health that in some respects was decades behind the rich countries, were often wowed. Besides, being paid or the promise

of being paid was also persuasive enough to have them put local views in second or third place.

International trauma experts found themselves piling on the trauma with exaggerated claims regarding trauma mental health treatment. One reported: “there may be more than one million people in the former Yugoslavia who have suffered psychological trauma sufficient to merit professional help” and “there is no doubt in my mind that post-traumatic stress is going to be the most important public health problem in the former Yugoslavia for a generation and beyond” (Kinzer, 1995).

After war, they claimed, trauma was everywhere. Huge numbers of persons needed trauma treatment. In the former Yugoslavia, this became a dominant narrative which framed the work of many NGOs and of major grants given by government funders. However, after the emergency phase, the funds never arrived to realise the visions of trauma treatment for all, allowing trauma mental health professionals to claim that their visions were sound, but for the shortcoming of donors. Then again, even if the money came, would it ever be possible to achieve the ambitions of trauma treatment for all? Though seductive, it is implausible because it defies help seeking behaviours and a public health perspective in rich settings, as well as the obvious fiscal realities of resource poor-settings.

In some better off countries, the vacuum created by the eventual withdrawal of international humanitarian community and the international trauma experts, led to the entry of the pharmaceutical industry. Seeing a profit to be made amidst a population of traumatised, they courted psychiatrists and psychiatric organisations to prescribe medications for PTSD and depression.

When we think about mass traumatisation in situations of political violence, then we cannot sever trauma from the concerns of peacebuilding and development. Peacebuilding (as distinct form peacekeeping and peacemaking) has been defined as "action to identify and support structures and relationships that will strengthen and consolidate peace in order to avoid resort to, an intensification of, or a relapse to violence" (Jennings, 2003, p.). Development has been defined as "actions that expand people's choices and capacities to improve the economic, social, and political character of their communities" (Jennings, 2003, p.). The relationships between trauma and peacebuilding, and development have been undertheorised and understudied.

In some respects, the goals and methods of trauma work and peacebuilding have been moving closer together in recent years. Trauma work may overlap with peacebuilding in the sense that it aims to diminish fears and negative representations of self or others, not only in individuals but in families, communities, and society thus contributing to consolidating peace. Peacebuilding is not only focussed on governments, but on the human elements of peace, including beliefs, relationships, and communication. Hamber has described the use of narrative strategies for reframing experiences of surviving violence in Northern Ireland and South Africa (2003, 2005, 2007). Weine has explored the use of the testimony to address torture in Chile, the Holocaust, and ethnic cleaning in Bosnia-Herzegovina and Kosovo (2006). Mass traumatisation is both a consequence of a prior failure of peacebuilding, and a possible cause of future failure. Staub has spoken of prior trauma as a possible cause of committing genocide (1999, 2003).

Of course there have been important differences in approaches. Trauma work tends to be emergency and crisis focussed whereas peacebuilding is often more preventive and involves measures taken to strengthen structures and support relationships toward human equity to prevent violence in the future (Christie, 2006). Both trauma and peacebuilding share the assumption that violence springs from disparities and dissatisfaction over structural conditions. But trauma's effects are more focused, whereas the types of structural violence which peacebuilding aims to rectify are characterised as more chronic and indirect. Another distinction lies in the targets of intervention. The trauma perspective envisions a movement toward the status quo restoring the peace that once existed. However, peacebuilding approaches want to rectify structural violence, so the purpose is to challenge and transform the status quo. One additional obstacle to trauma and peacebuilding working together is that the trauma field typically focusses on work with victims, whereas peacebuilding recognises that it is possible to deal with the perpetrators.

Some have pondered the concept of trauma in relation to that of development. Trauma work may be considered part of development in the sense that it enhances locals' capacities to manage post-conflict psychosocial problems in ways that are less of a functional burden. However, trauma work with a clinical focus cannot have much public health impact. Also, PTSD diagnosis often entails getting disability for the affected person. However, trauma work emphasises goals which are distinct from development goals, as the latter focus on transforming socioeconomic conditions. Some in the humanitarian intervention field have posted the concept of the "relief to development spectrum" which to most observers is more of a hope than a reality.

A consideration of the role of trauma in relation to peacebuilding and development should also take into account the ongoing discourse regarding the complicated relationship between peacebuilding and development. Some have claimed that development can be a tool of peacebuilding, in that it also seeks to ameliorate some of the "root causes" of political violence, namely poverty and bad governance (Scholdan, 2000). Multiple governmental and intergovernmental agencies have articulated guidelines for development as peacebuilding. Others attribute the expansion of humanitarian interventions (to encompass peacebuilding) in the 1990s to the shortcomings of government in intervening to prevent and stop political violence. Humanitarian agencies and trauma experts are said to be reluctant to criticise "powerful or regulatory agencies, including government", because it may interfere in their ability to get and do work. As this includes refraining from criticism of political acts it has led to a depoliticisation of their work.

It is not difficult to see that trauma is largely a psychological theory, whereas peacebuilding and development are concepts that belong to social theories. If we want to bring trauma closer to peacebuilding and development, then we are implicitly asking if we are prepared to help trauma enter the social.

We should be aware of several existing concepts that attempted to conceptualise trauma from the vantage point of social and cultural theory, including: Kai Erikson's (1995) notion of "collective trauma", Veena Das' (2001) notion of "social trauma", Maurice Eisenbruch's (1991) "cultural bereavement," Arthur Kleinman's (1997) "social suffering", and Pierre Bourdieu's (1993) "positional suffering", and Weine's "cultural trauma"(2006) and the "trauma bundle"(2008). These conceptualisations are rather

different from the trauma of the dominant paradigm, in which the bottom line claims are that trauma causes emotional injury and psychological dysfunction or disability. Only those who are prepared to relinquish that foundational view of trauma are going to be able to consider socially oriented definitions or to devise others.

Paralleling the expansion and specialization of the PTSD regime has been a growing number of challenges to its hegemony. A proliferation of critiques, which we will review in some depth in subsequent sections, have explored the limitations of a positivisitic, medicalising, individualistic approach to mass suffering. These critiques reflected that all is not so well explained by the dominant trauma paradigm and suggested new paths.

One point of dispute has been over the legitimacy and appropriateness of applying the PTSD diagnosis in catastrophic situations. The tools for diagnosing PTSD get applied in more and more situations, generating epidemiologic research findings that support the claim that PTSD is a global phenomenon. Cultural critics see this as an imposition of outside cultural models that are not sensitive to the needs or strengths of local families or communities and speak of cultural trauma or cultural bereavement. Sociologists draw attention to the fact that trauma can happen to social units also, and call for a paradigm shift toward collective trauma (Erikson, 1995). At the heart of this dispute are differences over the definitions or trauma and differences regarding whether trauma should be the foundation of assessment. However, the hodgepodge of different assessment practices that vary by trauma expert, humanitarian organisation, or by country have not yet suggested a set of principles, standards, or guidelines as coherent as PTSD. PTSD still has the advantage of clarity and technical replicability over all its proposed alternatives.

The accumulated experiences of interveners and programmers globally implementing trauma focussed models, have led to an increased awareness of the key roles of context in shaping effective services. David Becker (1995, 2006), for example, has rejected the diagnosis of PTSD because he claimed that survivors of human rights violations are not necessarily “post”, stressed, or disordered. He proposed a concept of “extreme traumatization” which encompasses both individual and collective processes and social context and occurs over time. Trauma was defined by the feeling of death, the sense of fragmentation, and could be addressed through a special form of psychotherapy. Beyond psychotherapy, the principles of respect, comprehension, and relationship should guide psychosocial work. Trauma, with a psychiatric slant, remained the primary construct around which practice is to be organised.

Another focal point has been the concern over developing services that work in real world situations where disasters strike and help is offered. This requires attention to cultural values and practices, which may not prioritise trauma, memory, or even individuals. It also requires attention to the broad range of psychosocial contexts, especially family and community, which often become focal points for survivors. The psychosocial framework proposed by a consortium of humanitarian interveners is one example of an alternative proposition aimed at making psychosocial work in situations of mass violence less individualistic and diagnostic focussed, and more attuned to broader psychosocial needs. We will consider its strengths and weaknesses in greater depth in a next section.

Meanwhile, innovations in the science of mental health interventions which emphasise community-collaboration, cultural adaptation, and qualitative research, are

slowly being brought to bear upon the trauma model, encouraging further modifications. One example is the emphasis on community resilience, which comes from community psychology.

Nowadays community resilience and family strengths are terms that we hear articulated by some of the same individuals and institutions that previously pushed PTSD models of trauma. Should they be taken seriously? Yes, enough that we pay careful attention to how they use these terms, especially when community resilience collides with PTSD. One such author recently wrote:

"Communities with high rates of posttraumatic stress disorder or substance abuse or domestic violence or child maltreatment cannot be said to be well. If these or similarly severe problems emerge and persist in the aftermath of a disaster, the community has not exhibited resilience" (Norris et al, 2008).

According to this author, PTSD must trump community resilience. If this were so, then the possibility for resilience in communities that have suffered mass violence have been rendered extremely small and insignificant. Is that a conclusion based on an inquiry or is it because for the authors, the conceptualisation of PTSD is more foundational then that of community resilience?

In the trauma field, the dominant cultural narratives of PTSD and the damaged self are so pervasive and foundational as to displace other narratives that suggest either family or community as the levels of analysis or strength and resilience as essential properties. The trauma narrative also tends to displace other societal, community, and family problems from serious consideration, so that narratives that interweave trauma

with these other present problems tend not to get produced. The difficult spot remains primarily a land of plenty of PTSD.

The conventions of clinical science tend to contribute to sustaining dominant cultural notions of trauma in that: 1) trauma work tends to be organised largely around traumatic stress theory; 2) reliable measurement of traumatic events and traumatic stress is the priority; 3) social dimensions are relegated to the background or to secondary or tertiary variables; 4) ecological or family dimensions often defy existing measurement technology; 5) processes or mechanisms are less easily studied than static factors.

Another point of dispute concerns the tensions between clinical and public health views of trauma. We suspect that many of us agree with the public health critiques of mental health in complex emergencies (de Jong, 2002). Disaster interveners find themselves trying to provide immediate services in environments that may have already been lacking in the provision of basic health or mental health services. Public health infrastructure may be weak or non-existent, not only because of damage done by the catastrophe to basic structure, but by ongoing processes of underdevelopment linked with poverty or policy failings. The effectiveness and sustainability of disaster focussed mental health interventions cannot be separated from those matters of ongoing public health.

Another disputed issue concerns the status of prevention. Trauma professionals have advocated early interventions post trauma exposure to ward off developing PTSD (Halperin & Tramontin, 2007). However, research has not shown clear benefit at this point (Ritchie, Watson, & Friedman, 2006). In focussing on early clinical interventions, the trauma field may have not adequately considered the broad array of possible

preventive activities. According to both the WHO (2004, p.) and IOM (Mrazek, 1994, p.), mental disorder prevention aims at, "reducing incidence, prevalence, and recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society". *Primary prevention* which encompasses: 1) *Selective prevention* which targets individuals or subgroups at elevated risk for a mental disorder because of risk factors (e.g. exposure to trauma); 2) *Indicated prevention* which targets persons at high-risk with minimal but detectable signs or symptoms (e.g. traumatic stress symptoms); *Secondary prevention* that seeks to lower the rate of established disorders (e.g. PTSD) through early detection and treatment; *Tertiary prevention* which seeks to reduce disability, enhance rehabilitation, and prevent relapse and recurrence. Preventive interventions in trauma mental health may focus on any of these different points, separately or together. This is a much broader array of possible interventions than the early clinical treatment literature suggests. Prevention is likely possible, but requires more research and practice to know for sure. Unfortunately, in the trauma mental health field there are few if any systematic evaluations of preventive interventions. Furthermore, the existing theories in trauma mental health, while helpful for thinking about clinical treatment and recovery, are not adequate to order this assortment of possibilities into a coherent strategy of preventive services that fits with the IOM and WHO frameworks.

The effort to build different trauma models, such as those focussed on prevention, is often not helped by the funding environment. Mental health across the board is on the defensive, having to provide its value to funders. Relying on the established science of

PTSD is a more reliable strategy than venturing into the land of prevention, which is so much more dependent upon culture and context. It may take years to build relationships and to get to know a context and culture. By the time those arise, and one has developed a formulation based upon local narratives, the funding is over and the humanitarian aid community has moved on to the next disaster.

It is also necessary to question how reliable is "the local" as a reservoir of resilience. Often local resources (e.g. family and community relationships) have been so overwhelmed by circumstances, or inequalities have been revealed. Instead of idealising the local, we should pay careful attention to the tension, fissures, fragments, and conflicts that are a part of local resources and narratives.

Meanwhile, the pressures to change the trauma model have grown due to the proliferation of catastrophes globally. Global warming has intensified weather catastrophes, and changes in environment have also stimulated wars and conflict. Domestic and global terrorism and new and ongoing wars have led to mass casualties among both combatants and civilians.

It may be considered a positive development when each new event receives attention not only from mental health professionals, but from multiple sectors and multiple professions, including first responders, doctors, nurses, lawyers, journalists, aid workers, peace advocates, and even writers and artists. Another focal point has been the interaction with multidisciplinary professionals and scholars, especially in situations of conflict and post-conflict. Journalists have evolved new approaches to reporting on trauma (see the work of the Dart Center for Journalism and Trauma). Legal scholars have explored new approaches to transitional justice which often has a trauma focus (Teitel,

2000). Multi-denominational religious leaders and educators are considering the spiritual dimensions of trauma. These are all examples of attempts to shape not only disciplinary practice but also the public discourse on trauma which in turn impacts on the work of mental health professionals and their use of trauma models. No paradigm exists in isolation or goes unchallenged in this environment.

With all these potentials for interaction, mental health professionals doing trauma work have never seen more opportunities for collaboration, including collaboration between local and national or international colleagues, or collaboration with multi-sectoral and multi-disciplinary providers, and collaboration with communities. Whether there is true collaboration depends on many factors, principle among them being whether mental health professionals are responsive to new demands and new voices that are calling out. Some are, and we are seeing more and more collaborations with multi-disciplinary professionals and with locals. Of course it is also possible that the greater the techniques for communication and spread of information, the more uniform becomes the view of trauma as local views are no competition for the universal trauma paradigm.

We think an important determinant of the response to trauma is the narrative strategies deployed to story trauma, including those used by professionals and scholars. Even when trauma professionals want to deploy trauma approaches in difficult spots, they face the challenge of how to articulate the trauma model. For example, if they want to do prevention, then exactly what is being prevented? We should look more closely at what some voices speaking not for the dominant trauma paradigm have been saying.

ALTERNATIVE PERSPECTIVES ON TRAUMA

Earlier we mentioned some new perspectives have emerged that challenge the traumatic stress model of trauma. Based on theory, methodology, empirical findings, and field practice, from multiple realms of knowledge these have elaborated different ways of mapping trauma. In this section, we consider in greater detail several examples of scholars and professionals who find shortcomings in the stories being told about trauma in the traumatic stress paradigm and who have elaborated alternative perspectives. We consider alternative perspectives from social and cultural critics, mental health professionals, scientists, and humanitarian workers. Each of these perspectives makes different narrative claims and suggests a different path for trauma work.

Cultural and social critiques have taken aim at the conceptualisation of trauma that underlies current patterns of practice in situations of catastrophe. Derrick Summerfield (1999) has written that the diagnosis of PTSD is an example of the "medicalization of distress" and the "rise of psychological therapies". PTSD is a "product of a globalizing culture and increasingly presented as definitive knowledge" (2004, p. 385). Psychiatric labels are placed on persons whose difficulties are more reflective of social and political problems. Summerfield especially objects to refugees being labelled as having psychiatric problems, when what is really the problem are the human rights abuses they have suffered and the disruption to family and community. The term "traumatization" is used too indiscriminately and is basically "pathologizing". "What is fundamental in humanitarian operations is the role of a social world, invariably targeted in today's 'total' war and yet still embodying the collective capacity of survivor populations to mourn, endure, and rebuild". He also opposes the dependency upon "professional helpers" and trauma experts. To Summerfield, the trauma narrative is a

product of western globalised industry and thereby false and must be rejected. The only true narrative is local and social.

In two books, *Mad Travelers* (1998) and *Rewriting the Soul* (1995), Ian Hacking, a philosopher of science, argues that psychiatry took elements of the human responses to suffering that were originally found in religious and cultural activities and then tried to render them accessible only to itself by employing highly privileged technical understandings. Psychiatrists made the claim that the phenomenon of trauma could not be grasped without understanding traumatic memory as only they understood traumatic memory. Psychiatry prioritised trauma-related cognitions and in comparison de-prioritised other dimensions of human experience, including consciousness and ethics. Hacking critically examined the processes that led to their prioritisation by a profession trying to establish a legitimate niche in its society. Hacking questioned trauma mental health professionals' claim that they alone could perform treatment and interpret the meaning of its content and trauma in general. Relieving survivors' suffering through psychiatric professional activities may have been useful to build the profession, but is it necessary or the best for individual patients or for society as a whole?

Patrick Bracken (2002), drew on the philosophy of Heidegger to write that the focus on memory is so biased toward individual cognition as to remove persons and their stories from cultural, social, and historical contexts. He wrote: "The trauma, or the traumatic memory, is understood to be 'stuck,' or 'repressed' somewhere in the individual's mind. It has to be brought forward, centre-stage, examined and processed". Because trauma mental health work typically regards traumatic memory as residing in individuals, it looks to individual interventions and focuses on changing their cognitions

to diminish trauma-related symptoms. Bracken strongly questioned the appropriateness of applying these western assumptions in cross-cultural settings, especially in postwar countries. Bracken also critiqued the tendency: (1) to overemphasise that trauma-disturbed cognitive mechanisms in individuals pose obstacles to peace and reconciliation; (2) to extrapolate these individual phenomena to the larger group level; and (3) to believe that these must be transformed through clinical or psychosocial interventions. He wrote: "A Western, 'technical' way of thinking about suffering and loss is being introduced to people when they are weak and vulnerable. The effect is often to undermine respect for local healers and traditions and ways of coping that are embedded in local ways of life" (p.) Imposing the western based cognitive approach may be a form of disrespect for local cultures of local people.

Cultural anthropologists have critiqued the "judicial or media-oriented confessional models" of knowledge of political violence and have advanced the role of ethnography in documenting histories through longer-term and community-oriented methods. Arthur Kleinman (2001, p.) referred to the "crucial mediatization of violence and trauma in the global moral economy of our times" which "creates a form of inauthentic social experience: witnessing at a distance, a kind of voyeurism in which nothing is acutely at stake for the observer". By imposing theory-driven "social scripts" explaining collective violence, "global institutions and agencies of the state have often inhibited the mechanisms of restraint and notions of limit that have been crafted in local moral worlds". Trauma narratives, as designed by trauma professionals, also find a place in the media. They are culturally determined social scripts which may be better serving global processes than local ones.

The anthropologist Veena Das (2001) focusses on “social traumas” and the “remaking of everyday life” in survivor communities. After experiencing the extremities of atrocity and loss, she showed survivors trying to reassert the normal in their lives, and how this necessarily involved their struggling with language. Das contrasted the efforts of individual survivors and communities to remake everyday life with professionals’ heavy-handed efforts to claim those experiences as a part of the clinical enterprise. Das expressed a faith in survivors’ ways of working things out in their lives. To Das, survivors were conversing, sharing, and exchanging in many ways that facilitated healing, and what her text did was document, rather than engineer, those processes.

These social and cultural critiques give new perspectives and new models, and they also create new sensibilities and new narrative frameworks that challenge the dominant trauma paradigm. However, in and of themselves they do not build programmes or policies. We would like to review the work of several professional and scientific practitioners whom have designed, operationalised, and evaluated new models that challenge the trauma paradigm. They have also tried to build systematic knowledge on their work.

Peace psychology, which aims to prevent violence, has developed innovative approaches to trauma work including preventive community action; mental health counselling; and psychoeducation (Hoshmand & Kass, 2003). Psychosocial interventions in post-conflict reconstruction aim to facilitate the transition from war to peace, halting the “ongoing cycles of violence” (e.g. disruptions caused by persons who consider themselves “wronged victims”, or by families and communities that are awash in fear or traumatic memories). Psychosocial reconstruction may include a broad range of

activities, including, “the social reintegration of former soldiers; community mobilization; social integration of displaced persons.” (Wessells, 1999, p. 264). Wessells described a “community-based approach” towards addressing war stresses and towards reintegrating underage soldiers in Angola. The central principles of these programmes are: 1) a holistic rather than individualistic approach; 2) community-based focus on local participation and leadership; 3) a culturally sensitive approach that is consonant with local beliefs and attitudes; and 4) an emphasis upon systematic documentation and evaluation.

Joop de Jong (2002) and his colleagues at Healthnet/TPO designed, implemented, and evaluated a model of public mental health. Public mental health is defined as the discipline, the practice and the systemic social actions that protect, promote, and restore the mental health of a population. Public mental health is part of public health. In resource-poor countries, de Jong and colleagues have developed mental health programmes. In weighing if and how to intervene, one must weigh issues not often considered in the trauma paradigm, including prevalence, community concern, seriousness of disorders, treatability, sustainability, availability of professionals, political acceptability, ethical acceptability, cultural sensibility, and cost-effectiveness.

Some have approached the issue of public mental health with a focus on family, given that family is such an important social context for those who have endured political violence. Weine and colleagues have drawn from family ecological theory and developed several empirically based family interventions to provide access, treatment, and preventive interventions for refugees and other survivors of political violence. This has included multiple-family group support and education interventions for refugee families

and youth in situations of resettlement and a psychoeducational multiple family group for families of severely mentally ill in a post-conflict country. Research findings have demonstrated the interventions' effectiveness (2008). In Kosovo, the design, implementation, and evaluation of the psychoeducational multiple family group was part of a larger effort aimed at making broad systemic changes (2005, 2006). Through collaboration with local professionals and communities and the Ministry of Health, the team built a family-oriented national public mental health system, conducted research on psychoeducational family groups, and designed and piloted an intervention for HIV prevention amongst adolescents (2005). In addition to the focus upon family, this work used the methods of prevention science with an empirically based conceptual model, standardised intervention manual, and standardised methods of assessment.

A collaboration of academic centres and humanitarian agencies called the Psychosocial Working Group formed in 2000 to confront the confusion and variation surrounding psychosocial interventions (2002, 2003). The Group established a common framework for psychosocial interventions and created tools that agencies can utilise when determining the suitability of various types of interventions. It describes three key areas in which psychosocial well-being can be affected during complex humanitarian emergencies and therefore, may require restoration (human capacity, social ecology, and culture and values). In the setting of armed conflict and displacement, people may experience loss and disability, both in the household as well as in their greater community, which may lead to feelings of depression, isolation, and incapacitation. Community dynamics and social networks are disrupted, leading to broken relationships

and dysfunctional organisations. The culture and values of communities can be challenged, assaulted, and even destroyed.

Psychosocial interventions are directed toward reduction of the psychological consequences of mass violence. The "psycho"component facilitates "…the reconnection of the affected individual to his environment, his community and his culture" (de Jong & Kleber, 2002, p. 498). Programming includes psychiatric support through referral of clients, supportive counselling to strengthen coping mechanisms, and the training of national leaders toward listening attitudes. The "socio"-component aims to facilitate an environment that assists the individual with re-integration into society. Practical services such as food, sanitation, and medical care are undoubtedly of first priority. However, it is also critical to facilitate the rebuilding of a community's social fabric and encourage community activities and education, and to facilitate political advocacy. Sensitivity to local worldviews and cultural practices must be actively sought to ensure effective therapies. Cross-cultural programming and assessment is vital for community acceptance and participation. Ongoing monitoring and relevant human rights-based advocacy is also part of *Médecins Sans Frontières's* (MSF) intervention philosophy.

Several guidelines and standards for best practices in situations of complex emergency have been developed and disseminated such as the Inter-Agency Standing Committee Guidelines (2003) and the Sphere Project Handbook (2004). It has proven far more difficult to conduct empirical research with the psychosocial model in complex emergencies. From a prevention science point of view, the lack of tight conceptual models and clearly defined and measurable target goals raises concerns about the ability of the psychosocial framework to lead to demonstrably effective programmes.

The final area of alternative perspectives that we want to focus on explicitly concerns the narrative. The narrative is a key concept which has anchored alternatives to trauma work in situations of mass violence. When survivors give accounts of the events of political violence that they themselves have endured or witnessed, it often comes as a story, which is referred to as a testimony. Survivors of political violence give testimonies at trials and truth commissions, in families and communities, in religious institutions, in psychotherapies, documentaries, artworks, and even in solitude. These stories carry unusual intensity, beauty, truth, and power. Interveners often seek to shape and those stories to achieve the desired ends. Sometimes this is for good reason, but always a price is paid.

In 1997, the psychiatrist and psychoanalyst Dori Laub and the literary scholar Shoshana Felman used the concept of testimony in their influential work, *Testimony: Crisis of Witnessing in Literature, Psychoanalysis, and History* (1992), which combined literary criticism and psychoanalysis. Their writings are key texts of Holocaust studies and trauma work with survivors of the Shoah and other forms of political violence. They emphasised the value of listening to the entire story which is a value of both psychoanalysis and literature.

The Danish mental health professionals, Inger Agger and Søren Jensen described "the testimony method" (first derived by the Chileans), in their 1996 book *Trauma and Healing Under State Terrorism*. Inger Agger authored *The Blue Room: Trauma and Testimony among Refugee Women* (1994), based upon testimonies she conducted with women refugee survivors of trauma and torture. These works are widely read and cited by humanitarian workers and scholars concerned with political violence. Testimony is

shaped by gender and women's lives and offers an arena for meaning-making and for individual and social healing.

Richard Mollica (2000) describes the trauma story and argues for the healing potential of storytelling. Telling trauma stories can establish connections, diminish isolation, and enhance the biological extinction of traumatic memories. The "full trauma story" rather than the "toxic trauma story", encompasses more than just the horrific details of an attack; it also includes the broader experiences and knowledge of the person, including spirituality.

These uses of a narrative approach attempt to put the qualities of the narrative at the service of individual and social healing. They are deploying particular characteristics of narratives to bring about the types of changes that trauma psychotherapy deems worthwhile. They focus much more on the production of trauma narratives then on their reception, dissemination, or transformation. Trauma stories can be constructed by respecting or facilitating the survivor's need for a ***plot***, which lends structure by establishing a sequence of events over time. Trauma stories offer a means for including disparate and extreme experiences, memories, and emotions, which are otherwise ***non-articulable***, into one coherent narrative. Trauma stories convey a point of view and actively attempt to represent the individuals' interpretation of events. There tends to be more emphasis on production of these narratives, but their reception clearly matters to all the authors. Certain narrative principles are not adhered to by these purveyors of narrative. For example, the professional is given the power of authorship to shape, interpret, and communicate the narrative. Although many aspects of the individuals'

unique local perceptions come through, some do not, and that can be a limitation. In many cases, the foundational assumptions of trauma are not put into question.

The difficulty in conceiving of reception is in part the difficulty of making the shift from a focus on individual healing and truth-telling, to community resilience or resistance. It is far more difficult to conceptualise, let alone operationalise and assess, community level approaches to narration.

In work done with colleagues one of the authors (Weine, 2006) has applied the narrative philosophy of the Russian literary scholar Mikhail Bakhtin in ways that speak not only to healing strategies, but also that attempt to understand and reconceive the problems of trauma work in complicated situations. We contend that Bakhtin's dialogic work offers a way to rethink the dichotomous thinking that has polarised the field, where trauma either exists or does not exist and where we either focus on the individual or on the collective.

In his book on Dostoevsky (1963), Bakhtin described what he called "dialogic work," which Caryl Emerson explained as follows:

> Each word contains within itself diverse, discriminating, often contradictory 'talking' components. The more often a word is used in speech acts, the more contexts it accumulates and the more its meanings proliferate (Emerson, p. 36).

Words carry meanings, that when repeatedly used accumulate more and more meanings, creating ever more complex webs of memories, emotions, and experience. Dialogic work holds that truth must be sought through a "responsible and active discourse" involving the dynamic interactivity of multiple voices or points of view. One point of view is always shaped by its connections to other points of view, and all are held together in a

dialogic relation. Dialogic work is never easy. That is certainly true when applied to trauma and testimony. However, dialogic work can assist in getting a handle on the ongoing conversation on peacebuilding and development into which trauma has entered.

Unlike PTSD work, which has led to preparing clinical treatment guidelines based upon clinical research findings, and the psychosocial framework, which has led to guidelines, narrative approaches reject non-narrative codification and at present point to statements of principles and reflections on how they might be applied.

NARRATIVE ALTERNATIVES

"…following the lead of novelists such as Faulkner, Joyce, and Woolf we must relinquish the single, central, dominant, in a word, quasi-divine, point of view that is all to easily adopted by observers – and by readers too, at least to the extent they do not feel personally involved. We must work instead with the multiple perspectives that correspond to the multiplicity of coexisting, and sometimes directly competing, points of view." (Bourdieu, 1993, p. 3).

We who work in situations of mass violence labour in worlds saturated with a plethora of factors that, according to Saul Morson (2003), contribute to narratives being essential: presentness, contingency, messiness, unpredictability, the need for alertness, possibilities in excess of actualities.

Were we novelists, then we would ask: what do the narratives want from us? A novelist strives to maximise the status of the narrative in their books. As mental health professionals who do trauma work, our position is not so totally committed to the narrative as a novelist. But given all the pressures, and our proximity to survivors'

narratives, it is remarkable what little hold the narrative has on our professional and scientific approaches in our field.

The professions of psychiatry and psychology appear to be no longer in a position where they are centred on narrative. Contemporary trauma practice has moved away from being based upon trauma stories. Instead of narratives we have the science of traumatic stress. Has our science evolved to the point where narratives are no longer needed, except perhaps as illustrative examples? We know that if a person is exposed to a traumatic event that they are likely to develop traumatic stress symptoms and are at risk of developing PTSD. Isn't that enough? So do we really need narratives?

My answer is emphatically yes, we need narratives. We need them because what we know about trauma does not work adequately enough when we try to understand or address trauma in situations of mass violence, including when the agendas of peacebuilding and development intervene. Our review of trauma work in mass traumatisation revealed that many in our field, including those trying to find innovative approaches, may be trying to solve problems in difficult spots that may call for narrative approaches, but doing so without more fully using narrative approaches.

Perhaps we should learn from how similar challenges have been approached in other fields. Stewart and Rappaport (2005) has described a community narrative approach for HIV/AIDS, which lends itself well to the trauma field, as "an especially useful means to understanding, cultivating, and/or mobilizing shared experience and conceptualizations". Community narratives create narrative communities, whereby people are more than problem-ridden victims, and for example, can better commit to

preventive activities. In the trauma field, we need community narratives that story resilience as it is found in difficult spots.

Our services research team has been characterising resilience amongst adolescents and their families in refugee in the urban US (2004, 2006). Resilience research has largely employed longitudinal and epidemiological methods to describe risk and protective factors. Understanding the processes by which risk and protective factors lead to changes in different cultural contexts has not been a major focus. Amongst Burundian and Liberian refugees in the U.S., we are characterizing the protective processes which reside in families and communities, and are using that to inform the development of preventive interventions.

We would never claim that narratives are all that we need to do trauma work. We need, for example, theory, methods, and information that is not necessarily dependent upon narratives. We especially need science and quantitative analysis in that they provide us with reliable means of systematically understanding complex phenomenon, and evaluating their effects at helping. But the science we need is not restricted to one methodological or theoretical framework, as in the rut of traumatic stress. However, we recognize that science alone will not do it. Do we have cognitive behavioural therapy (CBT) because it suits the science of the randomized control trial (RCT) or because it suits the populations that need help? In our opinion, the trauma field needs to evolve in a direction in which narratives will have more of a place. But we are not novelists, so the narrative is not going to be the dominant organising principle. Because we are committed to the real word, we use narrative approaches to best represent the characteristics of living in those difficult spots. This section describes several considerations for narrative

approaches trauma work in difficult spots that we arrived at from the concept of dialogic work.

Speech Genres. Trauma itself is shaped by speech genres, including those of survivors, of politicians, of the media, of religion, of law, and of health and mental health professionals. Each of these groups has explicit rules or implicit expectations governing how trauma is named and expressed. Those of us who work in difficult spots could pay more attention to understanding the impact of these patterns of spoken language upon trauma work. My impression is that there are two errors that we who do trauma work are prone to making more than any others.

The first is that we are prone to believing that people who experienced traumas are necessarily wounded. Perhaps we say that because trauma is a confusing term in that it refers both to the event that may have wounded and to the wound itself (Erikson, 1995). As a consequence, we are too prone to thinking that they are one and the same thing and thus represent that all persons exposed to traumatic events are pathologically wounded and need professional help.

A second error that we are prone to is inflating the social significance of our trauma work or our roles as trauma professionals. Trauma work almost always borders on the social. But this does not mean that it is essentially social. The language of trauma, however, is prone to slippage between the individual and the social, as when we link our work with human rights. We may be prone to thinking that our trauma work is accomplishing something social, when it really isn't. As a consequence we may not be paying adequate attention to intermediate social fields such as the family and community.

These are two examples of the vulnerabilities with the language of trauma that we must take special care about. We need to start with better listening to those who are directly impacted by trauma in all kinds of different contexts. We must also pay attention to how the language of traumatic events, traumatic consequences, symptoms and distress, disability, treatment and rehabilitation, rights, resilience, transformations, and recovery are framed by the language of victims, families, communities, leaders, providers, service organizations, and donors. The concept of the speech genre, as originally described by Bakhtin, can assist with that analysis, as we have shown in a prior analysis of several speech genres of testimony (Weine, 2006).

Contingencies. Our trauma science prizes predictability. If we know these particular characteristics, then we can be certain to a degree of the outcome. We want to be able to predict what happens as a consequence of traumatic events and what happens as a consequence of interventions. But the worlds we enter are full of too many factors for us to be able to meaningfully predict the outcomes. We have built a predictive science that has described the factors to points of perfection that may have lost their correspondence with the realities of life in difficult spots.

Rather than focus on prediction, we might try focus upon contingencies, which are conceived of as possibilities, but for which uncertainty can never be eliminated. Of the many different types of contingencies, the most oft mentioned contingencies with respect to trauma response are context, culture, and time.

Contingencies in these realms cannot be described only by factors that are present or absent or quantifiable, although those are helpful. We need to see how those factors are being storied or how the stories being told about individuals, families, or communities

are built upon those contingencies. It is the stories enveloping the factor, not just the factor itself, which is a determinant of people's lives.

If our aim is to change behaviour, then we could be trying to look for the stories that matter the most in people's lives. If we know those stories, and can incorporate them into our behaviour-changing interventions, then our helping efforts are likely to be more compelling to people. They will make people want to participate and they might make a bigger impact. We do not know how to help people until we can understand them in their language, in their values and traditions, and in the places that they live. We learn that through how they story their lives.

Time may be the least well understood contingencies of traumas. Ironically, is often the one most elaborated. We have an excess of frameworks that describe set phases of trauma response. Why is it so difficult for many of us in the trauma field to appreciate the openness of time? Could it be our response to the sudden maximal collapse of time that traumatic events often bring? Or is it our heavy-handed attempt to limit the possibility for events being unpredictable? When experience is robbed of open time, then we know what is going to happen next. Because of our assumptions about the time characteristics of the traumatic event, we have deprived individuals who have experienced trauma of all possibilities and replaced them with known actualities. We have also collapsed into a unitary time sense all the various layers of time that pertain to individual development, family life cycle, social and cultural transitions, trauma recovery, etc. which are all active in trauma survivors.

A narrative perspective enables us to not let such time biases go unexamined, such that instead of binding ourselves to fixed frameworks of time for viewing trauma

(chronological time phases), we may consider alternative models of time such as heterochrony, which give survivors, communities, and professionals more flexibility to explore and represent trauma experiences. In the language of survivors (e.g. Hans Novac), and the artistic representations of the survivor experiences (e.g. W.G. Sebald), we may find brilliant examples of narratives with an open time sense. Our challenge, which is certainly achievable with narrative approaches, is to build professional and scientific models that similarly respect the openness of time, as well as other contingencies.

Collaborations. If we are committed to narratives, then we are committed to the many voices and positions from which narratives can be told. We want to hear what these others, be they survivors, family or community members, or elites, have to say. We want to respond to them with our own words, and let the dialogue begin. We despair how mistrust and competitiveness amongst and between professional disciplines, academies, and service organisations obstructs and limits the possibilities for dialogue. We would always prefer a vigorous debate to a false consensus or silent withdrawal.

Some of the most important collaborations that we can form are with survivors/victims groups, local professionals, religious persons, persons from other disciplines, and artists. These are the persons who have the knowledge, perspective, information, moral positioning, and relationships that we want to know if we want to understand and impact life in difficult spots. It is not possible for us to claim legitimacy if we are not actively soliciting and responding honestly to all these and other voices. However, to be able to respond to them means that we need to prepare ourselves and to clarify our approaches.

Aside from partners in the social sciences and humanities, we can derive incredible benefit learning from other types of scholars and professionals including those from rhetoric, anthropology, sociology, family studies, communications, history, and political science as well as the health disciplines of nursing, public health, and social work.

Lastly, as has been written about the impact of reading the Beat poet Allen Ginsberg: Never underestimate what can happen when you people encounter a great work or art or artist (Rosenthal, 2006). This serves as a reminder that literature and the arts provide many powerful examples of narrative means of representation of the experience of trauma and resilience.

Processes. Bakhtin used the concept of "eventness" to indicate that the meanings of a given event were open, and were created and recreated through dialogue. Eventness is another way of focussing on the processes by which changes occur or not, and the presence of these processes means that the story is not over. We do not yet know how things are going to turn out. There are several possible futures from a given past. For situations of mass traumatisation, there are so many important processes about which we actually know little. For example, what are the mechanisms through which protective factors confer resilience? How do family protective factors, such as parents talking with children about difficult topics, lead to better outcomes? The answers to these questions about processes can be best represented by narratives.

The scientific methodology that maximises looking at narrative process is ethnography. The ethnographer looks at the world from the inside and tries to see how others see it. If changes occur, then they are seen to occur in the context of daily lives.

The ethnographer begins with a set of questions or tentative claims and then goes to the field to listen and observe and collect data. Using an iterative process, questions and claims are refined, leading to more focussed data collection, and so on, until a set of more complete narrative understandings emerges. Nevertheless, it is quite possible to use ethnography or other qualitative methods but to not be concerned with process. In the trauma field, this has been done by ethnographers who turned to narrative simply as illustrations of the ready-made trauma paradigms. For that reason, it is of concern when we encounter naive endorsements from trauma professionals of qualitative research as an escape valve from its own closed system of meanings. Ethnography, like any narrative approach, offers that potential, but it is by no means guaranteed.

The study of process does not belong only to qualitative methodology. One exciting way of modelling processes of change can be found in hierarchical linear modelling (Hedeker & Gibbons, 2006). By not reducing variables to means, and instead by characterising the trajectory of individual variables, we are able to capture the sense of the process of change. This recognition gets us away from simplistic thinking that narrativeness is equivalent to qualitative research and not a part of quantitative research.

Services. Most of us who work in difficult spots want to be helpful and recognise that this means we have to be practical. We want to offer help that fits with the needs, meanings, and strengths of persons in the places where mass traumatisation strikes. If so, then instead of telling trauma stories based largely upon the psychopathologic core set of assumptions, the stories we want to tell should be about seeking, receiving, and offering help in difficult spots.

The story may go like this: You or someone you know has a problem for which help is needed beyond the capabilities of those to which we ordinarily turn. You didn't cause the problem but now it's with you. Who are you to go see, for what reasons, through what obstacles, and at what cost to you or your people?

Or if you are the provider, then you may ask, what situation do I need to build, with what kinds of doors, window, and walls, informed by what kinds of values and approaches, to get people to come and get the help that they need?

In such stories, services are not only mental health services. They include the help which is offered by mental health and health workers, teachers, religious leaders, attorneys, aid workers, community organisers, and even artists. The stories speak not only to individual experiences of services, but to the experiences at other social levels, such as family, for which there may be no readily available measurement.

The stories of services tell us something different that objective measures, if they are available. Instead of telling us what changes were caused, they tell us how or why they came about, in this particular setting, with these particular players.

Given the complexity of living in difficult spots, the stories would very likely show that trauma is social and does not stand alone. Rather, it coexists with other major social problems and demands, meanings, and resources. It would also likely show that trauma interacts in multiple and complex ways with peacebuilding or development. Narratives could tell new stories about the relationship between trauma, peacebuilding, and development.

Then the question is why stop with peacebuilding and development? Why not include relationships with other major social problems such as poverty, drugs,

HIV/AIDS, crime, education, and terrorism? The trauma field, which has sometimes shut the door on other difficulties, may have a lot to answer for. But when we open the door, we should be concerned whether we have found ways of dealing with how people live in those difficult spots that is likely how we will be judged.

In conclusion, existing models of narrating trauma in trauma work are very limited. It should be possible to narrate trauma in many different ways. There is no single way to narrate trauma that has the answer to help people in difficult spots. However, if we were to draw upon different possibilities for narrating trauma, then we would improve the possibilities for doing trauma work in difficult spots. We need new models that incorporate narratives. We will not get there without listening. We will not get there without dialogue and collaboration. Lastly, we need professional and scientific leadership that is committed to innovative approaches to what we can be done in difficult spots

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